Bundle Audit Committee 18 March 2021

1 10:00 - OPENING BUSINESS - OPEN SESSION

1.1 10:01 - AC21.01: Apologies for Absence

1.2 10:02 - AC21.02: Declarations of Interest

1.3 10:03 - AC21.03: Procedural Matters

1. To confirm the Minutes of the last meeting of the Committee held on 17/12/20 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 (in terms of publication of Board/Committee papers) to the Standing Orders (appendix c)
4. agree Audit Committee Cycle of Business (appendix d)
5. Approve the Joint Audit and Quality, Safety & Experience Committee Minutes. (appendix e)
6. To note that it is intended to present the draft Annual Report and draft Annual Governance Statement to the Audit Committee Workshop scheduled for 25th May. This workshop will also consider the suite of Committee Annual Reports together with the Audit Committee's draft Annual Report prior to finalising the reports for presentation and final sign off by the Audit Committee on 10th June. It is proposed that Members of the Audit Committee undertake a self-assessment of performance this year which will be facilitated by Internal Audit. The output of this assessment will be presented to the workshop on 25th May and will form part of the Audit Committee Annual Report.

AC21.03a: PUBLIC_Draft Minutes_Audit Committee_17.12.20_V0.01.docx

AC21.03b Public Summary Action Log_Audit Committee_live.docx

AC21.03c Breach log extract_.docx

AC21.03d Audit Committee CoB_March 21.docx

AC21.03e: Minutes JAQS 24.11.20 V0.03 agreed by QSE on 15.1.21.docx

1.4 10:18 - AC21.04: Issues Discussed in Previous Private Session

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

AC21.04 Private Session Items Reported in Public_March_21.docx

1.5 10:19 - AC21.05: Chair's Assurance Report: Risk Management Group

The Audit Committee is asked to receive the Risk Management Group Chair's Report.

AC21.05 Committee Chair's Assurance Report-RMG 18-Jan-2021-v0.1 draft.docx

2.0 10:29 - AC21.06: Internal Audit Progress Report

The Audit Committee is asked to:

1. Receive the progress report; and
2. Approve the Internal Audit Plan 2021/22
3. Receive and discuss the following Limited Assurance Reports:

** Business Continuity - Informatics*
** Governance Arrangements - Mental Health & Learning Disabilities*

AC21.06a BCUHB Internal Audit Committee cover sheet March 2021.docx

AC21.06b BCUHB Audit Committee progress report March 2021.docx

AC21.06c BCUHB Internal Audit Plan 21-22v5.docx

AC21.06d Final Internal Audit Report - Business Continuity - Informatics.pdf

AC21.06e Internal Audit Report MHLDS Governance arrangements.pdf

3.0 10:59 - AC21.07: Audit Wales Update Report

The Audit Committee is asked to receive and discuss:

1. Audit Update
2. Confirmation of External Audit Plan
3. Doing it differently, doing it right all Wales report on governance in the NHS during the pandemic
4. Procurement of PPE letter (for information)
5. BCU response to WFG report including the Implementing the Well Being of Future Generations Act - BCUHB, Management Response and letter from the Future Generations Commissioner to the BCUHB Interim Chief Executive

AC21.07 Audit Wales Coversheet - Audit Wales.docx

AC21.07a BCU AC Update Mar 2021.pdf

AC21.07b BCUHB_Audit_Plan_2021_Eng.pdf

AC21.07c Doing-it-right-Eng.pdf

AC21.07d PPE_Letter_English.pdf

AC21.07e Final_WFG paper April 2020.docx

AC21.07f FGW Appendix 1 - AGW report.pdf

AC21.07g FGW Appendix 2 -Audit_Management Response.docx

AC21.07h Well Being Future Generations Update.pdf

4.0 11:29 - AC21.08: Schedule of Financial Claims (public)

This report is presented to the Audit Committee to support the discharge of its responsibility to ensure the provision of effective governance.

The report includes two tables – one containing summary information for the public report and a more detailed tab for the private report which includes additional information that may be patient/staff identifiable (presented in Private session)

AC21.08a Claims Report - Over 50k Spend Closed Q3 2020-21.docx

AC21.08b PUBLIC Closed Claims Over 50k Spend - Q3 2020-21.xlsx

6.0 11:39 - AC21.09: Dental Assurance Report

The Audit Committee is asked to note the contents of this paper and the actions implemented to provide assurance of the maintenance of an effective dental service during the Covid-19 pandemic and other processes to protect the public purse expenditure the management and commissioning of General Dental Services.

AC21.09 Board and Committee Dental Report 20210309.docx

7.0 11:59 - AC21.10: Legislation Assurance Framework Bi Annual Report

AC21.10 Legislation Assurance Framework_Mar_2021.docx

8.0 12:14 - AC21.11: Issues of Significance for reporting to Board

8.1 12:15 - AC21.12: Date of Next Meeting: 10/06/21

8.2 12:16 - AC21.13: Exclusion of Press and Public

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

AUDIT COMMITTEE PUBLIC MEETING DRAFT
Minutes of the Meeting Held on 17.12.20
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	
Sally Baxter	Associate Director - Coronavirus Co-ordination, Planning (for Minute AC20.90)
Andrew Doughton	Performance Audit Lead, Audit Wales
Simon Evans-Evans	Interim Director of Governance
Sue Green	Executive Director of Workforce and Organisational Development (for Minute AC20.90 and AC20.91)
Dave Harries	Head of Internal Audit, NWSSP
Sue Hill	Executive Director of Finance
Amanda Hughes	Financial Audit Manager, Audit Wales
Matt Joyes	Acting Associate Director of Quality Assurance (for Minute AC20.69)
Dawn Sharp	Acting Board Secretary
Chris Stockport	Executive Director for Primary and Community Care(for Minute AC20.92)
Bethan Wassell	Statutory Compliance, Governance & Policy Manager

Agenda Item	**Action**
AC20/85: Opening Business and Apologies for Absence. The Chair welcomed members and attendees to the meeting. No apologies were received.	
AC20/86: Declarations of Interest. No declarations of interest were made at the meeting	
AC20/87: Procedural Matters. **AC20/87.01**: The Acting Board Secretary presented the items.	

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AC20/87.02: An administrative error was highlighted in the September minutes at AC20.70.01 – 'presented' should read 'prevented'.	DS
AC20/87.03: Whilst members concurred that it was a positive development to see that all actions had been addressed, there remained a question as to whether action AC20.71.08 (COSHH training) was complete. The Independent Member who raised the original query stated that further information was required as to the *uptake* of training. This was expected to be expressed as a percentage for compliance, similar to the information provided for mandatory training. i.e. Number of employees required to undertake training and numbers trained. Essentially, the Audit Committee was seeking assurance that the Acting Executive Director of Nursing & Midwifery was content that sufficient training was being undertaken. It was agreed that clarification would be sought from the Acting Executive Director of Nursing & Midwifery.	DS
AC20/87.04: An Independent Member queried the Breach Log and asked that the papers for the Board meeting in November be checked as it was their recollection that there may have been breaches in terms of late papers. The Acting Board Secretary agreed to review and update Members.	DS
AC20/87.05: Members proceeded to discuss the amended Terms of Reference (ToR) for the Remuneration & Terms of Service Committee. An Independent Member queried the language in section 6.1 (Quorum) and whether 'expected' was correct in terms of Executive attendance. The Acting Board Secretary advised that formal quoracy related to Independent Member attendance and that the language was utilised across all ToRs. Another Independent Member requested that section 3.1.3 be updated to ensure that the description sufficiently covered all clinical staff, for example – radiographers, who were not technically covered by use of the term 'allied professionals'. The suggestion was that 'allied professionals' be replaced with 'registered professionals'.	DS
AC20/87.06: An Independent Member queried the 'flag' icon utilised on the attendance table within the Local Partnership Forum Annual Report 2019/20 as it was not explained in the key. The Acting Board Secretary agreed to seek clarification.	DS
RESOLVED: That 1. the Minutes of the last meeting of the Committee held on 17/09/20 (Appendix A) be confirmed as a correct record subject to the minor correction referred to above ; 2. the Public Summary Action Log (Appendix B) was received and discussed;	

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3. the Standing Orders Details of Breaches (Appendix B) be noted and further clarification be sought as to the Board meeting on the 12/11/20; 4. the Clinical Audit Annual report approved at the Joint Audit & Quality, Safety & Experience Committee (JAQS) be noted; and 5. the Chair's Action in respect of the deferment of the Internal Audit Leaver Management Review be noted; 6. the Joint Chair's Action in respect of the COVID-19 Cabinet Terms of Reference be noted; 7. the Audit Wales consultation on proposals for fee rates and other aspects of the statutory fee regime for audit work be noted; 8. the amended Terms of Reference for the Remuneration & Terms of Service Committee (Appendix D) be approved subject to the amendment at 3.1.3 as outlined above; 9. the Chair's Action in respect of the approval of the following Committee Annual Reports be noted; • 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)	
AC20/67: Issues Discussed in Previous Private Committee Session. **RESOLVED:** That the report on issues discussed in the previous Private Committee session be noted.	
AC20/89: Chair's Assurance Report: Risk Management Group **AC20/89.01:** The Chair welcomed the Interim Director of Governance to their first Audit Committee meeting and went on to note that there were persistent governance concerns and themes in terms of meeting quoracy, frequency and minutes etc. across numerous areas, the Risk Management Group (RMG) being one of them. This had previously been raised at the September Audit Committee. The Interim Director of Governance advised that they were aware of this and it had recently been highlighted to the Acting Chief Executive (CEO). This was an item on their agenda and would be addressed in the next phase of work. Specifically, with regard to RMG, the Interim Director of Governance had attended two meetings where they had observed thorough discussion and debate, which was positive. However, the group was again not quorate and the RMG Chair had agreed to escalate this to the Executive Team's attention. **AC20/89.02:** The Chair also queried why the Executive Director of Workforce and Organisational Development had chaired the last RMG meeting as this was contrary to the Group's ToR that specified that the Chair was the Deputy Chief Executive and Executive Director of Nursing	

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& Midwifery. The Interim Director of Governance advised that this was due to temporary arrangements, namely that the Deputy Chief Executive and Executive Director of Nursing & Midwifery was currently acting up as the CEO. This role had a dual function and whilst the Nursing & Midwifery element of the Acting CEO's substantive role had been backfilled, the governance element of the Deputy CEO had not. This was currently being overseen by the Executive Director of Workforce and Organisational Development hence why they had chaired the meeting. However, it was expected that by January, the substantive CEO would be in post and the Acting CEO would return to their substantive role and resume the RMG Chair. 1. **RESOLVED:** That the report be noted.	
AC20.90: Board Assurance Framework and Corporate Risk Register **AC20.90.01:** The Interim Director of Governance presented the report. The Chair noted that the Audit Committee were not satisfied with the quality of the report. There were formatting issues, what appeared to be 'draft notes' and incomplete sections. This was not acceptable for a report at a board level public committee. The Interim Director of Governance agreed, it was disappointing that the report was incomplete though some of the formatting issues were due to the document being converted for uploading into the electronic agenda/papers system. However, the recommendation was to approve the general format/design of the report and there were other positive developments. The Board Assurance Framework (BAF) was now actively being discussed at the RMG and the Executive team. **AC20.90.02:** The Chair went on to note reference to a risk (risk ID 3739) that the Risk Management Strategy and Policy may not be timely and robustly implemented. The Chair queried this as Members had previously been assured at the Joint Audit, Quality & Safety Committee that implementation was on schedule. The Interim Director of Governance advised Members that the core Strategy had been implemented. All new risks were now raised at tier three and the BAF was live. The issue was that a number of high level risks at tier four and five had been underestimated. This work continued to be progressed and checked for quality assurance by the Risk Management Team. **AC20.90.03:** An Independent Member queried whether there was sufficient understanding as to the different terms 'inherent' and 'initial'. Furthermore, was the difference between the BAF and the Corporate Risk Register clear to those below Executive level. The Interim Director of Governance advised that this had been discussed at the Executive Management Group (EMG), the membership of which included non-Executives. Though acknowledged that there was further work to be	SEE

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done as to the meaning of the different tiers. The Risk Management team had targeted themselves to train 1000 members of staff. **AC20.90.03:** An Independent Member asked for an update as to the action plan, noting that there were staff absences within the Risk Management team. The Interim Director of Governance confirmed that there was one member of staff still seconded to support fit testing for the pandemic. However, they were expected to return to their substantive post at the start of January. **AC20.90.04:** The Head of Internal Audit recalled from a previous Audit Committee meeting that the intention was that a Board Workshop would reflect and agree corporate objectives, as opposed to the strategic priorities that the BAF now detailed. The Head of Internal Audit was concerned that working to 'priorities' did not deliver the same accountability as 'objectives', which were explicit – the Health Board either met its objectives, or it did not. There was a potential for ambiguity with 'priorities'. The Chair concurred, though recalled that this had not been completed at the workshop. The Executive Director of Finance advised that the Board were now closer to achieving this and needed to focus on 2021/22. The Executive Director of Workforce and Organisational Development advised Members that the Board did now have agreed objectives for Quarter three and four. **AC20.90.05:** The Associate Director - Coronavirus Co-ordination, Planning proceeded to provide Members with an update on the planning work for the EU transition period. The risk was now an entry on the BAF and updates had been provided to the Strategy, Partnership and Population Health (SPPH) Committee. The Health Board were awaiting details of daily reporting requirements from the Welsh Government, which were expected the following week. Supplies disruption was being considered in terms of medicines, food, fuel and medical devices. A group had been formed to oversee this. The Chair noted that Independent Members had received a briefing on the EU Exit the previous week. The Head of Internal Audit further advised that a briefing paper had been provided to the Acting Board Secretary and the Associate Director - Coronavirus Co-ordination, Planning to feed back on the questionnaire. **RESOLVED:** That 1. the progress on the management of the BAF and the Corporate Risk Register (Tier 1) be noted; and 2. The BAF format be approved for submission to the Board.	

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AC20.91: Internal Audit Progress Report **AC20.91.01:** The Head of Internal Audit proceeded to provide Members with an overview of the progress report, in particular, table 4 and the performance indicators, which were positive. The Head of Internal Audit went on to draw Members' attention to a number of reviews that had been identified for deferment. This had been agreed in principle with the Acting Board Secretary and Executive Team prior to final approval at Audit Committee. The deferments were in recognition of the demands placed upon operational teams as the Health Board managed a second wave of the pandemic. However, Members noted that any further deferments or reviews removed from the plan would impact on the Head of Internal Audit's ability to deliver a full assurance opinion. The Head of Internal Audit concluded by recording their thanks to both the Executive Director of Finance and the Acting Board Secretary. **AC20.91.02:** An Independent Member queried why it had been necessary to remove the Improvement Groups review from the plan. The Head of Internal Audit advised that this was due to the governance arrangements being revised. There was a paper scheduled for submission to the Finance & Performance (F&P) Committee. The Executive Director of Finance provided further clarification, the Improvement Groups had been stood down and a proposal had been submitted to Welsh Government. This was a new approach to improvement and the incoming Chief Executive had a very clear vision of what was required. The Independent Member advised that this was still concerning. There had been significant investment and it was important that the Health Board was able to measure the benefits of what was, a considerable spend. The Executive Director of Finance advised that the Improvement Groups superseded those pieces of work and were in place prior to the appointment of the Turnaround Director. The Interim Director of Governance further advised that there would be a presentation to the Board following a piece of work to identify positive learning. **AC20.91.03:** An Independent Member raised a query with regard to the Quality Impact Assessment review and whether there was further explanation as to why there had been no evidence of approval from the Chief Executive or the Director of Finance. The Head of Internal Audit advised that this was a design of operational procedure fault. The Independent Member went on to enquire whether a change should be recommended. The Head of Internal Audit assured Members that this was reflected in the Management Response and was confident that the issues identified had been addressed. **AC20.91.4:** The Head of Internal Audit proceeded to provide Members with an overview of the Delivery of Savings Ysbyty Glan Clwyd Hospital limited assurance report. The Executive Director of Finance advised that the target had not originally been seen as unrealistic as there were several opportunities for savings. However, whilst the division were	

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accepting of the report, a change in leadership had had an impact in terms of delivery. An Independent Member observed that whilst there were clearly issues, there was a question as to whether the Health Board should have intervened sooner. The Executive Director of Finance advised that this would have been the case if the issue had been escalated though agreed that there was a requirement for peer group support. The Independent Member concluded by asking whether the Health Board could be confident that lessons had been learnt. The Executive Director of Finance advised that this was the case. Conversations with the responsible Chief Financial Officer had resulted in improved clarity as to what needed to be done. The Head of Internal Audit added that whilst this was a limited assurance report, the division had made strides to achieve some savings hence why a 'no assurance report' would not have been appropriate. **AC20.91.5:** The Head of Internal Audit then proceeded to provide Members with an overview of the Staff Survey review. Members were advised that the report would have been 'no assurance' had the Estates & Facilities division not been exemplar. The Executive Director of Workforce and Organisational Development advised that following the review, the process had now changed though it did require divisional ownership. The lack of evidence provided by the Mental Health & Learning Disabilities (MH&LD) division had been expected due to both of the divisional leads being on long term sickness. These challenges had been discussed at Board and there was now further assurance in place due to a new leadership team. Members concurred that all of the actions were welcomed. **AC20.91.6:** Members went on to consider the Medical and Dental Recruitment review. The Head of Internal Audit advised that the review had identified issues of data completeness that had impacted the review. Had all of the data been available, there may have been a different opinion. The Executive Director of Workforce and Organisational Development provided Members with the background to the system implementation and advised of the actions taken to address the issues. This included the establishment of Medical Recruitment Panel that was intended to anticipate vacancies and aim towards there being no gap between leavers and new starters. An Independent Member noted the action plan and queried whether the plan included key performance indicators (KPIs). The Executive Director of Workforce and Organisational Development confirmed this to be correct and advised that KPI reporting was overseen internally by the operational workforce groups and externally via NHS Wales Shared Services Partnership (NWSSP). **AC20.91.7:** Members proceeded to discuss the final limited assurance report on Quality Impact Assessments (QIAs). The Executive Director of Finance stated that the process needed clarification and that it was important to reflect on the level of governance and alignment required.	

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The Chair referred back to his earlier comment in terms of governance issues – ToRs, Minutes etc. and an Independent member concurred. A follow up was required as it was felt that the report lacked narrative as to whether a QIA had been done for all Project Initiation Documents (PIDs). The Executive Director of Finance advised that every scheme went through a robust scrutiny process via the Financial Recovery Group where Executives were present. The Independent Member agreed though noted that it was apparent that the auditors struggled to source evidence for this. These were verbal, rather than written assurances. The Executive Director of Finance stated that it was important that the procedure was updated and advised that this would be picked up with the Head of Internal Audit. The Chair requested that an update be brought to the next Committee. ***AC20.91.7****: Following a meeting break, the Head of Internal Audit provided Members with an update following discussion with the Audit Team. It was confirmed that all PIDs sampled did have a QIA in place*. **RESOLVED:** That 1. the progress report and Internal Audit plan 2020/21 – to complete be received; 2. the deferments listed in the report be approved; 3. the Limited Assurance reports be received and discussions noted.	SH
AC20.92: Audit Wales Update Report **AC20.92.1:** Members agreed to take items out of order to enable the Executive Director for Primary Care and Community Services to attend and discuss the Continuing Healthcare (CHC) arrangements report. The Performance Audit Lead, Audit Wales provided Members with an overview of the report and the scope of the review, which did not consider CHC panels. Members noted that in 2019-20, the Health Board spent £106.2 million on CHC. This was an increase of approximately 8% compared to the previous year. Audit Wales had observed some weaknesses in governance and oversight. However, the Health Board was developing an ambitious plan for the future. The Chair noted that the Assistant Director that had been leading on the work had now retired and it was important that the momentum was not lost. The Executive Director for Primary Care and Community Services provided Members with an update on the actions being undertaken. There were both challenges and opportunities that the pandemic had presented. An Independent Member requested an update on the outline business case to adopt a 'Business Hub' model and the target date. The Executive Director advised that the principle of the business model was broadly there though the current environment necessitated that the April 2021 date was more likely to be a starting date than business approval date. An Independent Member	

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queried which Committee would be overseeing this and the Executive Director advised that this would be Strategy, Partnerships and Population Health Committee.. **AC20.92.2:** The Executive Director of Finance provided Members with an update on the North Wales Pooled Fund report. Conversations were ongoing with the Local Authorities and there was a genuine intention to pool funds. However, it remained a complex area and there were difficulties when trying to progress within the restrictions of each organisation. The Chair observed that complexities were not only evident between organisations, but also internally. The Performance Audit Lead, Audit Wales agreed and provided the example between MH&LD and Area teams. The Executive Director for Primary Care and Community Services noted that the temporary oversight of the MH&LD division by the Executive Director of Public Health had proven positive with the Corporate team intervening where necessary and providing some degree of brokerage. Members discussed the most appropriate Committee to refer the pooled funds report to and agreed that the most appropriate Committee would be the Finance & Performance Committee. **AC20.92.3:** The Performance Audit Lead, Audit Wales concluded by providing Members with an overview of the update report and Structured Assessment. The Chair highlighted that this had been sighted by the full Board at a workshop. Members noted the proposed future structure of the assessment would be split into two reports. **RESOLVED:** That 1. the programme update be received; 2. the Structured Assessment 2020 report together with the Annual Audit Report be received; 3. the Review of Continuing Healthcare Management Arrangements be received; 4. the Welsh Community care Information Report be received; and 5. the update on North Wales Pooled Fund Report by the Executive Director of Finance be noted.	
AC20.93: Financial Governance during Covid-19 Update Report **AC20.93.1:** The Executive Director of Finance presented the report. The Chair queried whether this report was specific to Covid or related to financial governance in general. The Executive Director of Finance advised that this was specifically in response to Covid though lessons would be taken and applied across the Health Board. The Executive Director of Finance was pleased to report that all actions were on track and being progressed. The Head of Internal Audit noted that the Executive Director of Finance had requested this review from the outset	

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and it had now become an all Wales review, which was positive. The Chair agreed and noted that this was a good piece of work. **RESOLVED:** That 1. the level of collaborative work undertaken through the Financial Governance Cell be noted; 2. the planned next steps, through the establishment of a Financial Improvement Group be noted.	
AC20.94: Charitable Funds Annual Report and Accounts **AC20.94.1**: The Executive Director presented the report and drew Members' attention to the new format. Members concurred that the new look report was excellent and very user friendly. It was a notable improvement. Furthermore, the amount of work that the team had done in managing funds during Covid was commendable. The Financial Audit Manager, Audit Wales advised that the Charity Committee had considered the report when it had met earlier in the month. Members concluded by expressing thanks to the Charities team. **RESOLVED:** That the Charitable Funds Annual Report and Accounts be received.	
AC20.95: Schedule of Financial Claims **AC20.95.1:** The Acting Associate Director of Quality Assurance presented the report and outlined the key governance controls. An Independent Member raised an information governance concern and Members discussed whether it would be more suitable for the report to be received in private committee due to the potential to identify individuals. Members agreed that in future, a summary would be presented in public committee in the interests of transparency with further details to be received in private committee to prevent any personal identifiable information being inadvertently disclosed. **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.	DS/MJ
AC20.96: Ablett Redevelopment Report **AC20.96.1:** The Interim Director of Governance presented the report which had been prepared following concerns being express by Members of the Board as a result of being aware of a change in the project board's preferred option through media briefing associated with the nationally mandated, newly introduced pre-planning application process. Members noted that whilst the Policy had been followed, the Senior Responsible	

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Officer (SRO) should have been an Executive Director. Members then received an update on the work being done to address the issues. This included a defined range for project leads. Projects over £10m or of a contentious nature, to be led by an Executive, with projects under £5m being led by a senior leader with an Executive 'buddy'. **AC20.96.2:** The Chair asked what assurances were in place that this would not happen again and whether the Interim Director of Governance was confident that the recommendations addressed the issues. The Interim Director of Governance advised that a group would be actively looking at projects from development to delivery to prevent this happening again. The Performance Audit Lead, Audit Wales noted that the report was a good example of internal management arrangements. **RESOLVED:** That 1. the establishment of the Capital Investment Group that had met twice and would provide monthly reports to the Executive Team and specifically highlight any changes in assumptions or any schemes that might be off track be noted; 2. the role of the Senior Responsible Owners as clarified by the Executive Team and SRO reporting into the Executive Team which was being formalised be noted; 3. the regular reporting to Finance and Performance Committee on progress against approved capital projects be noted; and 4. it be noted that any future planning consultations will be specifically drawn to the attention of Board Members well in advance of their publication, in the same way as service consultations.	
AC20.97: Performance & Accountability Framework **AC20.97.1:** The Interim Director of Governance presented the report. Members noted that the Framework and been developed with input from the incoming Chief Executive and had previously been presented to Independent Members. The Director of Performance would be taking the document through consultation. The Chair observed that the document was clear and taking the organisation in the right direction. The Chair went on to query how the organisation would measure good performance and success. The Interim Director of Governance advised that this would be in terms of overall performance – better communication cascaded up and down the organisation and better debates in terms of risk. An Independent Member raised concerns in terms of standing membership and queried whether this meant 'essential' or on average as it was an onerous task to ensure everyone was there at the same time. There was a further query as to the membership of the regional team, it was important to ensure that the membership reflected pan BCUHB with all	

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specialties being represented. The Interim Director of Governance assured Members that this was provided for in the Terms of Reference. **AC20.97.2:** An Independent Member raised a query with regard to accountability (section 2.3) and how this related to annual appraisal meetings. The Interim Director of Governance advised that the framework was broadly team based and whilst individual accountability was important, this was not the purpose of the framework. However, where a team was underperforming, one of the issues may be a low level of team compliance for Performance and Development Reviews (PADR). The Executive Director of Finance observed that it might be beneficial to nominate an Executive to lead on this, as leadership was critical. **RESOLVED:** That the implementation of the Performance and Accountability Framework be noted and the impact/effectiveness of the framework be reviewed in September 2021.	SEE SEE
AC20.98 Clinical Audit Plan **AC20.98.1:** Members noted that the Clinical Audit Plan had received substantial prior scrutiny by Independent Members as well as approval from the Quality, Safety & Experience Committee. Hence, the decision had been made not to ask the Senior Associate Medical Director to attend. **RESOLVED:** That the Clinical Audit Plan be approved.	
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: 18.3.21	
AC20/78: Exclusion of Press and Public Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960".	

Audit Committee Summary Action Log: Public Committee

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Dawn Sharp	**AC20/87.02:** September minutes. Administrative error	March	Complete. 'presented' amended to 'prevented' and approved minutes uploaded to external web.	close
Debra Hickman	**AC20/87.03:** Decontamination Audit – confirmation on COSHH training and recruitment. Members noted the update submitted for December Committee. However, felt that further clarification as to compliance figures was required so as to fully address the original query.	March	COSHH awareness is covered in the 3yrly Health & Safety Welfare at work training. Although we have a strong degree of compliance ranging from 85-90% across our clinical areas, there is room for improvement particularly given the increasing number of products being used in our environment now as a result of COVID response and reducing the risk of transmission. We are working closely with our H&S colleagues to strengthen this.	close
Dawn Sharp	**AC20/87.04:** Breach Log. Confirmation of possible breaches / late papers at the 12/11/20 Board meeting	March	Position re 12/11/20 Board papers verified. Position as reported to last meeting i.e. no additional breaches to report.	Close
Dawn Sharp	**AC20/87.05:** Terms of Reference (ToR) for the Remuneration & Terms of Service Committee. Amend section 3.1.3 – replace 'allied professionals' with 'registered professionals'.	March	Complete. ToR updated and approved 01.02.21	close
Dawn Sharp	**AC20/87.06:** Local Partnership Forum Annual Report 2019/20. Attendance details table uses 'flag' icons, which are not provided for / explained in table key	March	The 'flag' icon is attributed to ibabs uploading / conversion from pdf to word. The originally submitted report has 'ticks'.	close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Simon Evans-Evans	**AC20.90.01:** Board Assurance Framework. Formatting issues.	March	The Assistant Director of Information Governance & Risk has reviewed the document. The report has been protected/restricted. This will limit unintended editing and ensure consistency across all sections when uploaded/converted to pdf.	close
Sue Hill	**AC20.91.7:** QIS Limited Assurance report. Requirement to update the procedure. Discussion with Head of Internal Audit	March	The procedure is being updated by the PMO Team (supported by the Head of Savings) and will then be reviewed by the CFOs (to ensure it is comprehensive) and Internal Audit colleagues	close
Dawn Sharp	**AC20.91 / AC20.92:** Referral of audit reports to relevant Committees	March	Reports distributed to corresponding committees	close
Matt Joyes	**AC20.95.1:** Schedule of Financial Claims information governance issues relating to potential identifiable information. Report to be split into two. Detailed report to be submitted in private committee	March	Complete. March report split into public/private	close
Sue Hill/Dawn Sharp	**AC20.97.2:** Performance & Accountability Framework. Consideration to be given for Executive sponsorship.	March	The Executive Director of Nursing is the Exec lead for Governance but will require the relevant Executive to lead in specific circumstances (eg if it is a workforce matter, it would be the Executive Director of Workforce)	close

Audit Committee

18.3.21

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
21.1.21	Finance and Performance Committee	Publication of papers 7 days before meeting	Delayed publication of public papers to web
23.2.21	Strategy, Partnerships & Population Health Committee	Publication of papers 7 days before meeting	Follow on paper required

Dawn Sharp

Deputy Board Secretary

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 18.03.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Audit Committee Cycle of Business 2021/22
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Board Secretary
Atodiadau Appendices:	Appendix 1: Audit Committee Proposed Annual Cycle of Business: 2021/22

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- discuss and agree the 2021/22 Cycle of Business (CoB)

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:

As part of the 2021/22 cycle of business, Audit Committee Members are asked to review and agree the proposed CoB for the next financial year.

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 items on the CoB.

Options considered

There are no options listed within this report. Audit Committee Members are asked to review and agree the proposed CoB. Members are able to consider and suggest additions and/or amendments.

Financial Implications

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

Risk Analysis

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

Legal and Compliance

Visibility of the Audit Committee's CoB and forward work plan supports good practice and transparency in accordance with Section B, part 7 of the Health Board's Standing Orders.

Impact Assessment

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

Appendix 1: Audit Committee Proposed Annual Cycle of Business 2021-22.

Agenda Item	25/05/21 (May) workshop	10/06/2021	28/09/21	14/12/21	15/03/22	Notes	Public or Private Ctte
Opening Business							
Members discussions with internal and external audit		√	√	√	√	Independent Members and Auditors to have 15 minute pre-meeting before each meeting.	Private
Apologies for absence		√	√	√	√		Public
Minutes of previous meeting for accuracy & matters arising and review of summary action plan		√	√	√	√		Public
Governance							
Chair's Assurance Report Risk Management Group		√	√	√	√	Risk Management Group. Standing item added as of March 2020	Public
Review Board Assurance Framework		√		√			Public
Risk Management Strategy Review		√			√	Annual review prior to final approval at Board. Interim review in June following review of risk appetite in June.	Public
Review of Corporate Risk Register		√		√			Public
Performance Accountability Framework			√			First received in December 2020. Review due in September 2021 as agreed at December Audit Committee meeting.	Public
Other sources of assurance (audit reports, regulatory body reports, external reviews, shared services reports)		√	√	√	√	Whilst the majority of reports are received in public session, the nature of some reports necessitate that they must be received in private committee. For example, commercial sensitivity or cyber security.	Public and private
Note the business of other committees and review inter-relationships	review cttee annual reports					Self assessment now being undertaken via the Committee Business Management Group	Public
Review of amendments to Standing Orders		√	√	√	√	Where there are no amendments, this will not be listed as an agenda item.	Public
Details of Breaches of Standing Orders (late papers etc.)		√	√	√	√		Public
Review draft Annual Governance Statement	draft	approval					Public
Review organisation's annual report	draft	approval					Public
Annual review of gifts & hospitality and Declaration of Interest registers			√				Public
Legislation Assurance Framework			√		√		Public
Finance							

Agenda Item	25/05/21 (May) workshop	10/06/2021	28/09/21	14/12/21	15/03/22	Notes	Public or Private Ctte
Review of amendments to Standing Financial Instructions		√	√	√	√		Public
Details of Breaches of Standing Financial Instructions		√	√	√	√	Addressed as part of the financial conformance report.	Public
Post payment verification progress report			√		√		Private
Dental Assurance Report			√		√		Public
Financial Conformance report (inc review of losses & special payments, review of risks and controls and reporting of any Standing Order breaches)		√	√	√	√		Private
Review annual accounting progress and note financial accounting timetable					√	Included in Financial Conformance Report	Private
Schedule of Financial Claims		√	√	√	√	Report split into two. Detailed section to be received in private committee to prevent any personal identifiable information being disclosed	Public and Private
Review of audited annual accounts and financial statements including Charitable Funds if ready		√		CF final			Public
Internal Audit							
Internal Audit (IA) progress report		√	√	√	√		Public
Report from Internal Audit tracker tool		√	√	√	√		Private
Review and approval of Internal Audit plan					√		Public
Internal Audit Charter (incorporating ToR for internal audit)					√		Public
Receive annual internal audit report (Head of Internal Audit Opinion)		√					Public
Review effectiveness of Internal Audit		√	√	√	√	Continuous process and via regular meetings prior to Committee	Public and Private
Any no assurance or limited assurance reports as a substantive item		√	√	√	√	Whilst the majority of reports are received in public session, the nature of some reports necessitate that they must be received in private committee. For example, commercial sensitivity or cyber security	Public
External Audit							
Auditor General's (external audit) progress reports		√	√	√	√		Public
Report from External Audit tracker tool		√	√	√	√		Private
National audit reports for information		√	√	√	√		Public
Review and approval of Auditor General's (external audit) plan					√		Public

Agenda Item	25/05/21 (May) workshop	10/06/2021	28/09/21	14/12/21	15/03/22	Notes	Public or Private Ctte
Structured Assessment				√			Public
Receive Auditor General's report to those charged with governance (through letter of representation)		√					Public
Receive the Auditor General's annual audit report				√			Public
Review the effectiveness of external audit (through quarterly Audit Wales progress reports)		√	√	√	√	Continuous process and via regular meetings prior to Committee	Public and Private
Counter Fraud							
Review counter fraud progress reports		√	√	√	√		Private
Agree counter fraud annual work plan		√					Private
Review effectiveness of LCFS Specialist (through Counter Fraud Authority Quality Assessment)			√				Private
Counter fraud annual report		√					Private
Clinical Audit							
Clinical audit plan		√			√	June progress update against plan and sign off of plan in March.	Public
Audit Committee							
Plan how to discharge audit committee duties					Agree Cycle of Business		Public
Undertake self-assessment of Committee effectiveness	review	Sign off				Undertaken via online/electronic self-assessment issued by Internal Audit.	Public and Private
Briefings and update sessions (as appropriate)	√	√	√	√	√		Public
Produce Committee annual report including refresh of ToR	x draft	x final					Public
Members discussion with Head of Counter Fraud				√		Meetings arranged independently between Head of Counter Fraud and Chair	Private
Closing Business							
Summary of Private business to be reported in public		√	√	√	√		Public
Issues of Significance		√	√	√	√		Public
Date of Next meeting(s)		√	√	√	√		Public

Joint Audit and Quality, Safety & Experience (QSE) Committee (JAQS)
Draft minutes of meeting held in public on 24.11.20
via Webex

Present:

Cheryl Carlisle	Independent Member
Jackie Hughes	Independent Member
Medwyn Hughes	Independent Member (Joint Chair)
Lyn Meadows	Independent Member
Lucy Reid	Independent Member (Joint Chair)

In Attendance:

Kate Clark	Acting Deputy Medical Director
Andrew Doughton	Audit Lead, Audit Wales
Simon Evans-Evans	Interim Director of Governance
Sue Green	Executive Director of Workforce & Organisational Development (OD) (Part meeting)
Dave Harries	Head of Internal Audit
Debra Hickman	Acting Executive Director of Nursing & Midwifery
Matt Joyes	Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety & Experience
Andrew Kent	Head of Planned Care (part meeting)
Grace Lewis-Parry	Assistant Director Primary Care
Melanie Maxwell	Senior Associate Medical Director / Improvement Cymru Clinical Lead
Rob Nolan	Finance Director – Commissioning (part meeting)
Dawn Sharp	Acting Board Secretary
Adrian Thomas	Executive Director of Therapies & Health Sciences

Agenda Item Discussed	Action By
JAQS20/1 Chairs' Welcome Attendees were welcomed to the meeting.	
JAQS20/2 Declarations of Interest None declared.	
JAQS20/3 Apologies for Absence Recorded for Gareth Evans, Arpan Guha, Sue Hill, Eifion Jones, Teresa Owen and Chris Stockport. Noted that Sue Green would need to leave before the end of the meeting. Deputies were welcomed to the meeting on behalf of Chris Stockport, Arpan Guha and Sue Hill.	

JAQS20/4 Review of Summary Action Log **JAQS20/4.1** The QSE Committee Chair introduced this item by acknowledging the length of time some actions had remained open and reminded members that at the last meeting in 2019 the JAQS Committee did not feel that they had seen sufficient evidence on which to close them down. She confirmed that matters had now moved on and the action log had been reviewed by Executive colleagues and it was accepted that the range of actions relating to clinical audit had been superseded by the refreshed approach to clinical audit across the organisation. The Acting Executive Director of Nursing and Midwifery felt that the revised process set out in the clinical audit paper later on the agenda would address multiple actions which had evolved within the action log. The Senior Associate Medical Director / Improvement Cymru Clinical Lead noted that the assurances around clinical audit would get stronger year on year although she acknowledged there was a remaining gap around primary care. **JAQS20/4.2** A suggestion was made that actions from JAQS should be allocated to either QSE or Audit Committee so they were followed up and reviewed in a more timely manner. The QSE Chair indicated there had been an element of this previously but agreed that progress of actions could be better managed. It was agreed to ask the Interim Director of Governance to review the role and effectiveness of JAQS and to consider the use of a decision log rather than action log. **JAQS20/4.3** Further updates were noted for inclusion within the action log.	SEE
JAQS20/5 Clinical Audit Annual Report 2019-20 **JAQS20/5.1** The Senior Associate Medical Director / Improvement Cymru Clinical Lead presented the report which she felt was a much stronger format as a result of lessons having been learned from previous years. She indicated that the report set out a list of mandated audits and identified where there were outliers which would require the development of improvement plans which would need to be 'SMART' and timely. *[Rob Nolan joined the meeting]* The Senior Associate Medical Director / Improvement Cymru Clinical Lead added that the report contained two elements of performance data - one against the national benchmark and the other against the last BCU report. Where data had not been submitted this was RAG rated red and would be addressed. In terms of a baseline report the Senior Associate Medical Director / Improvement Cymru Clinical Lead was comfortable that the Board was in a better position in terms of knowing current performance and where the gaps in assurance were. **JAQS20/5.2** The Senior Associate Medical Director / Improvement Cymru Clinical Lead then drew members' attention to the Priority 2 audits noting that detail around delays were contained within the appendices. She acknowledged there was a substantial amount of work to be done around locally initiated projects but suggested that the chart on page 31 supported that the organisation should now be undertaking some Tier 3 audits and that she would also like to see some speciality audit work too. It was confirmed that the Clinical Audit Policy had been approved in March 2020 but that the roll out of audit work had been stood down with the onset of the Covid-19 pandemic, however, this was now starting to be embedded within the quality governance framework. Clinical Audit leads had been identified against all of the mandated audits which was a positive improvement, and an Interim Head of Clinical Effectiveness had been appointed who had commenced	

conversations around developing a business case for clinical audit and improving support to divisions and sites. Finally it was noted that there was a notable increase in the number of Tier 3 projects being registered, and that an escalation report would be provided for the Clinical Effectiveness Group on a regular basis.

JAQS20/5.3 The Audit Committee Chair felt that the report was clear and easy to understand and provided good examples of strengthening governance. He noted that many of the red rated actions were related to a lack of administrative support and enquired as to progress with the business case for funding. The Senior Associate Medical Director / Improvement Cymru Clinical Lead indicated it was hoped to complete the business case by the end of January 2021 but that there was also a need to think longer term around ensuring that the right support for teams and specialties could be sustained. The QSE Committee Chair noted that the paper made references to resources required to deliver on some audits and sought assurance that this was being flagged with finance colleagues. The Finance Director (Commissioning) confirmed that business cases underwent a "fit for purpose" review before they were considered at Executive Team, and subsequently would go through a prioritisation process and up to the Finance & Performance (F&P) Committee. It was also highlighted that there were some improvement actions that did not necessarily have a cost implication. The QSE Committee Chair felt it was reassuring that the right sort of conversations around the clinical audit agenda were now being taken forward.

JAQS20/5.4 A member enquired what improvements in terms of behaviours and culture could be made, alongside procedural improvements, to encourage more individuals to want to undertake clinical audit. It was felt that recently audit had not had the required visibility across the organisation and that it was now being linked to pathways to try and address this. There was also a need to ensure that individuals had the capacity to undertake audit as part of normal business and that audit be embedded within service improvements. A member requested that page 30 be amended to refer to a radiology department rather than radiology service, as there had been recent efforts to portray the specialty as a single service. She went on to enquire whether the audits set out within Appendix 3 had an associated date for completion, and it was clarified they only related to Tier 3 audits for which there was a report available at year end. A question was raised regarding the consistency of RAG scoring against the national benchmark and the last BCU report and it was clarified that the green rating in that scenario reflected an improvement on last year's performance.

JAQS20/5.5 The QSE Committee Chair made a general comment that the report was very much improved and gave a more robust source of assurance around the clinical audit function, although she would like to see evidence of learning more clearly set out. She commented that the key on page 26 would be easier to read above the table rather than below it.

JAQS20/5.6 Internal Audit and Audit Wales colleagues were supportive of the progress made with this agenda and that the audit plan was broadly in line with their expectations.

JAQS20/5.7 It was resolved that the Joint Committee approve the Clinical Audit Annual Report 2019/20.

JAQS20/6 Delivering Effective Clinical Audit **JAQS20/6.1** Members felt the paper was clear and logical. **JAQS20/6.2 It was resolved that** the Joint Committee agreed the proposed actions to provide an effective clinical audit function that will support quality improvement leading to safe, high quality care whilst providing the assurance required by the Joint Committee.	
JAQS20/8 Audit Reviews *[Agenda item taken out of order at Chair's discretion. Mr Andrew Kent joined the meeting]* **JAQS20/8.1** The QSE Committee Chair informed members that the Audit Committee had determined that relevant audit reports would be shared with respective committees to provide an opportunity for overall reflection and to consider what had changed as a result of the review. She confirmed that the responsibility for monitoring the associated audit recommendations remained with the Audit Committee. **JAQS20/8.2** The Interim Director of Planned Care gave a verbal update in terms of the review of operating theatres. He explained the booking process which aimed to improve theatre utilisation, highlighting that although the principles were in place, progress had been delayed by the onset of the Covid-19 pandemic and the need to focus on essential services. He confirmed that 5 theatres had been maintained on each acute site for emergency and cancer care but there remained a lack of capacity at the current time to be able to undertake routine activity. This position was monitored on a weekly basis and officers were working closely with clinicians on how capacity could be increased whilst meeting Personal Protective Equipment (PPE) and other Covid-19 requirements such as a the new regime for pre-operative care. He confirmed that the Planned Care Group had developed a 6 point recovery plan which would be discussed by the F&P Committee in December 2020. He concluded by saying officers were disappointed not to have been able to implement the transformational improvements for theatres yet, but they remained committed to this aim. **JAQS20/8.3** A member enquired whether private companies may be contracted with to provide additional capacity at weekends, and expressed concern that this solution was not sustainable. The Interim Director of Planned Care confirmed that a paper was to be discussed by the Executive Team on the 25th November 2020 which included this possibility for high risk patients. In response to a question as to why existing staff could not be utilised if capacity was currently 40% down, the Interim Director of Planned Care reported that this would have an impact on the resilience of the workforce and that staff were already being redeployed to support the Covid-19 response and undertake additional training for example. *[Mrs S Green left the meeting]* He added that waiting list initiatives utilising local staff at an overtime rate were being pursued, together with an insourcing option which would provide a more consistent contractual arrangement. Historically the organisation had outsourced a large amount of activity but this was no longer possible as those providers were having to deal with their own backlog. The QSE Committee Chair sought assurance that the issues originally raised in the review were still on the radar and it was confirmed that they would be incorporated into the 6 point recovery plan utilising a 'once for North Wales' approach to provide consistency. The Audit Committee Chair was content that the recommendations were being addressed, although progress was not at a level he would have wished to have seen. The Audit Lead for Audit Wales reminded	

members that the original review had taken place in 2014 with a follow up in 2019, resulting in a mix of recommendations which were now being combined into a consolidated approach. He felt that there were key positive messages from the 2019 review and that the development of a Diagnostic & Treatment Centre (DTC) approach would over time impact on theatre performance and improvement. *[Mr Andrew Kent left the meeting]* **JAQS20/8.4** The Acting Executive Director of Nursing and Midwifery presented the paper which provided an update against the internal audit review into adult in-patient falls. She highlighted that the direction of travel was focusing on a wider approach to ensure sustainability. **JAQS20/8.5** A member drew attention to reference within the appendix to training being mandatory for nursing staff, and suggested that this was a statement as opposed to an achievement in terms of implementing the falls strategy. The Acting Executive Director of Nursing and Midwifery accepted this point and that there needed to be a more strategic analysis to give a broader overview. In response to a question around ward accreditation she confirmed that this process had continued but through a revised approach due to Covid-19. The Audit Committee Chair noted that the report stated that "due to a number of changes in the senior leadership roles, the overarching Strategic Falls Group referenced within the internal audit review report has not met for some time", and queried whether the implementation of the falls strategy should not be at ward level. The Acting Executive Director of Nursing and Midwifery confirmed that primarily implementation was an operational front-line responsibility and that the Falls Group mentioned was a co-ordinating forum. The Audit Committee Chair felt that if the group was important it should be meeting and wondered if changes in leadership was being given as an excuse. The QSE Committee Chair shared these concerns and asked the Interim Director of Governance to ensure the principle of governance frameworks being robust enough to ensure that changes in leadership did not impact. The Interim Director of Governance indicated he was to present on the governance framework at the Board Workshop on the 3rd December 2020. The Head of Internal Audit noted that he was minded to include falls within the internal audit plan for 2021-22. **JAQS20/8.6 It was resolved that** the Joint Committee receive the update.	SEE
JAQS20/7 Progress Update on Risk Management Strategy **JAQS20/7.1** The Interim Director of Governance presented the paper. He confirmed that the commitment to move to a tier 3 system by the 1st October 2020 had been achieved but did highlight a range of anomalies which were now being quality assured with the corporate risk team. He felt this was a useful process to help staff understand their risk scores and controls. It was noted that the Executive-led Risk Management Group (RMG) oversaw the quality assurance process which had been refreshed alongside the improvement plan and reporting arrangements. The Interim Director of Governance reported there had been good progress on a broader risk discussion with divisions being invited to attend the RMG in turn and aligning risk more closely to accountability meetings. He concluded by confirming that the development of a Board Assurance Framework was on track for the December 2020 Audit Committee. **JAQS20/7.2** The Head of Internal Audit sought clarification around slippage in the implementation plan is and whether there was a risk that the revised strategy would not be	

fully implemented by year end. The Interim Director of Governance reported that he did not feel there was slippage but that some risks had been over scored at Tier 3 level. He confirmed that the strategy was in place and being utilised with the associated quality assurance process scheduled for completion by year end. A member asked whether any of the highly scoring risks were of particular concern and the Interim Director of Governance indicated that the vast majority of entries on the register were real risks to the Board but that the quality assurance process was fundamental to ensuring consistency in scoring and robust management of risks. The QSE Committee Chair was encouraged to read about the self-assessment tool. **JAQS20/7.3 It was resolved that** the Joint Audit and QSE Committee note the progress implementing the Health Board`s new Risk Management Strategy & Policy. *[Mr S Evans-Evans left the meeting]*	
JAQS20/9 Quality Governance Self-Assessment Action Plan **JAQS20/9.1** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety & Experience presented the paper and confirmed that all actions were due for completion by the end of March 2021. He confirmed that progress had been made in-year with an update having been provided to the QSE Committee in August 2020. Since that update the most significant progress had been around the Risk Management Strategy and that a further update would be provided to QSE Committee in January 2020. **JAQS20/9.2** The QSE Committee Chair indicated she did not personally feel sighted on progress against the development of a clinical strategy by the end of March 2021. It was noted that the Acting Executive Medical Director had recently given a presentation to the Strategy, Partnerships & Population Health (SPPH) Committee and that at a recent Board meeting the Chair had requested a firm trajectory and timeline. The Acting Deputy Medical Director stated that a clear direction of travel would be prepared by the end of March 2021, aligned with the development of the Digital Strategy. The Joint Chairs expressed concern that since the former Executive Medical Director had presented to the Board on a digitally enabled clinical strategy, the emphasis and approach would appear to have changed and that from a governance perspective the Board needed to be sighted on this and be supportive of the strategic direction. The QSE Committee Chair would raise this with the Health Board Chair. **JAQS20/9.23 It was resolved that t**he Joint Committee note the update of the Quality Governance Self-Assessment Action Plan.	LR
JAQS20/10 Governance Arrangements During Covid-19 **JAQS20/10.1** The QSE Committee Chair noted that Audit Committee members would previously have received this internal audit report but not QSE members, and there was now an opportunity to ask questions and seek assurance as to how governance and meeting structures may be taken forward in a major subsequent Covid-19 wave. The Acting Board Secretary confirmed that the considerations within the paper were being tracked.	

JAQS20/10.2 The Head of Internal Audit extended his thanks for the time and input by officers into the review. He highlighted that a number of actions from the review fell within the remit of finance and that an anonymised report was being developed with All Wales Directors of Finance and Board Secretaries. He drew members' attention to the good practice identified around the work of the Cabinet and the establishment of the financial governance cell. The Audit Lead (Audit Wales) indicated that the Structured Assessment was being shared with the Board at a workshop on the 3rd December 2020 and he recorded that the organisation had been very responsive. He felt there were opportunities to learn from the challenges that were faced during the first wave but that delivery of change had occurred with pace. The QSE Committee Chair noted the reference to maintaining the requirements of General Data Protection Regulation (GDPR) as a priority for consideration, and suggested that the Digital and Information Governance (DIG) Committee may need to pick this up. The Acting Board Secretary would raise this with the DIG Committee Chair and Lead Executive. **JAQS20/10.3 It was resolved that t**he Joint Committee note:- (1) the Internal Audit report and in particular the priority considerations for the future; (2) that these priority considerations are being actively via Team Central and reported to the Audit Committee; (3) the Guidance as issued by Welsh Government in respect of discharging Board Committee responsibilities during COVID-19 response phase.	DS
JAQS20/11 Any Other Business **JAQS20/11.1** The Audit Lead (Audit Wales) flagged that as part of the audit programme there would be some wrap around governance work scheduled. **JAQS20/11.2** The Head of Internal Audit suggested the Board needed to ensure it was sufficiently sighted on the risks pertaining to Brexit. The Acting Board Secretary confirmed this was in hand and there was a meeting scheduled involving the Audit Committee Chair.	

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 18/03/21**
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:	Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Board Secretary
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Audit 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 private Committee meeting of 17/12/20:

- Financial Conformance Report
- KPMG Field Hospitals Report and Field Hospitals Consequential Losses
- Counter Fraud Progress Report
- Update on Internal/External Audit Actions (Tracker Tool).

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

18th March 2021

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:	18 January 2021
Name of Chair:	Deputy CEO / Executive Director of Nursing and Midwifery
Responsible Director:	Interim Governance Director
Summary of business discussed:	This report summarises the activity of the Risk Management Group (RMG). The Group was quorate with good representation, however the impact of COVID-19 was recognised. The RMG members noted: 1. The minutes from the previous meetings on the 23rd October and 30th November 2020 were approved as an accurate record. 2. Of the 27 actions on the Action Tracker, 21 were completed and closed. 3 remain outstanding but on track with the agreed completion timescale, 1 which had exceeded it's timescale has since been closed and 2 remain overdue which are in relation to clarity and assurance on the purpose and use of RM04 – Model Risk Management Procedure; Concerns raised regarding appropriate risk scoring on the Ysbyty Gwynedd Site. The movement from the 5 to 3 Tier approach was also discussed and whilst the Corporate Risk Team are continuing to review anomalies with the risk scoring, concerns were being expressed on the ability of operational teams to complete the work of reviewing and updating their risks due to impact from the COVID-19 Pandemic. Whilst there was a commitment to try and achieve completion of this exercise by 31st January 2021, due to the above this will not be possible and so the deadline date for the 31st March 2021 is more realistic. The outstanding risks to be reviewed and updated are as below: **Total** / **As at June 2020** / **Week Ending 15/01/2021** / **Current as at 24/02/2021** Figures / 1300 / 351 / 296 A comprehensive action plan has been set up to actively monitor the achievement of reviewing the outstanding risks within the agreed timeframe. 3. The updated Terms of Reference was approved and will be submitted to the Executive Leadership Team for information.

	4. A comprehensive review was undertaken on the Board Assurance Framework. Controls and Mitigations were checked and challenged, alongside a review of the scoring in line with the current Health Board's Risk Appetite Statement. Feedback has been provided to all individual Executive Directors and Lead Officers to ensure all risks are updated before the next submission to the Executive Team and appropriate Committees of the Board due in February and March 2021. 5. A comprehensive review was undertaken on the Tier 1 Corporate Risk Register. Controls and Mitigations were checked and challenged, alongside a review of the scoring in line with the current Health Board's Risk Appetite Statement. Feedback has been provided to all individual Executive Directors and Lead Officers to ensure all risks are updated before the next submission to the Executive Team and appropriate Committees of the Board due in February and March 2021. 6. The COVID-19 High Level risk report was presented with confirmation of a comprehensive review undertaken the previous week by Sally Baxter. The Corporate Risk Team are now providing weekly COVID-19 Risk Reports for scrutiny at the Executive Incident Management Team (EIMT). It was agreed that a separate EIMT be held to focus solely on reviewing these risks. 7. The following Divisional risk report was provided, but no lead officer was available for the presentation: o Area West – Members noted within the report that 4 risks were scoring outside the risk scoring matrix and were to be considered for escalation. The Group agreed to escalate the risk in relation to the Diabetic Service to the Executive Team, but feedback and further work was required with regards to the remaining 3 risks as controls and mitigations did not align corporate mechanisms put in place to mitigate the risks. The Group also discussed the absence of the other 4 Divisional Risk Reports. It was agreed that the Corporate Risk Team would look at alternatives in populating the reports to support the divisions during the management of the COVID-19 Pandemic. This includes drafting the narrative on the findings from the Datix system on the maturity of the division. Executive Director approval would still be required before any future submission to the RMG. 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 that was intended to go

	live from April 2021 may be delayed by the national programme team. The Health Board remains committed to the original date and will continue to ensure preparedness. 9. The updated RM02 – Risk Management Procedure and Guide was presented and approved for implementation. 10. The updated RM03 – Risk Management Training Plan was presented and approved for implementation.
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 and escalation of risks. • Progress with the management of COVID-19 related risks and reporting arrangements. • Follow up of outstanding actions incorporated into future improvement plans.
Key risks including mitigating actions and milestones	Compliance with the Risk Management Strategy and Policy
Issues to be referred to another Committee	None of note
Matters requiring escalation to the Board:	The ongoing impact of Covid-19 on Services/Directorates/Divisional resources and their ability to actively manage and review their risks.
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:	• Review of Corporate Risks • Review of Board Assurance Framework • Review of Extreme Covid-19 Risks • Review and approve risks for escalation to the Executive Team • Review of Divisional Risk Reports • Update on Once for Wales Integrated Risk Management Project • Review 2020/21 Risk Management Improvement Plan and future reporting requirements
Date of next meeting:	15th March 2021

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 December 2020 to 28th February 2021** **Internal Audit Plan 2021/22**
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton – Board Secretary
Awdur yr Adroddiad Report Author:	Dave Harries – Head of Internal Audit
Craffu blaenorol: Prior Scrutiny:	The progress report and audit plan have been discussed with and agreed by the Board Secretary and the plan shared with the Executive Team.
Atodiadau Appendices:	• Appendix 1: Progress Report • Appendix 2: Mental Health & Learning Disabilities Division - Governance arrangements • Appendix 3: Business Continuity – Informatics • Appendix 4: Internal Audit Plan 2021/22

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive the progress report; and
- Approve the Internal Audit Plan 2021/22.

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.

The Internal Audit Plan is produced in accordance with the requirements as set out within the Public Sector Internal Audit Standards: Standard 2010 – Planning.

Cefndir / Background:

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

- Substantial assurance (green) – one;
- Limited assurance (amber) – two; and
- Assurance not applicable (blue) – one.

The report also details:

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

The internal audit plan for 2021/22 details the risk based planned reviews for 2021/22 following review of Board and Committee papers; Board Assurance Framework; Corporate Risk Register; and risk based meetings with Independent Members and Directors.

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.

The plan for 2021/22 is risk based.

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.*

The audit plan for 2021/22 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.4 Reviewing the internal audit plan.*

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 December 2020 to 28th February 2021

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. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Office of the 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
Caldicott Principles into Practice (C-PIP) Review completed December 2020 with Executive approval February 2021 *There were a small number of areas where the narrative / score did not fully reflect the Health Board position.*	Substantial	-	-	1	There is a formal process in place for putting together the C-PIP submission with a network of key departmental feeds for specific areas within the assessment to ensure accuracy of the submission narrative. There is a review process in place and the submission is approved by the Caldicott Guardian and the Digital and Information Governance (DIG) Committee. In the main we noted that the scoring in the assessment is accurate and that the narrative accurately reflects the Health Board position. We did identify a small number of areas within the assessment where there were minor variances from the true position.
Mental Health & Learning Disabilities Division - Governance arrangements Review completed October 2020 with Executive approval January	Limited	3	-	-	There has been limited progress since the previous internal audit report in addressing governance issues. This has been compounded by the absence/vacancies at Director level and COVID-19. With the exception of progress at QSEEL, no other definitive progress can be evidenced. There remains a high number of groups/meetings within the division and it remains unclear whether these add to effective governance. The Together for Mental Health Strategy

Title	Assurance Level	High	Medium	Low	Key Messages
2021 *Together for Mental Health Strategy project plan has not been maintained and has lost direction due to elapsed tasks. Psychological Therapy services are not subject to the same focus and support.*					implementation plan has not been updated since July 2019. There are a number of tasks that should have been completed by the time of this review but no evidence or updates were provided to us that demonstrates the Strategy is on time for delivery. Our review found little to no regular reporting on Psychological therapy services during our review of papers with greatest focus on mental health services. Further the Director of Psychology Services post is vacant and it is unclear if/when this head of service post will be advertised.
Business Continuity – Informatics Review completed December 2020 with Executive approval January 2021 *Business continuity plans have not been tested; Informatics attendance at the Health Board's Civil Contingencies/ Business Continuity Groups was not evident.*	Limited	1	3	-	We reviewed a sample of Informatics Business Continuity Plans (BCPs) and Business Impact Analysis (BIA) documents and noted: • Instances within both BCPs and BIAs where the required information had not been completed – examples included action boxes having not been filled, incomplete tables (Prioritised Activities – Impact of Disruption and Risk Assessment), and incomplete staff mapping. • Document tracking information had not been completed in all cases. • Whilst the content was largely similar, we noted that different Business Continuity Plan templates had been used. • Several documents remained marked as "draft". We sought evidence that exercises had taken place testing the effectiveness of the Business Continuity Plans reviewed. We also requested evidence that a debriefing session had been held to review the outcome of the testing exercise with evidence of lessons learned being considered and implemented into revised plans where appropriate. Programmes Assurance and Improvement (PAI) and Information confirmed that no Business Continuity Plan testing exercise, or relevant

Title	Assurance Level	High	Medium	Low	Key Messages
					debriefing sessions, had taken place during this financial year. We did not receive a response from ICT Services or Health Records. We sought assurance that Business Continuity Leads had received relevant training per the Health Board Business Continuity policy. Responses from Programmes Assurance and Improvement (PAI) and Information stated that they had no record of formal training having been undertaken. We did not receive a response from ICT Services or Health Records. Informatics has limited representation at either the Civil Contingencies Group, which sits monthly, or the Business Continuity Working Group, which meet twice per year. We noted that the Deputy Head of Health Records had attended both Business Continuity Working Group meetings during 2020.
Advisory Review: Preparations for EU exit (Brexit) Review completed December 2020 with Executive approval January 2021 *This review is supportive in nature and we have suggested one possible action for the SRO to receive ongoing assurance from all operational leads.*	Not applicable	-	-	-	Whilst there was a poor response overall, there are a number of areas that both the responding Committee Chairs and Operational Leads have identified that require further consideration and provision of assurance. Some testing of plans is reported as the Health Board responded to COVID-19, although we note that not all operational services have plans developed. There is a risk that local supply chain interdependencies have not been identified, recognising that the Health Board participated in a national review. As the SRO is accountable for the preparedness, it would be prudent for them to seek and receive assurance and subsequently provide to the Board and/or Committee that all key topics of the NHS Confederation local action checklist are actively being managed.

Work in Progress Summary

4. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Engagement of Interim Appointments	Discussion draft report issued and additional information shared with the Director of Finance and Board Secretary.	29th January 2021
Budgetary Control & Financial Reporting	Draft report issued.	23rd February 2021
IM&T Control and risk assessment	Report issued and awaiting management comments to the risks identified.	15th January 2021
Patient monies and property	Discussion briefing paper issued and initial comments received.	29th January 2021
Statutory compliance: Water management	Draft report issued.	23rd February 2021
Security	Draft report issued and discussions held with management.	27th January 2021
Control of Contractors	Draft report issued.	22nd February 2021

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.
- Violence and Aggression – Obligatory responses to violence in healthcare – Review is complete and the draft report being prepared.
- Performance measure reporting to the Board: Accuracy of information – The review has commenced.
- HASCAS & Ockenden external reports: Recommendation progress and reporting - We have been provided with further evidence to support recommendations that have been approved for closure.
- Capital systems – The review has commenced.
- Ablett Unit – The review has commenced.

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
The National Health Service (Concerns,	Datix administration	Closed – Verified

Review Title	Recommendation Title	Follow-up status
Complaints and Redress Arrangements) (Wales) Regulations 2011 – Part 6: Redress		

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.

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 Board Secretary, Deputy Board Secretary and Director of Finance with subsequent dialogue with the Executive Team.

13. 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.

14. Table 4 is reporting a positive status across all indicators with management response to draft reports maintaining 75%.

15. 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 Board Secretary/Deputy 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%
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	Green	75%	80%	v>20%	10%<v <20%	v<10%

Indicator	Status	Actual	Target	Red	Amber	Green
Lead at time of agreeing the audit brief						
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	Review in progress.	
Risk Management	Q4	Review in progress.	
Health and Safety	Q4	Draft brief agreed.	
Security	Q2	Draft report issued.	
Violence and Aggression – Obligatory responses to violence in healthcare	Q3	Review in progress.	
Engagement of interim appointments	Q2	Draft report issued.	
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	Final report issued.	Limited
Strategic planning, performance management and reporting			
Performance measure reporting to the Board – Accuracy of information	Q2	Review in progress.	
Improvement Groups	Q3		Recommended for deferral by Committee.
Advisory Review: Preparations for EU exit (Brexit)	Q3	Final report issued.	Advisory Review
Financial governance and management			
Delivery of Savings – Ysbyty Glan Clwyd Hospital	Q1	Final report issued.	Limited
Budgetary Control & Financial Reporting	Q2-3	Draft report issued.	

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 deferral by Committee.
Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices	Q2	Review in progress.	
Follow up of previous Healthcare Inspectorate Wales reports	Q2-4	On-going review as and when evidence is received.	
Information governance and security			
IM&T Control and risk assessment	Q2	Draft report issued.	
Caldicott Principles into Practice (CPiP)	Q2	Draft report issued.	
Disaster Recovery/Business Continuity Plan - Informatics	Q2-3	Final report issued.	Limited
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	Draft report issued.	
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	Draft report issued.	

Planned output	Outline timing	Status	Assurance
Statutory Compliance: Water Safety	Q2	Draft report issued.	
Capital Systems	Q2	Review in progress.	
Integrated Audit and Assurance Plan(s): • Ablett Unit	Q1-4	Review in progress.	

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.

Betsi Cadwaladr University Local Health Board

Internal Audit Plan 2021/22

March 2021

NHS Wales Shared Services Partnership
Audit and Assurance Services

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2021/22 ('the Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

As a reminder, the Accountable Officer (the Health Board's Chief Executive) is required to certify in the Annual Governance Statement that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards require that *"The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities."*

Accordingly this document sets out the risk based approach and the Plan for 2021/22. The Plan will be delivered in accordance with the Internal Audit Charter. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives

and risks;

- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- quantification of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering the:

- organisation's risk assessment and maturity;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities, and is mindful of significant national changes that are taking place, in particular the ongoing impact of COVID-19. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual review, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year.

In addition, we are also aiming to agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

- Annual audit work: Areas where annual audit work will support the most efficient and effective delivery of an annual opinion. These cover the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing where required.

- Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

  We recognise that there is a need to audit in a more agile way and to this end we have prepared a full annual programme of work identified at this stage recognising that some audit reviews may change during the year.
- Follow up: this is follow-up work on previous limited and no assurance reports. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
- Work agreed with the Board Secretaries, Directors of Finance, other Executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.
- The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely Public Health Wales (PHW), Health Education Improvement Wales (HEIW), NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales, WHSSC and EASC.
- Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure the our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board systems of assurance; thus, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Plan;
- an assessment of the Health Board's governance and assurance arrangements and the contents of the Board assurance framework/corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and the Quality, Safety and Experience Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and

control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit, working in partnership with the Audit Wales Performance Lead, sought to meet with a number of Health Board Executives and Independent Members to discuss current areas of risk and related assurance needs. Recognising the impact the second wave of COVID-19 has had on the Health Board, we reduced the number of meetings and met the following key individuals during the planning process:

- Health Board Chair/Chair of the Finance & Performance Committee;
- Chair of the Audit Committee;
- Vice Chair/Chair of the Quality, Safety and Experience Committee/Chair of the Mental Health Act Committee;
- Chief Executive;
- Deputy Chief Executive/Director of Nursing & Midwifery;
- Board Secretary;
- Deputy Board Secretary;
- Interim Director of Governance;
- Director of Public Health; and
- Director of Finance.

The draft Plan was then discussed with the Board Secretary and the Executive Team to ensure that internal audit resource was best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage is based on the organisation's assessment of risk and assurance requirements as defined in the Board assurance framework.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal control). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, potential

for fraud and sensitivity.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2021/22

The Plan is set out in Appendix A and identifies the audit assignment, lead executive officer, outline scope, and proposed timing.

Where appropriate the Plan makes cross reference to key strategic risks identified within the Board assurance framework, corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible Executive Director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

Audit coverage in terms of information governance and IT security, capital audit and estates assurance will either be delivered locally or through our Capital & Estates/IM&T Team.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales as your External Auditor and Healthcare Inspectorate Wales will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

Internal Audit has the necessary resources to deliver the agreed programme through both the local audit team and access to specialist resources.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

In accordance with the NHS Wales Infrastructure Investment Guidance all business cases are required to include an Integrated Assurance and Approval Plan (IAAP) that sets out assurance and approval points for each stage of the project/ programme. Accordingly, Health Boards/Trusts are required to outline the various formalised assurance mechanisms proposed (e.g. internal audit, Gateway reviews, functional reviews etc.), and the timing of each, within all business case submissions.

By outlining the various assurance mechanisms proposed at the Business Case and reflecting the proposed costs within the Business Case Cost Forms, Health Boards/Trusts are able to capitalise the costs of its associated internal audit coverage. Accordingly, during the forthcoming year, our Capital & Estates Team will work with management to develop appropriate project/programme audit plans (based on risk assessments), for inclusion within key business cases. The internal audit plan will be updated to reflect any associated business case approvals.

The Public Sector Internal Audit Standards enable internal audit to provide consulting services to management. The commissioning of these additional services by the Health Board is discretionary and therefore not included in the Plan. Accordingly, any requirements to service management consulting requests would be additional to the Plan and would need to be negotiated separately.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2021/22 and:

- Approve the Internal Audit Plan for 2021/22;
- Approve the Internal Audit Charter; and
- Note the associated internal audit resource requirements and key performance indicators.

Dave Harries CMIIA QiCA
Pennaeth yr Archwiliad Mewnol (Bwrdd Iechyd Prif Ysgol Betsi Cadwaladr)
Head of Internal Audit (Betsi Cadwaladr University Local Health Board)
Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2021/2022

Planned output	BAF/CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
Risk Management		We will review the continued implementation of the Risk Management Strategy across the Health Board. We will also review: • Management of clinical risks. • The process surrounding the move from five to three tiers. • Effectiveness of the training provided.	Deputy Chief Executive	Q1-2
Governance structure		We will review the implementation and effectiveness of the revised governance structure across the Health Board.	Board Secretary	Q4
Targeted Intervention		We will review the evidence underpinning the self-assessment and completion of the maturity matrix.	Deputy Chief Executive	Q3
Transformation of services		We will review improvement groups and the PMO as well as the overarching transformation of services and seek to answer *"Are there effective programme, project and improvement arrangements to support transformation".*	Director of Finance/ Director of Planning & Performance	Q3-4
Impact Assessments	Audit Committee	We will review the completion of all impact assessments, including evidencing consideration of the Wellbeing of Future Generations Act.	Director of Finance/ Director of Planning & Performance	Q2
Standards of Business Conduct: Declarations		To review compliance with the Standards of Business Conduct, including arrangements in place to manage declarations.	Board Secretary	Q3
Integrated Service Boards (ISB)		We will review the governance surrounding delegation of authority within the Health Board coupled with identifying how decisions taken by ISBs impact Health Board services.	Director of Primary and Community Care	Q2-3
Budgetary Control & Financial Reporting, including COVID-19 financial governance	BAF20-17	To review key financial controls and compliance in accordance with Finance policies/procedures. We will review the governance surrounding decisions taken in line with the Scheme of Delegation and whether effective risk management arrangements are in place that underpin decisions concerning COVID-19.	Director of Finance	Q2-3
Procurement & Tendering	BAF20-17	To review action taken to improve arrangements in respect of contract	Director of Finance	Q1

Planned output	BAF/CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
		management, and use of single tender and single quotation actions.		
Value Based Healthcare	BAF20-17	Following publication of WHC (2020)003 Value Based Health Care Programme – Data Requirements, we will review the use of information to drive healthcare decisions in North Wales.	Director of Finance & Medical Director	Q2-3
Learning Lessons	BAF20-12	We will review a sample of complaints; incidents; and never events to ascertain what lessons have been learnt, documented and evidence as having made a difference.	Director of Nursing & Midwifery	Q1-2
HASCAS & Ockenden external reports – Recommendation progress and reporting		We will continue to review the reporting of progress against the agreed management actions for those recommendations outstanding and implemented by the Health Board. We will also review the implementation of agreed actions stemming from the Holden Report.	Director of Nursing & Midwifery	Q1-4
Clinical Audit	Deferred from 20/21	Following adoption of the Clinical Audit Policy, we will review the clinical audit process, with particular focus on the management of recommendations and follow-up.	Medical Director	Q2-3
Planned care – Waiting list management	BAF20-05	Following the reporting of essential services and re-start updates to Committee, we will review the process followed in the management of waiting lists.	Deputy Chief Executive	Q1
Network and Information Systems Regulations 2018 (NIS Regulations)		To review the self-assessment back to source documents and review implementation of an agreed action plan.	Director of Primary and Community Care	Q3-4
Digital Strategy	BAF20-18	We will review progress against the timelines set out in the plan to understand if the Health Board is achieving its expected goals and whether the Digital Strategy is aligned and supports the delivery of corporate plans.	Director of Primary and Community Care	Q3
Cluster working/Health and Social Care Localities governance and accountability	BAF20-04/ CRR20-05	We will review a sample of Localities governance and accountability arrangements and assess in accordance with Welsh Government issued *Primary Care Cluster Governance – A Good Practice Guide.*	Director of Primary & Community Care	Q2-3
Unscheduled Care	BAF20-02	We will review the planning arrangements/assumptions and	Deputy Chief Executive	Q1

Planned output	BAF/CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
		efficacy in the delivery of the winter schemes.		
Business Continuity Plans	BAF20-06	We will review the current status of business continuity plans and sample a number of areas to ascertain their effectiveness.	Director of Planning & Performance	Q2
Secondary Care Division – Ysbyty Glan Clwyd		Building on the Quality Governance Review, we will undertake a benchmark governance review following discussion with the Board Secretary.	Deputy Chief Executive/ Board Secretary	Q2
Women's Services Division – Sustainability of services		We will liaise with the Director of Midwifery & Womens Services to revisit previously commissioned reviews and analyse current service provision and use, comparing the Health Board with its peers in NHS Wales.	Director of Public Health	Q1-2
Recruitment – Employment of medical locum doctors	BAF20-21	In accordance with standard operating procedure MD01 *Medical Agency Locum Appointments* and other operating procedures, we will review the process in place for ensuring pre-employment checks are undertaken of seeking references from the most recent employer.	Director of Workforce & OD	Q1-2
Roster management		Using WP28 – Rostering Policy and associated guides, we will review the controls operating for those shifts paid for agency staff. **This review is subject to C-19 restrictions on Ward visits being possible.**	Director of Workforce & OD	Q2
Establishment control – Leaver management		We will review the submission of employee leaver forms for timeliness.	Director of Workforce & OD	Q1-2
Upholding Professional Standards in Wales		We will review the Health Board's compliance with the Circular M&D(W)3/2015 *Upholding Professional Standards in Wales.*	Director of Workforce & OD	Q1
On-Call arrangements		We will review the on-call arrangements in operation across the Health Board.	Deputy Chief Executive/ Director of Workforce & OD	Q2
Statutory Compliance: Asbestos Management	BAF20-15/ CRR20-01	We will review the Health Board's compliance with the Control of Asbestos Regulations 2006 and associated Health Board policy.	Director of Planning & Performance/ Director of Estates & Facilities	Q1
Waste Management		To review arrangements in place for the management of waste.	Director of Planning &	Q2-3

Planned output	BAF/CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
			Performance/ Director of Estates & Facilities	
Preparedness for Climate Change/ Decarbonisation		To determine the adequacy of management arrangements to ensure compliance with the Welsh Government decarbonisation strategy.	Director of Planning & Performance	Q2-3
Capital Funded Systems		A review of the systems, policies and procedures in place to manage those projects not specifically identified within the audit plan. The focus on 2021/22 would be on the tendering and contract procurement stages. However, recognising the number of major capital investment programmes being progressed, the proposed systems coverage may be deferred in year with focus provided on the capital project requirements (subject to Welsh Government approval of respective business cases).	Director of Planning & Performance/ Director of Therapies & Health Sciences/ Medical Director/ Director of Primary and Community Care	Q3
Integrated Audit and Assurance Plans: • North Denbighshire • Ablett Unit • Wrexham Maelor Hospital - Backlog maintenance requirements • Residential Accommodation • Diagnostic & Treatment Centres		NHS Wales Infrastructure Investment Guidance (updated guidance issued by Welsh Government in October 2018) requires an Integrated Assurance and Approval Plan (IAAP), which sets out assurance and approval points for each stage of the Business Case process. Accordingly, the organisation is required to outline the various formalised assurance mechanisms proposed (e.g. internal audit, Gateway reviews, functional reviews etc.) and the timing of each. The Integrated Audit Plans proposed include a combination of programme-level, functional and consultancy assurance that, when combined, provide a balanced programme for the client to achieve the desired level of assurance required by Welsh Government. We are working with the Director of Planning & Performance to develop appropriate integrated plans for the major investment proposals.	Director of Planning & Performance	Q1-4

Appendix B: Key performance indicators (KPI)

The KPIs reported monthly for Internal Audit are:

KPI	SLA required	Target 2021/22
Audit plan 2021/22 agreed/in draft by 30 April	☑	100%
Audit opinion 2020/21 delivered by 31 May	☑	100%
Audits reported vs. total planned audits	☑	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	☑	80%
Report turnaround management response to draft report [20 working days minimum]	☑	80%
Report turnaround draft response to final reporting [10 days]	☑	80%

Appendix C: Internal Audit Charter

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Local Health Board

INTERNAL AUDIT CHARTER

March 2021

Contents

1 Introduction

1.1 This Charter is produced and updated regularly to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Betsi Cadwaladr University Local Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Betsi Cadwaladr University Local Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Betsi Cadwaladr University Local Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control[1]. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system

[1] *Audit work designed to deliver an audit opinion on the risk management, control, and governance arrangements is referred to in this Internal Audit Charter as Assurance Work because management use the audit opinion to derive assurance about the effectiveness of their controls.*

of assurance;

- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective advisory service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such advisory work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit budget and resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not

develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Public Sector Internal Audit Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly the Head of Internal Audit has a direct right of access to the Accountable Officer the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance e.g. Quality, Safety and Experience Committee.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, internal audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

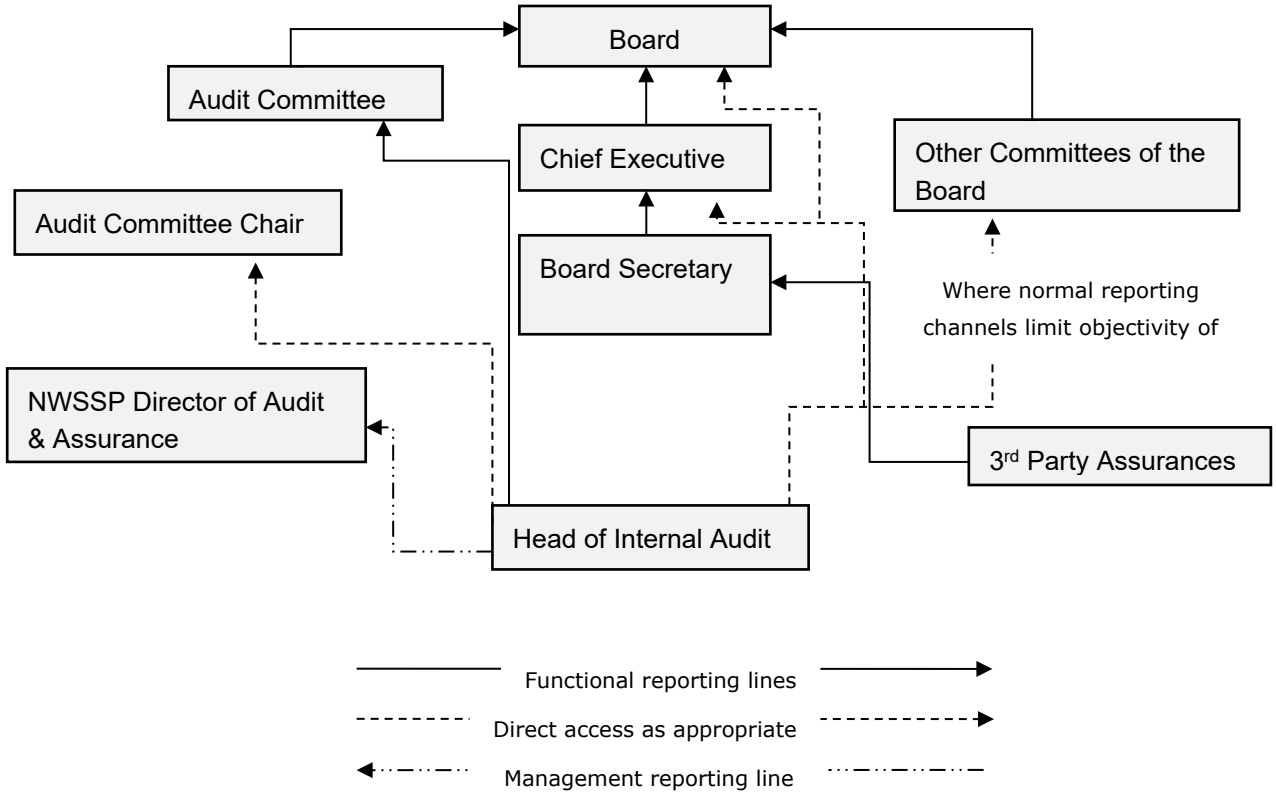
5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, e.g. the NHS Wales Shared Services Partnership, WHCCS, EASC and NWIS (NWIS becomes a Special Health Authority called Digital Health and Care Wales from 1st April 2021).

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The key organisational reporting lines for Internal Audit are summarised in Figure 1 overleaf. As part of this, the Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all reports.

Figure 1 Audit reporting lines



6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2019) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;

- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- reviewing arrangements for demonstrating compliance with the Health and Care Standards.
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit, or prejudice the ability of internal audit to deliver a services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

7.4 The scope of the audit coverage will take into account and include any hosted body.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit

work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 2:

Figure 2 Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales to meet
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Public sector Internal Audit Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisations objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which "are appropriate, sufficient and effectively deployed to achieve the approved plan";
- effective co-operation with external auditors and other review bodies functioning in the organisation; and

- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information, and outlining the scope and timing of audit assignments to be completed during the year ahead.

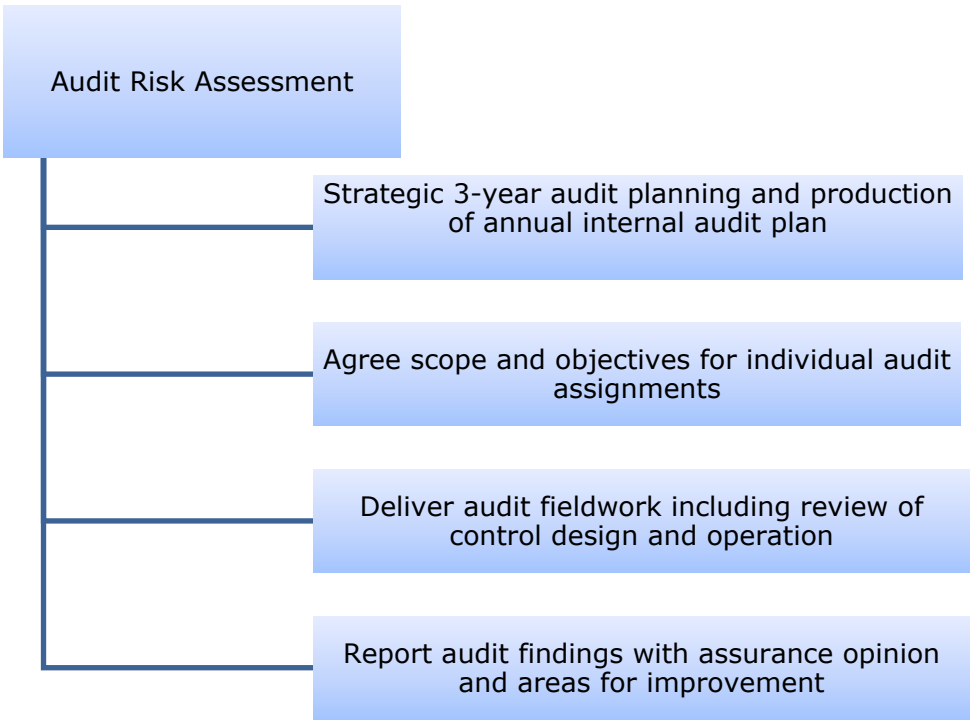
8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board. The Office of the Board Secretary will also screen Internal Audit Plan long lists to determine which audit topics link to Board Champion roles. The Office of the Board Secretary will then notify the relevant Board Champion that their area of interest features in the IA plan.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead, and will also be copied to the Board Secretary. The key stages in this risk based audit approach are illustrated in figure 3 below.

Figure 3 Risk based audit approach



9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement. The process for arriving at the appropriate assurance level for each Head of Internal Audit opinion is subject to a review process and was last updated in 2020/21;
- The Head of Internal Audit opinion will:

a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes, with reference to compliance with the Health and Care Standards;

b) Disclose any qualification to that opinion, together with the reasons for the qualification;

c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;

d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;

e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and

f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below and presented in flowchart format in Appendix A:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B. The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 20 working days of issue, stating their agreement or otherwise to the content of the report, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;

  Where the Executive lead advises Internal Audit that responding to the draft report within 20 days cannot be achieved due to the geographical nature of the Health Board, an alternative number of days will be agreed and formally reported to the Board Secretary and Audit Committee.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the

Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;

- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Final reports inclusive of management comments will be issued by Internal Audit to the relevant Executive Director within 10 working days of management responses being received; and
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee. Where relevant, the Office of the Board Secretary will forward the final report to the Independent Member identified as Board Champion for the subject matter.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

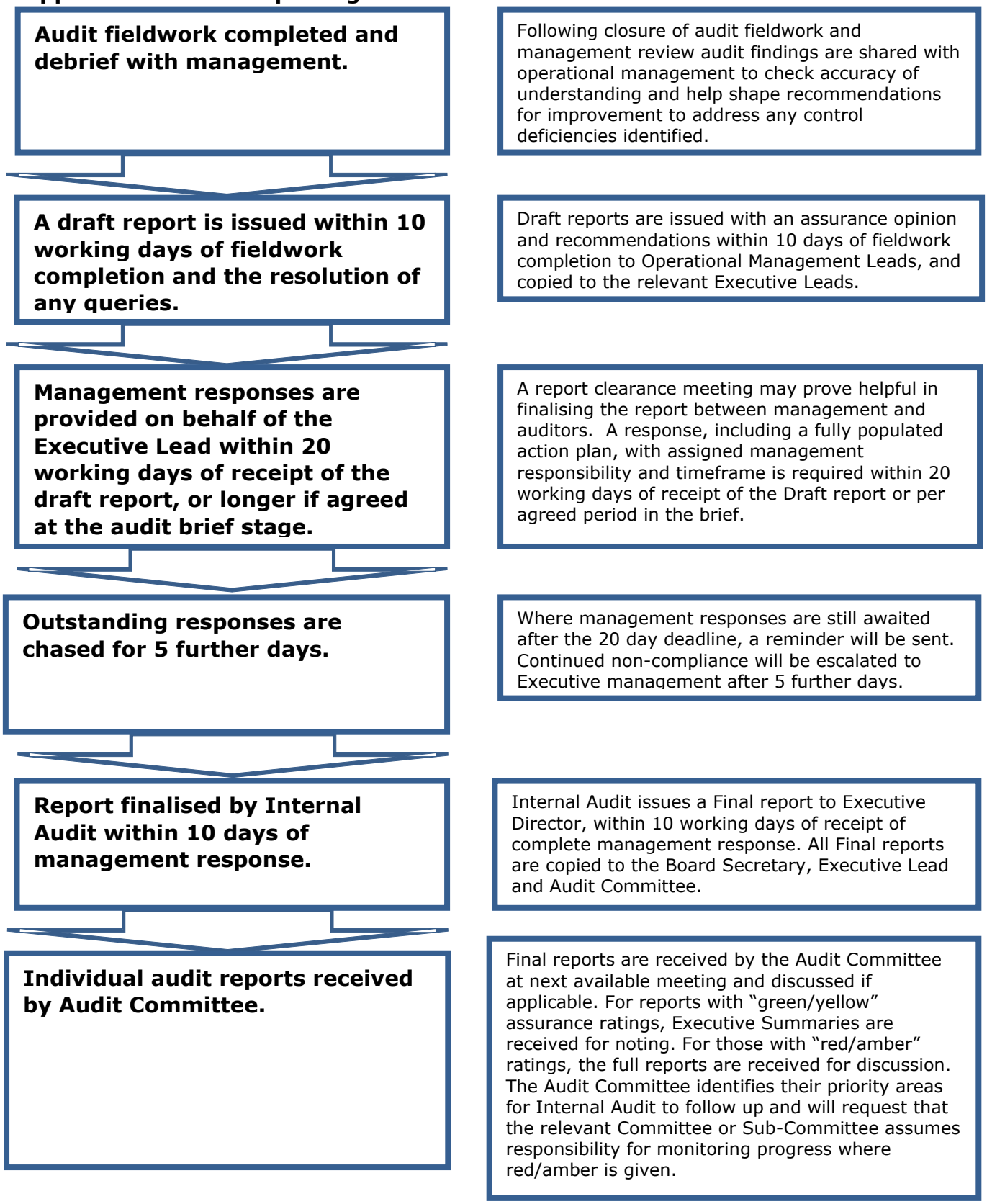
13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance - NHS Wales Shared Services Partnership
February 2021

Appendix A: Audit Reporting Process



Appendix B: Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	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	 - + Yellow	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	 - + Amber	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	 - + Red	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	 - + Blue	**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.

Betsi Cadwaladr University Health Board

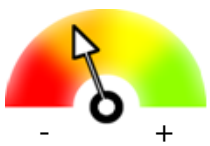
Business Continuity - Informatics

Final Internal Audit Report

BCU 2020/21

January 2021

NHS Wales Shared Services Partnership

Limited Assurance

Previous review rating N/A

Contents **Page**

Review reference:	BCU-2021-20
Report status:	Final Internal Audit Report
Fieldwork commencement:	19th October 2020
Fieldwork completion:	14th December 2020
Draft discussion report issued:	14th December 2020
Draft report issued:	8th January 2021
Management response received:	18th January 2021
Final report issued:	18th January 2021
Auditor/s:	Senior Internal Auditor Head of Internal Audit
Executive sign off:	Chief Information Officer on behalf of the Director Primary & Community Care
Distribution:	Deputy Head of ICT Head of Informatics Programmes Assurance and Improvement Informatics Senior Assurance and Improvement Officer Head of Emergency Preparedness & Resilience Business Continuity Manager Acting Board Secretary Statutory Compliance, Governance & Policy Manager
Committee:	Audit Committee

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.

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

Business continuity is vital to the survival and ongoing operation of any organisation. It is the process of creating systems of prevention and recovery to deal with any potential risks or threats to a company, whilst ensuring that processes are in place to enable the organisation to continue in the event that such risks or threats materialise.

The Health Board Business Continuity Management Policy BCMP01 states that; "Business Continuity Management is a management led process which identifies and mitigates risks and disruptions that could affect the capability of the organisation to continue to deliver its prioritised activities during a disruptive incident".

The processes therefore provides a framework for building resilience and the capability for an effective response which safeguards and ensures continuity of critical functions in the event of a disruption.

Examples of risks to the Health Board operations range from disruption to isolated systems or departments, more significant incidents impacting Health Board properties, staff groups, or services, through major incidences effecting the wider community. In all instances the Health Board must have in place a rapid, proportionate, and efficient response to manage the incident and ensure continued operation.

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 ensure that effective business continuity measures are in place and comply with relevant policies, legislation, and best practice. The review focused on the Health Board Informatics Department. Our approach to this review was to identify and evaluate controls in place and highlight potential weaknesses.

The review considered the following:

- Policy compliance;
- Plan testing and lessons learned;
- Business Continuity Lead training;
- Management, administration and reporting.

3. Associated Risks

The potential risks considered at the outset were:

- Health Board unable to undertake prioritised activities in event of business disruption;
- Inadequate or out of date impact/risk assessments adversely affecting the Health Board's ability to respond to an incident appropriately;
- Business continuity plans have not been developed and/or communicated effectively;

- Adverse impact of business disruption on patients, staff and other stakeholders;
- Plans in place untested and not sufficiently robust;
- Failure to adhere with legislative requirements.

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 Informatics Business Continuity 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	Health Board governance arrangements			✓	
2	Informatics Business Continuity documentation		✓		

Assurance Summary					
3	Testing exercises and lessons learned		✓		
4	Business Continuity Leads training		✓		
5	Meeting / group representation		✓		

** 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 a weakness in the system control/design for Informatics Business Continuity arrangements.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as a weakness in the operation of the designed system/control for Informatics Business Continuity arrangements.

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. Due to the current COVID-19 restrictions all fieldwork and discussions were undertaken remotely.

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.

Health Board governance arrangements and documentation

The Health Board has robust governance arrangements in place to support the delivery of effective Business Continuity Management. Business Continuity Management is organisationally led and facilitated by the Health Board Resilience Team within Planning and Performance, with the day-to-day operational management delegated to each Health Board department and/or service via nominated Business Continuity Leads.

Business Continuity is a standing agenda item on the Civil Contingencies Group which reports to the Strategy, Partnership and Population Health (SPPH) Committee. Furthermore a Business Continuity Working Group has been established as a forum to identify best practice, develop consistent and robust business continuity management systems, and share information and experiences across services.

To support the development and implementation of effective business continuity

management whilst ensuring compliance with relevant legislative requirements, the Health Board has in place robust policies, procedures and guidance documentation detailing the process, requirements, governance arrangements, and template documentation. We confirmed that the documentation had recently been reviewed and updated (during the review period), however note that our findings are based on a comparison of working practice against the policy documentation that was in place during the first half of 2020.

Informatics Business Continuity documentation

This review has focussed solely on the Informatics department and aims to determine the extent to which working practice complies with Health Board Business Continuity policy and requirements.

We were advised at the outset that Informatics comprises four main services across the East, Central and West areas. The services are, ICT Services, Informatics Programmes Assurance and Improvement (PAI), Information, and Health Records.

We obtained copies of current Business Continuity Plans (BCP) and Business Impact Analysis (BIA) documentation for each of the four services. The following findings and limitations were noted:

- All BCP and BIA were in place for the services reviewed.
- The approach to documentation differed between services: ICT Services, Information, and Health Records utilised a single BCP and BIA across the three regions whilst PIA maintained individual region specific BCP and BIA documents (i.e. specific versions for East, Central and West respectively).
- The senior manager responsible for site was recorded on all six Business Continuity Plans reviewed and for five of the six Business Impact Assessments reviewed (was not noted on Health Records BIA).
- Each of the three region PAI Services BCPs and BIAs had been reviewed during 2020 which is consistent with best practice, though we did note that the BIA versions provided for review were still marked as "draft".
- Health Records had also reviewed their BIA during March 2020, however their BCP had not been reviewed since November 2017 (date of next review noted as 29/07/20 – see below).
- ICT Services had last reviewed their BIA during March 2018. The date of last review was not recorded on the BCP provided, and this document was also marked as "draft".
- Information had last reviewed both BIA and BCP during February 2018. The BCP was marked as "draft".
- Of the twelve documents reviewed, only one noted a date of next review - this was Health Records BCP which was due for review during July 2020.
- All four Informatics services had utilised the same Business Impact Analysis template. We noted that ICT Services and PAI East had completed the document comprehensively. We found some gaps in the completion of the four remaining BIAs specifically around staff mapping.

- Similar omissions were observed in the completed Business Continuity Plans of both PAI Services (all three areas) and Health Records. We found examples of action boxes having not been filled, incomplete tables (Prioritised Activities – Impact of Disruption and Risk Assessment), and incomplete staff mapping.
- Though the content is comparable, we did note that a different / amended version of the Business Continuity Plan template had been utilised by ICT Services – though the document was comprehensively completed.
- Recognising the differences in approaches and service requirements we noted that Informatics have developed a Business Continuity Plan Standard Operating Procedure (SOP) document to aid Business Continuity Leads across services and ensure practice complies with Health Board policy requirements. At the time of review, the SOP was in draft stage.

Testing exercises and lessons learned

Health Board policy supporting document A Guide to Business Continuity Management BCMP01(a) states that:

> *"An organisation's business continuity and incident management arrangements cannot be considered reliable until exercised. Exercising is essential to developing teamwork, competence, confidence and knowledge, which is vital at the time of an incident. Arrangements should be verified through exercising, and a process of audit and self-assessment, to ensure that they are fit for purpose."*

Furthermore, the Business Continuity Management Policy BCMP01 states that:

> *"Each department will test annually its business continuity arrangements via an exercise or debrief of a business continuity event and produce a report of the lessons identified."*

We sought evidence that exercises had taken place testing the effectiveness of the Business Continuity Plans reviewed. We also requested evidence that a debriefing session had been held to review the outcome of the testing exercise with evidence of lessons learned being considered and implemented into revised plans where appropriate.

Programmes Assurance and Improvement (PAI) and Information confirmed that no Business Continuity Plan testing exercise, or relevant debriefing sessions, had taken place during this financial year. We did not receive a response from ICT Services or Health Records.

Business Continuity Leads training

With regard to training, the Business Continuity Management Policy BCMP01 states that:

> *"Each department must have an identified, competent Business Continuity Lead. Nominated individuals must meet the requirements of the Business Continuity Lead role profile, full training and on-going support will be provided to the Business Continuity Lead by the Business Continuity Manager."*

We queried whether Business Continuity Leads had received appropriate training. Responses from Programmes Assurance and Improvement (PAI) and Information stated that they had no record of formal training having been undertaken. We did not receive a response from ICT Services or Health Records.

The Health Board Business Continuity Manager confirmed that no formal training had been provided this financial year. Training sessions / workshops had been arranged however these were postponed due to the onset of COVID-19 related work restrictions and reprioritisation. New sessions have been arranged for early 2021 and we were advised that work is currently underway to incorporate the Business Continuity training requirements onto Electronic Staff Records (ESR).

Business Continuity meeting/group representation

As previously noted Business Continuity is a standing agenda item on the Civil Contingencies Group, which sits monthly, and is subject to its own Business Continuity Working Group which meet twice per year.

We reviewed the 2020 minutes of the Business Continuity Working Group (held 28th February 2020 and 14th October 2020) and the July, September, October, and November 2020 minutes for the Civil Contingencies Group and noted the following:

- Medical Records had senior representation at each of two Business Continuity Working Groups held during 2020.
- Information had senior representation at the Business Continuity Working Group held in February 2020 but none at the recent (October) meeting.
- No representatives from PAI or ICT Services were present at either of the two meetings.
- Informatics have no representation on the Civil Contingencies Group.

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	**1**	**3**	**0**	**4**

Finding - ISS.1 – Informatics Business Continuity Documentation (Operating effectiveness)	Risk
We reviewed a sample of Informatics Business Continuity Plans (BCPs) and Business Impact Analysis (BIA) documents and found the following issues and limitations: • Whilst the majority of the forms had been completed appropriately, we found instances within both BCPs and BIAs where the required information had not been completed – examples included action boxes having not been filled, incomplete tables (Prioritised Activities – Impact of Disruption and Risk Assessment), and incomplete staff mapping. • Document tracking information had not been completed in all cases. • Whilst the content was largely similar, we noted that different Business Continuity Plan templates had been used. • Several documents remained marked as "draft".	Failure to adhere to policy and guidance documents. Lack of transparency. Lack of consistency.
Recommendation	**Priority level**
Following relevant scrutiny and approval, Business Continuity Plans and Business Impact Analysis documentation to be issued as final. Informatics Business Continuity Leads review the Informatics BC SOP and ensure it is consistent with the newly revised Health Board Business Continuity Policy.	**Medium**

Management Response	Responsible Officer/ Deadline
To update all Business Continuity Plans and Business Impact Analysis and gain approval of Informatics SMT.	Chief Information Officer 30/6/21
Work with DIGC on an assurance review for Business Continuity compliance to be part of the Assurance Report on an annual basis.	Head of Informatics Programmes Assurance and Improvement 1/2/21
Review and update the Informatics BC SOP so that it is aligned to the Health Board Business Continuity Policy.	Head of Informatics Programmes Assurance and Improvement 31/4/21

Finding - ISS.2 – Testing Exercises and Lessons Learned (Operating effectiveness)	Risk
We sought evidence that exercises had taken place testing the effectiveness of the Business Continuity Plans reviewed. We also requested evidence that a debriefing session had been held to review the outcome of the testing exercise with evidence of lessons learned being considered and implemented into revised plans where appropriate. Programmes Assurance and Improvement (PAI) and Information confirmed that no Business Continuity Plan testing exercise, or relevant debriefing sessions, had taken place during this financial year. We did not receive a response from ICT Services or Health Records.	Failure to adhere to policy and guidance documents. Plans in place untested and not operating as intended. Health Board unable to undertake prioritised activities in event of business disruption.
Recommendation	**Priority level**
Informatics management ensure that controls are in place to meet policy and legislative requirements. Programme of annual BC Plan testing and debrief / lessons learned to be documented and retained.	**High**
Management Response	**Responsible Officer/ Deadline**
Develop a scope and exercise for a single service exercise as a pilot. Arrange a BC Plan Exercise for the whole service* (Note: Due to the priority level we would hold this sooner but would want to do this as a live event with all key individuals in a room to gain maximum learning)	Head of Informatics Programmes Assurance and Improvement 30/6/21 Head of Informatics Programmes Assurance and Improvement 31/10/21

Finding - ISS.3 – Business Continuity Leads Training (Operating effectiveness)	Risk
We sought assurance that Business Continuity Leads had received relevant training per the Health Board Business Continuity policy. Responses from Programmes Assurance and Improvement (PAI) and Information stated that they had no record of formal training having been undertaken. We did not receive a response from ICT Services or Health Records. The Health Board Business Continuity Manager confirmed that no formal training had been provided this financial year.	Failure to adhere to policy and guidance documents. Lack of accountability.
Recommendation	**Priority level**
Informatics management ensure all Business Continuity Leads attend regular training.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Business Continuity Leads will attend training when provided by the BCUHB Business Continuity Team.	Head of Informatics Programmes Assurance and Improvement 1/12/21

Finding - ISS.4 – Business Continuity Meeting/Group Representation (Operating effectiveness)	Risk
Informatics has limited representation at either the Civil Contingencies Group, which sits monthly, or the Business Continuity Working Group, which meet twice per year. We noted that the Deputy Head of Health Records had attended both Business Continuity Working Group meetings during 2020.	Lack of consistency. Opportunities for identifying and implementing best practice missed. Interdependencies not identified or accounted for.
Recommendation	**Priority level**
Chief Information Officer considers the importance of Informatics engagement and representation at key Business Continuity meetings.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The CIO will ensure a representative attends at the Civil Contingencies Group and reports back to the Informatics SMT. Attendance will be reviewed at SMT.	Chief Information Officer 17/2/21 Quarterly Review

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

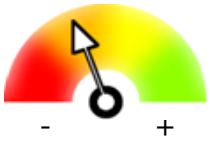
Governance Arrangements Mental Health & Learning Disabilities

Internal Audit Report

BCU 2020/21

January 2021

NHS Wales Shared Services Partnership

Limited Assurance

Previous review rating Limited Assurance

Contents **Page**

Review reference:	BCU-2021-38
Report status:	Internal Audit Report
Fieldwork commencement:	5th August 2020
Fieldwork completion:	20th October 2020
Discussion draft report issued:	21st October 2020
Draft report issued:	4th November 2020
Management response received:	7th January 2021
Final report issued:	8th January 2021
Auditor/s:	Principal Auditor Head of Internal Audit Director of Audit & Assurance
Executive sign off:	Director of Public Health/Acting Deputy Chief Executive
Distribution:	Interim Director of Mental Health & Learning Disabilities, Interim Director of Nursing MHLD, Head of Governance & Statutory Compliance, Governance & Policy Manager & Acting Board Secretary
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:

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 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

Governance structures and their application are fundamental to ensuring the success of the Health Board in delivering its statutory obligations.

Good corporate governance plays a vital role in underpinning the integrity and efficiency of the Health Board and the wider community in which it operates. Robust, properly developed, and embedded governance structures are fundamental to ensuring the achievement of the Health Board's strategic objectives and in delivering its statutory, regulatory and legal requirements.

The division is led by a director and is required to have effective governance arrangements in place for the services they are held accountable for, in order to provide assurance to the Board and its Committees on the quality and effectiveness of the services provided to its users, coupled with ensuring the aims and objectives set by the Board, and set out in the Health Board Operational Plan, are delivered.

2. Scope and Objectives

The overall objective was to review the governance arrangements in place for Mental Health and Learning Disabilities Division (MH&LD) in line with the previous internal audit review undertaken in February 2019 and follow-up on previous agreed management actions.

The scope of this review considered:

- Follow-up implementation of agreed actions;
- Status of Together for Mental Health Strategy;
- Identifying current management and scrutiny structure; and
- Establishing the governance arrangements, application of scrutiny and provision of assurance to Executive management and Board.

3. Associated Risks

The following risks have been identified at the outset:

- Poor ineffective governance leads to decisions taken without appropriate timely accurate information, lack of challenge/scrutiny and authority;
- Quality and safety matters are not regularly reviewed which impacts on the delivery of patient care;
- Key Risks to the Health Board are not identified, assessed, managed/mitigated, reviewed;
- Reputational damage; or
- Performance is not properly managed.

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 **Governance Arrangements Mental Health & Learning Disabilities** 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	Governance arrangements pre & post COVID-19		✓		
2	Together for Mental Health Strategy implementation		✓		
3	Follow-up		✓		

** 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 Governance Arrangements Mental Health & Learning Disabilities.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weakness in the operation of the designed system/control for Governance Arrangements Mental Health & Learning Disabilities.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided by the Acting Director of Mental Health/Director Partnership, Head of Governance and Compliance and the Business Support Manager. 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.

Governance arrangements pre & post COVID-19

Substantive Management structure

Currently the Director of Mental Health & Learning Disability (MH&LD) has overall responsibility for the MH&LD structure underpinned by six directors:

- Director of Nursing
- Director of Operations & Service Delivery
- Director of Psychology Services
- Director of Transformation
- Director of Partnership
- Medical Director

At the time of writing this report senior management arrangements were not as stable as expected, with a number of sickness related absences/vacancies. We have detailed this below in table 1.

Table 1 – Senior leadership status

Post	Status
Director of MHLD	Unplanned absence since 6th November 2019; Director of Partnerships covering from December 2019 [but have been unable to corroborate this was officially confirmed]; an Interim Director appointed from 1st October 2020.
Medical Director	In post.
Director of Nursing	Unplanned absence since 22nd April 2020. Internal cover arranged, initially, followed by external support from the beginning of May

	for a short period, followed by Director of Nursing support from within BCUHB until the Interim Director appointed from 10th August 2020.
Director of Psychology Services	Vacant.
Director of Operations & Service Delivery	Director was in post, but was asked to be the Programme Director for The Ablett Redevelopment. As of June 2019 with substantive Director of Nursing covering both posts.
Director of Partnerships	In post but covering two other posts also (Director of MHLD & Director of Transformation). Secondment to Welsh Government from 1st October 2020.
Director of Transformation	Unplanned absence since 4th March 2019 with Director of Partnerships covering.

The Director of Partnerships was requested to cover three roles (Director of MHLD & Director of Transformation), including their own. This was further affected due to COVID-19 where the Director of Partnerships also took responsibility for the communications work stream within the Gold command structure.

We have been advised that an Interim Director of Improvement has been appointed from the 29th June 2020 but this post does not appear in the current management structure.

Overview of MH&LD Governance arrangements

Our initial findings are based on the governance structure we were provided with and being worked to [pre the impact of COVID-19] and agreed by Divisional Directors on the 3rd December 2019. As MHLD entered phase 1 of COVID, the existing Governance Structure/Meetings were stood down and replaced by the Gold Command structure and Clinical reference Group (CRG).

We requested evidence of minutes, Terms of Reference (TORs) and the cycle of business for Tier 1 and Tier 2 meeting for November 2019 to March 2020 inclusive [Pre COVID-19].

The Division has two 'Tier 1' and three 'Tier 2' meetings established through which it governs its business. Underpinning both tiers is 'Tier 3' with twenty (20) groups /meetings through which Tier 2 receives its assurance and holds others to account.

Eleven of the Tier 3 groups/meetings feed into Tier 2 Quality – Safe, Effective, Experience, and Leadership (QSEEL), these being:

- Divisional QSEEL sub group;
- Mortality Review sub group;
- Safeguarding Forum;
- Policy sub group;
- Clinical effectiveness sub group;
- Health and Safety sub group;
- Risk & Governance sub group;
- Medicines Management sub group; and
- Locality QSEEL sub groups x 3.

Five of the Tier 3 groups feed into Tier 2 Operational Accountability meeting (OAM):

- Charitable funds sub group; and
- Operational Accountability Sub group x 4.

Six of the Tier 3 groups feeding into the Strategy, Service and Redesign Group (SSRD):

- Quality & Workforce Sub Group x 6.

Governance Structure

Tier 1 Divisional Directors [Business] meeting - monthly

We were provided with a ToR which was neither signed nor dated, nor does the ToR formally record the established Tier 2 meetings that report to them. We have been unable to confirm that the ToR has been approved.

The purpose for the meeting is recorded as:

> "*To create a single line of accountability for all aspects of performance, governance, quality and patient safety, patient experience, operational standards, financial performance, workforce and environmental issues".*

We reviewed the minutes of the meetings provided to us and cross referenced with the cycle of business. All three sets of minutes met the monthly requests for information as detailed within the cycle of business.

With regards to the Divisional Directors (Business) meeting, December 2019, Chairs Assurance reports cannot be seen being presented to the meeting from any Tier 2 groups/meetings. For both January and February 2020 meetings, Chairs Assurance reports can be evidenced for both QSEEL and OAM.

The March Business Divisional Directors meeting was stood down due to COVID.

In reviewing minutes and verifying to the TOR, we noted the quorum stated:

> *"At least the Chair or Vice Chair plus 2 members of Divisional Directors Business Group must be present to ensure the quorum of the Group*."

The Chair is noted as the Director of Mental Health and Learning Disabilities,

however Vice Chair, at the time of our review, was still to be recorded.

Of the three sets of minutes we were provided, only the meeting of the 25th February 2020 was quorate; 3rd December 2019 meeting chaired by Director of Partnerships; and 28th January 2020 meeting was chaired by the Medical Director with Chief Finance Officer noted as Vice Chair.

Tier 1 Divisional Directors Strategic meeting

We were provided with ToR which was neither signed, dated or formally records the established Tier 2 meeting(s) that report to it. We have been unable to confirm that the ToR has been approved.

The monthly Divisional Directors strategic meeting notes its purpose as

> "*The purpose of the Divisional Directors Strategic Group, has been established to create a single line of accountability for the Divisional Directors to formally report Strategic matters relating to their portfolios".*

We reviewed the minutes of the meetings provided to us, but were unable to cross reference with the cycle of business as we only received a template which was incomplete.

Although Strategy and Service Re-design (SSRD) Chair's Assurance report forms part of the Tier 1 Strategic agenda, we were unable to see a Chairs Assurance report being presented to this meeting for December 2019, January and February 2020 but we did note a Chairs Assurance report presented to the Strategic meeting on the 10th March 2020.

In reviewing minutes and verifying to the TOR, we confirmed that the meetings were quorate.

Division reporting to Committee/Executive

Whilst the Divisional Directors ToRs (Reporting and Assurance Arrangements) were noted as reporting through to the Executive Team, we sought to review what assurance/reports/updates were provided to Committee(s).

We reviewed the agenda and minutes for the Strategy, Partnerships and Population Health Committee (SPPH) and Quality, Safety and Experience Committee (QSE) respectively.

Below is a table of corporate meetings we identified to determine what was reported.

Table 2 – Divisional reporting to SPPH Committee

Committee	Date	Findings
SPPH	12th November 2019	No report
	3rd December 2020	No report
	14th January 2020	No report
	5th March 2020	No report
	9th June 2020	No report
	13th August 2020	SP20/44.2 Learning Disability: North Wales Together: Seamless Service for

Committee	Date	Findings
		People with Learning Disabilities Strategy 2018-2023: Programme response to COVID-19: Highlight Report and Recovery Plan. SP20/44.3 Mental Health - Healthier Wales – Together for Mental Health Q1 Progress Update

Table 3 – Divisional reporting to QSE

Committee	Date	Findings
QSE	19th November 2019	QS19/175 Mental Health Services - Quality & Performance Assurance Report
	28th January 2020	QS20/13 Mental Health and Learning Disabilities Exception Report
	17th March 2020	QS20/56 Psychological Therapies Update QS20/75 Joint Follow up Report on Audit of Conwy CMHT
	5th May 2020	QS20/90 Psychological Therapy Services - update report
	3rd July 2020	No report required
	29th July 2020	No report required
	28 August 2020	QS20/161 report provided

Table 4 – Divisional reporting to the Executive QSG meeting

Executive Meeting	Date	Finding
Quality Safety Group	8th November 2019	Assurance reports MHLD QSG Report November 30.10.19
	12th December 2019	Assurance reports MH report December 19
	10th January 2020	Mental Health and LD IoS QSG January 2020 report MHLD
	18th February 2020	Mental Health & Learning disabilities MHLD QSG report Feb 20

Tier 2 – Quality – Safe, Effective, Experience, and Leadership Group (QSEEL)

The ToR were signed by the Chair [Director of Nursing] on the 21st March 2019 and approved on the 20th September 2018.

Although the nine sub groups/meetings were identified within the organisational structure as feeding into the QSEEL none of these are formally noted as reporting to QSEEL in its ToR.

In line with the Cycle of Business for QSEEL, reports requested from the sub groups can be seen feeding into the meetings of 17th December 2019, 21st January 2020 and 18th February 2020. No Health & Safety reports can be seen requested within the cycle of business for 2019, this is because H&S reports form part of the locality QSE reports and are reported as part of the Chair's assurance report.

Issues of Significance that report/escalate matters to Divisional Directors and feedback from Corporate QSG meetings were viewed on the agenda.

The Quorum states:-

> *The Chair or Vice-Chair plus six substantive members of the Q-SEEL group. A nominated deputy for any substantive member who is unable to attend.*

According to the membership within the ToR the chair is the Director of Nursing and the Vice Chair is the Medical Director. From the four meetings we reviewed three of the meetings were chaired by the Assistant Director of Nursing (17th December 2019, 18th February 2020 and the 17th March 2020) with the Medical Director not in attendance – The three meetings were not quorate.

Tier 2 – Operational Accountability Meeting (OAM)

We were provided with a signed and dated ToR [14th November 2019] by the Director of Operations and Service Delivery. Within the organisational structure the OAM has five sub groups (as noted previously) reporting into the meeting; none of these are identified within the ToR.

Exception reports can be seen presented to the OAM from the East, Central, West and Regional Specialist Services (RSS). We did not see evidence of the charitable funds group reporting to any of the meetings provided. We did receive evidence of a charitable funds Chair's assurance report relating to a charitable funds meeting held on the 20th February 2020, which was due to be on the agenda at the OAM meeting in March 2020, however this meeting was subsequently stood down due to COVID.

No cycle of business was available although we were informed that the meeting has a standardised agenda each month and therefore not required.

In reviewing minutes and verifying to the TOR, we noted the quorum stated:

> *The quorum shall consist of no less than 4 and must include, as a minimum, the Chair or Vice Chair of the Group*

Within the membership of the ToR it identifies the chair as the Director of Nursing and Operations and the vice chair as Head of Programme. From the three sets of minutes provided on the 17th December 2019 and the 8th February 2020 the named Vice Chair that undertook the meeting was the Chief finance officer.

Tier 2 – Strategy and Service Re-design Group (SSRD)

We were provided with a ToR which was neither signed nor dated. We have been unable to confirm that the ToR has been approved

Within the organisational structure, SSRD has six established quality and workforce sub-groups, which is formally noted as reporting to SSRD in the ToR.

From the minutes provided to us we have not been able to identify the six sub quality and workforce groups reporting into the SSRD.

No items for escalation can be seen as an agenda point within the minutes.

We have not received a copy of the cycle of business and we were informed that one has not been developed.

We confirmed that the meetings we received were all quorate, however it should be noted that the attendance at the meetings is low.

Walk through test of pre COVID-19 governance arrangements

During our review we were sighted on a key report within the division that we sought to evidence as progressing through the established governance arrangements, this being the Psychological Therapies Report.

Psychological Therapies report

From the minutes provided we see the report being discussed at the Divisional Directors strategic meeting on the 10th December 2019, recording the following:

> *DDS19.165 Psychological Therapies Review*
>
> *This item had been discussed at the Divisional Directors Strategy meeting held on the 12th November 2019, but members agreed further time was required to review and discuss the review further and it was agreed by members for the review to be on the agenda at 10.12.19 Strategic Meeting.*
>
> *Members agreed the report needs to be on the OAM, QSEEL and SSRD agendas.*

We were unable to see the report appearing on any of the QSEEL, OAM and Strategic agendas provided to us but are aware it was presented to the Together for Mental Health Partnership Board in December 2019 but have been unable to corroborate this.

The report was discussed at the corporate QSE committee meeting on the on the 28th January 2020; 17th March 2020; and 5th May 2020.

COVID-19 governance arrangements within the Division (Gold Command)

As the Health Board entered phase 1 of COVID-19, the existing Divisional governance structure/meetings were stood down and replaced by the Gold Command structure and Clinical reference Group (CRG).

Gold Command met regularly during phase 1, initially twice daily, then daily and then weekly.

As well as Gold Command, during May 2020 a Planning Performance Governance (PPG) meeting was established to replace the Divisional Business meeting [stood down in March 2020 due to COVID-19].

We were provided with Gold command minutes for March, April, May and June 2020 and PPG minutes for May, June, July and August 2020.

We were able to identify situation reports from the areas reporting into the Gold command, focusing on COVID matters. The PPG considered issues within the wider Division, however there was no apparent accountability or scrutiny of day to day operations with no assurance reports being received from any of the tier 2 groups, following the resumption of 'business as usual' in July and August 2020 respectively.

During our review we were sighted on a further key report within the division that we sought to evidence as progressing through the established governance

arrangements, this being a Safeguarding Review at Heddfan.

Heddfan Safeguarding Peer Review Report 31st July 2020

We were made aware that the Corporate Safeguarding Team had produced a report on the Heddfan Unit and sought to evidence the report progressing through the local quality and safety structure.

We reviewed the minutes of the Planning Performance Governance meeting [established in place of Divisional Directors Business meeting] and could find no reference to the review in minutes could be found.

Healthcare Inspectorate Wales (HIW) Reviews

We obtained a list of all HIW reports pertaining to the Division to further evaluate the effectiveness of the governance arrangements in receiving and considering each report.

We sought to identify the following reviews beginning with the QSEEL sub group's Chairs Assurance Reports escalating through the MH&LD governance structure.

- 16th, 17th and 18th September 2019 - Unannounced Inspection of Cemlyn Ward, Cefni Hospital;
- 15th to 16th October 2019 - Unannounced Inspection of Wrexham Community Mental Health Team (CMHT); and
- 27th to 29th January 2020 - Unannounced Inspection of Ty Llywelyn.

Our review of papers identified the following:

Cemlyn Ward

- Tier 1 Divisional Directors - Business

  DD19.146 c HIW Improvement Plan – Cefni Hospital – 19037 3rd December 2019

  Members had received an email dated 27.11.19 from the Director of Nursing, Service Delivery and Operations asking for this item to be reviewed by members at today's meeting before final submission.

Wrexham Community

- Divisional QSEEL Group Meeting Tuesday 18 February 2020

  Ref 20200218.7 EFFECTIVE 7.1.3 HIW – Wrexham CMHT Improvement Plan

  Received by Divisional QSEEL. Accepted by HIW. Team progressing actions.

- Divisional Directors - Business Tuesday 25th February 2020

  Ref DD20.18 Quality, Safety & Experience Healthcare Inspectorate Wales

  Action plan for Wrexham CMHT discussed. Noted that HIW have recently visited Ty Llywelyn. Report not received to date.

- Divisional QSEEL Group Meeting (Mini Review) 17th March 2020

  Ref 20200317.7 EFFECTIVE 7.1.3 HIW – Wrexham CMHT Improvement Plan.

Ty Llywelyn

- Tuesday 18th February 2020 RSS chairs assurance feeding into the Divisional QSEEL

  HIW/CHC action plans:

  HIW visited Ty Llywelyn week commencing 27th January 2020 – positive feedback received. Action plan developed and progressed.

- Divisional Directors Meeting [Business] Tuesday 25th February 2020

  Ref DD20.18 Quality, Safety & Experience Healthcare Inspectorate Wales

  Action plan for Wrexham CMHT discussed. Noted that HIW have recently visited Ty Llywelyn. Report not received to date.

- Divisional QSEEL Group Meeting (Mini Review) 17th March 2020

  Ref 20200317.7 EFFECTIVE 7.1.9 Ty Llywelyn HIW Inspection Improvement Plan.

  Report currently embargoed.

QSE Committee

- For the meetings of 19th November 2019 and 28th January 2020, outstanding HIW action points are noted agenda points within the reports presented to the Committee.
- Mental Health Services: Quality & Performance Assurance Report presented 19th November 2019 - Inspection of Cemlyn Ward, Cefni Hospital and inspection of Wrexham Community Mental Health Team including outstanding actions. We noted the same for the meeting of the 28th January 2020.

No MH&LD Quality and Performance Report can be seen going to QSE on the 17th March 2020, however the inspection of Wrexham Community Mental Health Team was noted when the Committee was asked to approve the new Corporate Nursing Tracker Tool for improvement actions and the revised approach to monitoring the implementation of the actions.

<u>Interaction of Division within the Health Board</u>

As the division provides Community and Acute Services we contacted several key officers, seeking their views on how well the division interacted with other divisions/departments.

Whilst recognising these are the views from officers we met, we have not discussed these with the Division due to the unplanned ongoing absence of several senior staff who would have been in post to reply. Consequently, we have not corroborated these assertions:

- Positive feedback around ICAN team working in collaboration with others across the Health Board.
- At the local operational level, there was a general consensus that community-based services interact well but this was not the experience all the time.
- There was a view that the division is seen as separate to other Health Board services and acts akin to a mini Trust within the Health Board.
- No consultation with Areas on the quarter 2 plan or consultation regarding Psychological Therapies report.
- Some difficulty experienced in obtaining engagement from the division concerning Continuing Healthcare packages where the budget for EMI patients rests in the Areas.
- We were advised there was no Director communication between mental health and the area teams.

Together for Mental Health (T4MH) Strategy implementation

We sought to follow-up progress in delivering T4MH through reviewing the overarching Implementation Plan [created following a previous internal audit review] to evidence implementation of the approved strategy.

We were provided with a copy of the overarching plan on the 7th August 2020, but noted the last recorded update is the 23rd July 2019.

Our high level review of the status of the implementation plan is detailed in table 5 below. Table 6 details the tasks and status of each action as at the time of review.

Table 5 – High level status of the T4MH Strategy implementation plan

Plan Overview	Status of actions at last update 23rd July 2019	Status of actions at time of undertaking review
Number of Actions - Complete	6	6
Number of Actions - Processes Ongoing	5	0
Number of Actions - Underway/No concerns	33	1
Number of Actions - Part Complete/Concerns	0	0
Number of Actions - Past Completion Date	0	97
Number of Actions - Not due to Commence	81	10

Number of Actions – Past Commence Date but not Completion	-	13
Number of Actions – No Dates	-	13

Table 6 – T4MH Strategy tasks status and number past recorded completion date

Task	No of Actions	Actions past completion date at time of review
1. Project Management	8	6
2. Governance	5	5
3. Analysis	10	10
4. Primary Care	8	5
5. Community Care	17	13
6. Bed Based Care	13	5
7. Systems Leadership Programme	4	4
8. Workforce	24	14
9. Training and Development	13	7
10. Organisational Development	2	0
11. Performance	7	6
12. Evaluation	4	4
13. Commissioning	5	5
14. Communications and Engagement	9	9
15. Estates	6	0
16. Business Cases	1	0
17. Finance	4	4
Total	140	97

Based on our findings from the evidence provided to us we have been unable to determine that the strategy is on time for delivery. As highlighted above a number of actions (97) at the time of this review are out of date and past the date of when the task should have been completed.

Follow-up

As part of this review, we sought to follow-up and close recommendations made in the previous governance review on the division.

Utilising the TeamCentral tracking system we reviewed the last updates and uploaded evidence. We found that four recommendations had some progress noted with three having no progress detailed.

Based upon the findings, as detailed above, within this report, we do not believe the division has progressed all recommendations satisfactorily to enable any to be closed.

7. Summary of Recommendations

The audit findings and 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	**3**	**0**	**0**	**3**

Finding - ISS.1 – Divisional governance arrangements (Operating effectiveness)	Risk
There has been limited progress since the previous internal audit report in addressing governance issues. This has been compounded by the absence/vacancies at Director level and COVID-19. With the exception of progress at QSEEL, no other definitive progress can be evidenced. There remains a high number of groups/meetings within the division and it remains unclear whether these add to effective governance.	Established Terms of Reference that are not complied with/incomplete.
Recommendation	**Priority level**
The Lead Executive Director for Mental Health reviews the governance and management structure and whether it remains fit for purpose.	**High**
Management Response	**Responsible Officer/ Deadline**
The Division has reviewed its Governance and Accountability Framework which is aimed at setting out the framework within which it operates. It is a key internal governance document for the Division and its purpose is to maximise transparency efficiency and accountability regarding how the Division is run. The framework sets clear expectations on standards, roles, accountabilities and responsibilities across the Division. The Divisional Senior Leadership Team meet weekly. The Membership and Terms of Reference (x4) for this group have been developed to be aligned to	Director MHLD End March 2021

the business of the day – Quality, Safety and Experience; Finance and Performance; Clinical Advisory Group; Business. The meetings will receive Division wide reports relevant to that particular meeting and in accordance with the agreed cycle of business and meetings will focus on a specific business function. Agenda and supporting documents will be submitted aligned to the meeting schedule. The Framework has been approved by the Divisional Senior Leadership Team and is working towards full implementation.	

Finding - ISS.2 – Together for Mental Health Strategy (Operating effectiveness)	Risk
The Together for Mental Health Strategy implementation plan has not been updated since July 2019. There are a number of tasks that should have been completed by the time of this review but no evidence or updates were provided to us that demonstrates the Strategy is on time for delivery.	Strategy is no longer fit for purpose and has lost direction.
Recommendation	**Priority level**
The Health Board revisits the Strategy as a matter of urgency to ensure it remains relevant in delivering and supporting Mental Health services in North Wales.	**High**
Management Response	**Responsible Officer/ Deadline**
The principles of Together for Mental Health and Healthier Wales remain the strategic focus for delivery of Mental Health and Learning Disability services in North Wales. In line with the recommendation in this report, MHLD will undertake a review of the current interpretation and refocus to ensure services can respond appropriately to demand. MHLD will ensure there is a robust process established to ensure monitoring and achievement of key milestones.	Director MHLD March 2022

Finding - ISS.3 – Psychological Services (Operating effectiveness)	Risk
Our review found little to no regular reporting on Psychological therapy services during our review of papers with greatest focus on mental health services. Further the Director of Psychology Services post is vacant and it is unclear if/when this head of service post will be advertised.	Psychological Therapy services are not subject to the same focus and support.
Recommendation	**Priority level**
The Health Board considers whether all Psychological Therapy Services remain appropriately supported within the Division or become hosted/stand alone services.	**High**
Management Response	**Responsible Officer/ Deadline**
MHLD acknowledge there is a need to re-engage with the Psychology workforce. A key priority will be to ensure there is a Head of Psychology in post as part of the Senior Leadership Team to lead engagement with Psychology colleagues and determine clear proposals for the delivery of psychological therapies.	Director MHLD December 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:	**18th March 2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	• Audit Wales programme update • Audit Wales Audit Plan • Audit Wales Report: Doing it Differently, Doing it Right. All Wales Report on Governance in the NHS during the Pandemic • Procurement of PPE Letter (for information)
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary
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.

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 the regular audit update alongside reports finalised since the last audit committee.

Asesiad / Assessment & Analysis

Strategy Implications
The progress report may record issues/risks, identified as part of a specific review. The findings should be used to inform areas of work that support the Health Board in developing and delivering its associated strategies.

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
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
The WAO progress 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.

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: March 2021

Document reference: 2021A2020-21

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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).

2 In March 2021, we issued our 2021 Audit Plan which sets out the financial and performance audit work that we plan to undertake during 2021.

Accounts audit update

3 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2020-21 Financial Statements.	Planning work and interim audit testing is currently underway. Detailed work on the accounts will commence following their receipt on 30 April 2021.
Opinion on Financial Statements	Anticipated shortly after the submission of the audited financial statements on 11 June 2021.
Audit of the 2020-21 Funds Held on Trust Accounts	Audit currently anticipated in August 2021 but may be subject to change.

Performance audit update

4 The following tables set out the performance audit work included in our current and previous Audit Plans. However, given the on-going uncertainties around the impact of COVID-19 on the sector, some timings may need to be revisited.

Exhibit 2 – Work completed

Area of work	Audit Committee
Test, Trace and Protect	Published 18 March to be received at Audit Committee in June 2021

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 Services Commissioning Committee	This work is focussing on the governance and assurance arrangements of WHSSC. The draft report is in initial stages of clearance.	Drafting report June 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 regional partners are collaborating effectively to take account of demographic changes and other external pressures in the strategic commissioning of residential and nursing home care.	Fieldwork in progress, but some sites delayed as a result of service pressures. Fieldwork expected to be completed by May 2021.

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead – Chief Operating Officer	This review is examining the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges. Therefore, reporting has been moved to later in the Spring 2021 once the full year's position is known and Health Board's move to service recovery.	Drafting report
Quality Governance Executive Lead 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.	Fieldwork in progress June or September 2021
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 was postponed from 2020 to 2021. (Note this was replaced by work on Test, Track and Protect).

Exhibit 4 – Planned work not yet started or revised

Topic	Focus of the work	Current status
Structured Assessment	This work will be undertaken in two phases. • Phase 1 will review the effectiveness of operational planning arrangements. • Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management.	Fieldwork complete Not started
Ophthalmology services	We will recommence the review of eye care services, which we paused at the onset of the pandemic. This will consider both acute ophthalmology and community optometry service modernisation and action taken to reduce risk of harm resulting from delays in access to services.	Not started
Welsh Government additional funding	This work will provide an initial assessment of the Health Board's plans for the use of the additional Welsh Government financial allocation of up to £287m, which was agreed for a 3½ year period and commenced in 2020.	Not started
Follow-up outpatients	This work will provide a high-level commentary on the overall position of the Health Board, effectiveness of adoption of new technologies and ways of working, and to consider plans for recovering follow up outpatient performance.	Not started

Good Practice events and products

5 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.

6 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.

7 We have also developed a programme of webinars with a focus on how public sector bodies have responded to the various challenges that COVID has presented as well as looking to the future and how the pandemic could change how services are delivered going forward. The Covid Learning week is from 8th to 12th March and more details can be accessed here. Content will be released on daily and will be available on the Good Practice section of our website going forward.

NHS-related national studies and related products

8 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.

9 **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
Doing it Differently, Doing it Right? - Governance in the NHS during the COVID-19 crisis	January 2021

Title	Publication Date
Procurement and supply of PPE during the COVID-19 pandemic	December 2020
The National Fraud Initiative in Wales 2018-20	October 2020
Welsh Community Care Information System	October 2020
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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Archwilio Cymru
Audit Wales

2021 Audit Plan – Betsi Cadwaladr University Health Board

Audit year: 2020-21

Date issued: March 2021

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Contents

2021 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2021 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic continues to have an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 Audit Wales staff will continue to work pragmatically to deliver the audit work set out in this plan. In response to the government advice and subsequent restrictions, we will continue to work remotely until such time that it is safe to resume on-site activities. I remain committed to ensuring that the work of Audit Wales staff will not impede the vital activities that public bodies need to do to respond to ongoing challenges presented by the COVID-19 pandemic.

4 This audit plan sets out an initial timetable for the completion of my audit work. However, given the ongoing uncertainties around the impact of COVID-19 on the sector, some timings may need to be revisited.

Audit of financial statements

5 I am required to issue a report on the Health Board's financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. In preparing such a report, I will:

- give an opinion on your financial statements;
- give an opinion on the proper preparation of key elements of your Remuneration and Staff Report; and
- assess whether your Annual Governance Statement and other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

6 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

7 I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit Committee prior to completion of the audit.

8 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

9 I will also audit the financial statements of the Charitable Funds, for which I will issue a separate audit plan.

10 There have been no limitations imposed on me in planning the scope of this audit.

Audit of financial statement risks

11 The following table sets out the significant risks that have been identified for the audit of your financial statements.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
Significant risks	
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].	The 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.
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.

Financial audit risks	Proposed audit response
Significant risks	
Although the Board is currently forecasting to break even in 2020-21, it will once again fail to meet its first financial duty to break even over a three-year period. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion. The financial pressures on the Board increase the risk that management judgements and estimates could be biased to ensure the forecast position is met.	My audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias.
The COVID-19 national emergency continues and the pressures on staff resources and of remote working may impact on the preparation and audit of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.
The increased funding streams and expenditure in 2020-21 to deal with the COVID-19 pandemic will have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include accounting for field hospitals and their associated costs; fraud, error and regularity risks of additional spend; valuation of year-end inventory including PPE; and estimation of annual leave balances.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.

Financial audit risks	Proposed audit response
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. However, if any expenditure is made in year, we would consider it to be irregular as it contravenes the requirements of Managing Public Monies.	We will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.
Other areas of audit attention	
Introduction of IFRS 16 Leases has been deferred until 1 April 2022 and may pose implementation risks. There is considerable work required to identify leases and the COVID-19 national emergency may pose implementation risks.	The audit team will undertake some early work to review preparedness for the introduction of IFRS 16 Leases. See **Appendix 2, Exhibit 7** for more detail.

Performance audit work

12 In addition to my Audit of Financial Statements, I must also satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

13 Where appropriate, I will also take opportunities to assess the extent to which the Health Board is acting in accordance with the sustainable development principle[1] as per my duties set out in the Well-being of Future Generations (Wales) Act 2015. This work will be informed by the responses to my recent consultation on how I approach my duties in respect of the Act. I will be writing to the public bodies designated in the Act setting out the results of the consultation and how I intend to approach this work over the reporting period 2020-2025.

[1] The Act defines the sustainable development (SD) principle as acting in a manner: '…which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs'.

14 My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit. **Exhibit 2** sets out my current plans for performance audit work in 2021.

Exhibit 2: My planned 2021 performance audit work at the Health Board

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective and economical use of resources. The plans for 2021 structured assessment work reflect the ongoing arrangements of NHS bodies in response to the COVID-19 emergency. My 2021 work will be undertaken in two phases. Phase 1 will review the effectiveness of operational planning arrangements to help NHS bodies continue to respond to the challenges of the pandemic and to recover and restart services. Building on last year's work, Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management, drawing on lessons learnt from the initial response to the pandemic.
All Wales Thematic Reviews	**Unscheduled care arrangements** My 2020 audit plans included a thematic review examining different aspects of the unscheduled care system. However, this work was paused during the early stages of the pandemic and then ultimately replaced to allow resources to be diverted to a high-level review of the Test, Trace and Protect (TTP) programme. My planned work on unscheduled care will now be delivered as part of my 2021 programme. It will include an analysis of national data sets, a high-level commentary of the performance of the unscheduled care system. This will be followed by more detailed work focusing on the mechanisms for managing demand for unscheduled care and patient flow through the system.

Theme	Approach/key areas of focus
All Wales Thematic Reviews	**COVID-19-related outputs** I also plan to use an element of the 2021 audit fee to respond to aspects of the pandemic where my insight and knowledge across Wales will provide value to NHS bodies. The precise focus of this work will be kept under review and will be reflected in the regular updates that are produced for the audit committee.
Locally focused work	I will also undertake thematic performance audit work that reflects issues specific to the Health Board. This will include: • follow-up outpatients – to provide high-level commentary on the overall position of the Health Board, effectiveness of adoption of new technologies and ways of working, and to consider plans for recovering follow-up outpatient performance; and • an initial assessment of the Health Board's plans for the use of the additional Welsh Government financial allocation of up to £287 million, which was agreed for a 3½-year period and commenced in 2020.
Implementing previous audit recommendations	My structured assessment work will include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having. Expectations on the implementation of previous audit recommendations will be adjusted as appropriate to take account of the impact on COVID-19.

15 The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with you, are set out in **Appendix 1**.

Fee, audit team and timetable

16 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[2];
- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that both may have affected the financial statements and wider aspects of internal control.

Fee

17 My statutory 2021-22 Fee Scheme is due to be published soon. My fee estimates to audited bodies are then assessed and set. My audit team will therefore write to the Health Board soon with:

- my fee estimate for 2021; and
- my fee outturn for 2020, and any additional cost to be invoiced or rebate to be paid.

18 The fee letter will be presented to you at your next meeting. Planning will be ongoing, and changes to our programme of audit work and therefore the fee, may be required if any key new risks emerge. We shall make no changes without first discussing them with the Director of Finance.

19 Further information on my fee scales and fee setting can be found on our website.

[2] The agreed audit deliverables documents set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

Audit team

20 The main members of the audit team, together with their contact details, are summarised in **Exhibit 4**.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
Dave Thomas	Audit Director Performance Audit and Audit Wales Engagement Director for the Health Board	02920 320500	Dave.Thomas@audit.wales
Richard Harries	Audit Director Financial Audit	02920 320640	Richard.Harries@audit.wales
Amanda Hughes	Audit Manager (Financial Audit)	07969 919986	Amanda.Hughes@audit.wales
Simon Monkhouse	Audit Lead (Financial Audit)	02920 829394	Simon.Monkhouse@audit.wales
Andrew Doughton	Audit Lead (Performance Audit)	07812 094642	Andrew.Doughton@audit.wales

21 We can confirm that team members are all independent of you and your officers.

Timetable

22 The key milestones for the work set out in this plan are shown in **Exhibit 5**. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

Exhibit 5: Audit timetable

Planned output	Work undertaken	Report finalised
2021 Audit Plan	December 2020 to January 2021	February 2021
Audit of Financial statements work: • Audit of Financial Statements Report • Opinion on Financial Statements	February to June 2021	June 2021 June 2021
Performance audit work: • Structured Assessment • Unscheduled Care • COVID-19 outputs • High-level review of plans for the use of additional Welsh Government funding • Follow-up outpatients review	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	
2022 Audit Plan	December 2021 to January 2022	February 2022

Appendix 1

Performance audit work in last year's audit plan still in progress

The following table summarises the status of the audit work in last year's audit plan which is still in progress. The timing of our work may be impacted on as a result of the demand placed on the Health Board in its response to continued COVID-19 pressures.

Exhibit 6: Performance audit work still in progress.

Performance audit project	Status	Comment
Review of Welsh Health Specialised Services Committee	Reporting	A national report is due to be published in early 2021.
Unscheduled Care	Fieldwork	This work was paused as a result of the pandemic and replaced with a review of the Test, Trace and Protect (TTP) programme. Unscheduled care work has been carried forward to feature in this year's plan.
Test, Trace and Protect	Reporting	A national report is due to be published in early 2021.
Quality Governance	Fieldwork	This work has recently restarted with the aim to complete fieldwork by May 2021.
Review of eye care services	Not yet started	We will recommence the review of eye care services, which we paused at the onset of the pandemic. This will consider both acute ophthalmology and community optometry service modernisation, and action taken to reduce risk of harm resulting from delays in access to services.

Appendix 2

Other future developments

Forthcoming key IFRS changes

This table details the key future changes to International Financial Reporting Standards

Exhibit 7: changes to IFRS standards

Standard	Effective date	Further details
IFRS 16 Leases	1 April 2022	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on a balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.
IFRS 17 Insurance Contracts	2023-24 at the earliest	IFRS 17 replaces IFRS 4 **Insurance Contacts**, which permitted a variety of accounting practices resulting in accounting diversity and a lack of transparency about the generation and recognition of profits. IFRS 17 addresses such issues by requiring a current measurement model, using updated information on obligations and risks, and requiring service results to be presented separately from finance income or expense. It applies to all insurance contracts issued, irrespective of the type of entity issuing the contracts, so not relevant only for insurance companies. Entities will need to consider carefully whether any contractual obligations entered into meet the definition of an insurance contract. If that is the case, entities will need to determine whether they are covered by any of IFRS 17's specific scope exclusions.

Good Practice Exchange

Audit Wales' Good Practice (GPX) helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face to face and resources shared online. This year the work has focused on COVID-19 learning. Further information on this can be found our website.

Brexit: The United Kingdom's future outside the European Union

The United Kingdom left the European Union on 31 January 2020 under the terms of the Withdrawal Agreement. Between then and 31 December 2020, the UK entered a transition period, during which it continued to participate in EU programmes and follow EU regulations. On 31 December 2020, the transition period ended, and a new relationship between the UK and EU started, on the basis of a new free trade agreement.

The new agreement means some substantial changes in the trading relationship between the UK and the EU. There will also potentially be changes in administrative areas previously covered by EU law. In the short term, the UK has incorporated EU rules into domestic law. However, it is likely than in some key areas, such as public procurement, agricultural support and state aid, the UK will seek to diverge over time. In changing these rules, there will be some important constitutional issues around the relationship between the UK Government and devolved governments.

The wider opportunities and risks for Wales' economy, society and environment will become clearer as public services move from managing the short-term risks, especially around disruption to supply chains, to adapting to a different relationship with the EU and the wider world. We are also awaiting further details on the UK Government's plans to replace EU funding schemes for regional development and rural development.

The Auditor General will continue to keep a watching brief over developments. In November, he wrote to the Chair of the External Affairs and Additional Legislation Committee setting out some observations on the latest position with respect to preparations for the end of the transition period. His letter can be found here. His previous report on public bodies' Brexit preparations can be found here with his follow-up on progress here.

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Doing it Differently, Doing it Right?

Governance in the NHS During the COVID-19 Crisis – Key Themes, Lessons, and Opportunities

January 2021

This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998 and section 61(3) (b) of the Public Audit Wales Act 2004.

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg

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Summary

1 In times of crisis, the challenge for all public bodies is to adapt their governance systems, processes, and structures to ensure good governance is maintained. Indeed, it could be argued that maintaining good governance is more necessary than ever during a time of crisis to:

- sustain public confidence and trust;
- support agile and effective decision making;
- provide continued assurance to all relevant stakeholders; and
- facilitate post-crisis learning and recovery.

Governing during a crisis, therefore, is about doing it differently, but still doing it right.

2 As the COVID-19 crisis unfolded, it became increasingly clear there was no blueprint for governing during such unprecedented times. As a result, all NHS bodies in Wales were required to adapt their governance systems, structures, and processes and embrace new ways of working at an extraordinary pace.

3 Our structured assessment work this year provided a unique opportunity for us to see exactly how each NHS body adapted their governance systems, processes, and structures during the crisis to enable them to respond effectively to the numerous challenges and pressures posed by the pandemic.

4 We found that all NHS bodies operated effectively with a sense of urgency and a common purpose to adopt lean and agile ways of working and achieve rapid transformation whilst also maintaining a clear focus on core areas of business and governance.

5 This report provides an all-Wales summary of our structured assessment work with the aim of highlighting key themes, identifying future opportunities, and sharing learning in relation to the following areas of governance:

- putting citizens first;
- decision making and accountability; and
- gaining assurance.

> In times of crisis, the challenge for all public bodies is to adapt their governance systems, processes, and structures to ensure good governance is maintained. Indeed, it could be argued that maintaining good governance is more necessary than ever during a time of crisis.
>
> I have been assured that NHS bodies have largely maintained good governance throughout the crisis, with revised arrangements enabling them to govern in a lean, agile, and rigorous manner.
>
> The challenge now for each individual body is to fully evaluate their new ways of working, consider the opportunities outlined in this report, and maintain the sense of urgency and common purpose created during the crisis to establish and embed new approaches to governance in a post-pandemic world.

Adrian Crompton
Auditor General for Wales

1. Introduction

1.1 NHS bodies in Wales have faced unprecedented challenges and considerable pressures during the COVID-19 pandemic. Throughout this crisis, NHS bodies have had to balance several different, yet important, needs - the need to ensure sufficient capacity to care for people affected by the virus; the need to maintain essential services safely; the need to safeguard the health and wellbeing of their staff; and, the need to maintain good governance. In order to respond to these needs effectively, NHS bodies have been required to plan differently, operate differently, manage their resources differently, and govern differently.

1.2 Our structured assessment work[1] this year was designed and undertaken in the context of the ongoing pandemic. As a result, we were given a unique opportunity to see how NHS bodies have been adapting and responding to the numerous challenges and pressures posed by the COVID-19 crisis.

1.3 This report is the first of two publications which summarise the findings of our structured assessment work on an all-Wales basis with the aim of highlighting key themes, identifying future opportunities, and sharing learning both within the NHS and across the public sector in Wales more widely. This report focuses on how NHS bodies have governed during the COVID-19 crisis. Our second report will focus on how NHS bodies have supported the health and wellbeing of their staff during the pandemic, with a particular emphasis on the arrangements they have put in place to safeguard staff at higher risk from COVID-19.

1.4 In this report, we discuss the importance of maintaining good governance during a crisis and describe how NHS bodies in Wales operated differently during the pandemic in relation to the following areas of governance:

- putting citizens first;
- decision making and accountability; and
- gaining assurance.

This reports also considers the key lessons that can be drawn from the experiences of NHS bodies of governing during the COVID-19 crisis and concludes by highlighting potential opportunities for the future.

1 A structured assessment is undertaken in each NHS body to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied they have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources. Individual reports are produced for each NHS body, which are available on our website.

2. Maintaining good governance during a crisis

2.1 The systems, processes, and structures in place to maintain good governance are often placed under pressure when public bodies are reacting and responding to a crisis. This is understandable, as those systems, processes, and structures are largely designed to support and maintain good governance in normal times. In times of crisis, the challenge for public bodies is to adapt their systems, processes, and structures to ensure good governance is maintained and not weakened or overlooked in any way.

2.2 Indeed, it could be argued that maintaining good governance is more necessary than ever during a time of crisis for the following reasons:

- **Sustaining public confidence and trust** – public scrutiny is often greater during times of crisis. The public need to be assured that public bodies are responding appropriately in the public interest to the pressures and challenges they face during a crisis, and that any disruptions or changes to service provision or quality are managed, minimised, and communicated as much as possible. A failure to act in the public interest, to communicate effectively, and to maintain openness and transparency during a crisis could significantly weaken public confidence and trust in public bodies.
- **Ensuring the right decisions are made in the right way at the right time** – due to the uncertain, complex and dynamic nature of a crisis, leaders and managers need to be empowered to react and respond at pace. Agile and rapid decision making, therefore, are critical during a time of crisis. However, decision-making authority during a time of crisis needs to be clearly defined and communicated to ensure the right decisions are made by the right people in the right way at the right time. Furthermore, in the interests of openness, transparency, and accountability, decisions made during a time of crisis need to be documented accurately, accompanied by a clear rationale, and made available for inspection and scrutiny.

- **Providing continued assurance** – maintaining, and adapting where necessary, key internal controls is more necessary than ever during a time of crisis to assure stakeholders that all relevant risks are managed; that resources continue to be used efficiently and economically; and, that service quality and safety is maintained. The challenge, however, for those responsible for providing oversight and scrutiny of public bodies – both internally and externally – is not to overburden or distract leaders and managers whilst they are dealing with a crisis. Instead, the level of oversight and scrutiny should be proportionate and targeted to ensure the relevant stakeholders receive sufficient assurance over key matters during the crisis.
- **Supporting public bodies to build back better** – maintaining good governance during a crisis can support public bodies to transition effectively from the response phase of a crisis to the recovery phase by ensuring non-essential services, processes, and systems are reinstated and reintroduced in the right way at the right time. Good governance during a crisis can also support public bodies to 'build back better' by enabling them to capitalise on the opportunities created by a crisis for them to innovate, transform, and achieve greater resilience.

In short, therefore, governing during a crisis is about doing it differently, but still doing it right.

3. How health bodies governed differently during the pandemic

3.1 All NHS bodies quickly adapted their governance arrangements at the outset of the pandemic in line with their emergency plans and Welsh Government guidance.[2] The Welsh Government guidance, which was issued in May 2020, endorsed a series of principles developed by Board Secretaries which were designed to help focus consideration of governance matters during the response phase of the pandemic. The guidance also outlined key areas for the Quality and Safety Committees and Audit Committees of each NHS body to discharge during the period.

3.2 In this section, we briefly describe how NHS bodies governed differently during the pandemic, focusing in particular on their arrangements for putting citizens first, decision making and accountability, and gaining assurance.

Putting citizens first

3.3 All NHS bodies are expected to conduct their business in an open and transparent manner and actively encourage the engagement of their local populations, partners, and other stakeholders. This is achieved in a number of ways, including actively engaging partner organisations such as Community Health Councils, conducting board meetings in public, and making board and committee papers and minutes available for public inspection. However, NHS bodies have been unable to hold their meetings in public in the normal manner during the pandemic due to the need to observe social distancing guidelines and restrict public gatherings. As a result, they have been required to embrace new ways of working to maintain openness and transparency and to ensure effective engagement with all relevant stakeholders during the crisis.

3.4 We found that all NHS bodies moved swiftly to holding virtual board and committee meetings at the start of the pandemic. Although a small number of NHS bodies encountered some challenges rolling-out the necessary technology and software required to support virtual meetings, these were overcome relatively quickly. We found that all NHS bodies adapted well to virtual meetings, with participants observing suitable etiquette and using the relevant software features appropriately to ensure online meetings were conducted effectively.

2 Guidance Note: Discharging Board Committee Responsibilities during COVID19 response phase

3.5 In order to maintain openness and transparency during the pandemic, we found that NHS bodies have been using a range of different online video platforms to either live-stream or record all relevant meetings. Several NHS bodies also increased the frequency of their board meetings to provide greater public transparency on their response to the pandemic. In terms of facilitating public involvement in virtual meetings, we found that most NHS bodies have been able to support members of the public either to submit their questions in advance of a meeting or to ask their questions directly during the relevant meeting.

3.6 In addition to holding virtual meetings, we found that all NHS bodies continued to publish board and committee papers on their websites in advance of meetings. We also found that minutes of meetings were produced in a timely manner, with some NHS bodies publishing summary versions on their websites within a matter of days to enhance openness and transparency. In addition to publishing information on their websites, we found that all NHS bodies have also been making effective use of their official social media channels to provide information to the public and other stakeholders on a range of matters, including information relating to their revised governance arrangements.

3.7 We found that all NHS bodies established mechanisms to maintain regular communication with partners during the pandemic, such as Members of Parliament, Members of the Senedd, Local Authority Leaders and Chief Executives, Police Forces, Fire and Rescue Services, Community Health Councils, third sector organisations, and other health bodies within their regional footprint. In terms of Community Health Councils (CHCs), we saw examples of effective communication and joint working between some health bodies and their respective CHCs, such as:

- inviting CHC Chief Officers to participate in virtual board and committee meetings;
- sharing details of temporary services changes introduced during the pandemic with CHCs; and
- involving CHCs in quarterly operational planning arrangements, or consulting with them on draft operational plans prior to their submission to Welsh Government for approval.

Decision making and accountability

3.8 All NHS bodies are required to operate within a robust framework for decision making and accountability, which is largely codified in a series of governing documents such as Standing Orders, Schemes of Delegation, and Standing Financial Instructions. Collectively, these documents set out the arrangements within which the boards, committees, and the executive and operational structures of NHS bodies undertake their day-to-day activities, make decisions, and ensure accountability. However, during the COVID-19 crisis, all NHS bodies were required to revise their arrangements and structures in order to respond strategically, tactically, and operationally to the challenges and pressures posed by the pandemic.

3.9 We found that the majority of NHS bodies agreed temporary revisions to their Standing Orders to enable and facilitate new ways of working during the crisis; to ensure a focus on essential business and key COVID-19 related risks and matters; and, to minimise the administrative and reporting burden placed on leaders and managers during the pandemic. Whilst each body revised their Standing Orders to meet their own individual business needs and circumstances, we found some common temporary changes, including:

- standing down some board committees;
- redistributing essential committee business and postponing non-essential business;
- creating provision for streamlined agendas, including the use of a consent agenda[3] in some bodies;
- enabling focused reporting, including greater use of verbal reporting; and
- allowing Independent Members to submit questions and comments on papers in advance of board and committee meetings.

Revisions to Standing Orders were also made to enable the changes discussed previously relating to virtual meetings and public participation during the pandemic. We found that boards and committees adapted well to these new ways of working, with Independent Members continuing to provide effective scrutiny and challenge within the streamlined and virtual meeting environment.

3 A consent agenda is a technique for addressing and approving several matters in a single agenda item, such as reports, minutes, and other items that do not require discussion.

3.10 We found that all NHS bodies established formal command and control structures to enable rapid and agile decision making and ensure a coordinated response to the pandemic at a strategic, tactical, and operational level within their organisations. The command and control structures in most NHS bodies included Gold (Strategic) Groups, Silver (Tactical) Groups, and Bronze (Operational) Groups, underpinned by planning cells with responsibility for specific aspects of the response, such as securing and distributing personal protective equipment for example. All NHS bodies also had clear deputising arrangements in place to ensure resilience, responsiveness, and continuity as required.

3.11 We found that most command and control structures operated within existing frameworks for decision making. However, some NHS bodies needed to introduce temporary revisions to their Schemes of Delegation to ensure the relevant groups, managers and leaders were empowered to operate at pace during the pandemic. We found that most NHS bodies had clear arrangements in place for recording and documenting decisions, with some key decisions being published with the papers of board meetings to ensure openness and transparency.

3.12 All boards continued to meet during the pandemic, albeit virtually as noted earlier, thus allowing the corporate decision-making body of each organisation to maintain oversight of the response, hold the command structure to account, and make collective decisions on key matters during the crisis. Recognising the importance of reacting and responding at pace to the dynamic nature of the crisis, we found that each NHS body had suitable processes in place to enable Chair's actions on urgent matters. However, we found that Chair's actions were kept to a minimum and only used as a last resort in the majority of NHS bodies during the pandemic.

3.13 Some NHS bodies established temporary decision making and oversight groups involving Independent Members as part of their command and control structures. One body established a Cabinet, consisting of three Independent Members and three Executive Officers, to oversee the organisation's response and enable timely decision making and scrutiny. Another body established a Board Governance Group, which operated as a Chair's Action Group, to provide scrutiny and governance over the decision-making process as well as to provide assurance to the board that this was taking place. The membership of the Board Governance Group was restricted to the Chair, Chief Executive Officer, and two Independent Members.

Gaining assurance

3.14 All NHS bodies are required to establish and maintain a robust risk and assurance framework to ensure their boards and committees receive sufficient, timely, and reliable information that enables them to exercise good oversight of the management of risks, the quality and performance of services, and the efficient and effective use of resources. NHS bodies gain assurance from a range of internal and external sources, and report on the effectiveness of their arrangements to the public and other stakeholders via Annual Governance Statements and Annual Quality Statements. However, during the COVID-19 crisis, all NHS bodies were required to revise their arrangements to ensure the flows of assurance to their boards and committees were timely, proportionate, and covered the relevant key issues during the pandemic.

3.15 We found that all NHS bodies adapted their risk management arrangements and considered their risk appetite during the pandemic. However, only some bodies decided to increase their risk appetite during the crisis. We found that some NHS bodies established stand-alone risk registers to capture, manage, and mitigate the key risks relating to COVID-19, whereas others adapted existing risk registers to incorporate COVID-19 related risks. We found that all NHS bodies had suitable processes in place to monitor and manage strategic, tactical, and operational COVID-19 risks through their command and control structures. However, we found there were variable approaches to the oversight of significant COVID-19 risks at board and committee level, with some NHS bodies not fully utilising their committees to review and scrutinise all relevant risks during the pandemic.

3.16 We found that the Quality and Safety Committee of each NHS body continued to meet during the pandemic, with some increasing the frequency of meetings to provide timely oversight and scrutiny. The majority of committees adjusted their work programmes in line with Welsh Government guidance to enable them to maintain a handle on core quality, safety, and experience issues, as well as to provide an increased focus on the impact of COVID-19 on the quality and safety of services. We saw evidence of good information flows to boards and committees to provide assurance and enable effective oversight and scrutiny on the relevant quality and safety matters during the pandemic. However, we found there was scope to strengthen these arrangements in a very small number of NHS bodies.

3.17 In addition to providing information and assurance to Independent Members via board and committee papers, we found that all NHS bodies used a range of different approaches and mechanisms to keep their Independent Members informed and engaged during the crisis, including:

- sharing daily situational reports which provided status updates across a range of COVID-19 related indicators;
- providing written and face-to-face briefings, either on a daily or weekly basis;
- using board development sessions to highlight and discuss topics relating to the pandemic;
- providing access to the papers of command and control group meetings, mostly Gold Command Groups and Silver Command Groups;
- enabling committee chairs to meet with the relevant executive leads on a regular basis; and
- establishing virtual groups for Independent Members on online and mobile communication platforms to enable them to communicate and share information with each other on an ongoing basis.

We also found that some NHS bodies created opportunities to build knowledge, understanding and resilience across its cadre of Independent Members during the pandemic by, for example, inviting them to observe committees they do not normally sit on.

4. Key lessons and opportunities for the future

4.1 As the COVID-19 crisis unfolded, it became increasingly clear there was no blueprint for governing during such unprecedented times. As a result, NHS bodies were required to redefine their governance systems, structures, and processes and embrace new ways of working at an extraordinary pace to meet their own business needs and circumstances. Indeed, the crisis demonstrated that NHS bodies are capable of operating effectively with a sense of urgency and a common purpose to adopt lean and agile ways of working and achieve rapid transformation whilst also maintaining a focus on core areas of business.

4.2 As they slowly move towards the full recovery phase and enter a post-pandemic world, NHS bodies should seek to reflect on their experiences of governing during the crisis by evaluating fully their revised arrangements in order to:

- consider what worked well and what did not work so well;
- identify what they would do differently during another crisis; and
- establishing which new ways of working introduced during the pandemic should be retained going forward to enhance their governance arrangements for the future.

We suggest this evaluation is undertaken as part of a wider formal programme of learning within each NHS body which enables them to reflect on all aspects of their response to the pandemic in a systematic and meaningful way. Indeed, we believe the sense of urgency and common purpose created by the crisis presents a unique opportunity for each NHS body to continue encouraging, embracing, and embedding innovation, transformation and learning in all aspects of their work going forward in order to enable them to truly become learning organisations.

4.3 In terms of governance specifically, we have identified several potential opportunities for the future:

- **Virtual meetings** – virtual meetings have proven to be an efficient and effective way of working and have also enabled boards and committees to maintain and, in some respects, enhance openness and transparency. Even when restrictions on public gatherings are lifted and social distancing rules are relaxed, we believe there is scope for NHS bodies to consider sustaining virtual meetings in some form particularly given their benefits and the level of investment that occurred during the pandemic to support and facilitate virtual working.
- **Effective and efficient meetings** – all NHS bodies adopted leaner and agile ways of working during the crisis which generated less bureaucracy and enabled more effective and efficient board and committee meetings to take place. For example, using more focused and organised agendas (such as consent agendas), keeping meetings as paper light as possible, and inviting Independent Members to submit questions in advance of meetings. The use of online video platforms also forced NHS bodies to think differently about the way they organised and structured their meetings to ensure they were run as effectively and efficiently as possible in a virtual environment.
  We believe there is scope for NHS bodies to consider retaining and refining some of these new ways of working to ensure meetings continue to be as effective and efficient as possible in a post-pandemic world.
- **Agile decision making** – one of the key features of governance during the crisis in each NHS body was the introduction of structures and processes that facilitated rapid and agile decision making. For example, clinicians were empowered to make swifter decisions about patient care within revised clinical and ethical parameters, and leaders, managers, and groups were given greater autonomy to make spending decisions. Whilst all of this was necessitated by the need to react and respond at pace to the crisis, we believe there is scope for NHS bodies to consider retaining and refining agile approaches to decision making to enable and facilitate innovation, transformation and learning on an ongoing basis in a post-pandemic world. However, to enable this, each NHS body would need to review and realign their individual risk appetites and be assured they have robust internal controls in place to minimise fraud and ensure high standards of probity.

- **Reshaping strategy** – NHS bodies have been operating within shorter planning cycles during the crisis to enable them to respond appropriately to the various operational challenges and risks posed by the pandemic. As NHS bodies slowly move towards the full recovery phase, there is both a need and an opportunity for them to review and reshape their vision and priorities to ensure they're appropriate for a post-pandemic world. Indeed, the crisis has enabled some NHS bodies to deliver their priorities in certain areas sooner than expected, such as rolling-out digital health and care. Furthermore, the crisis has also highlighted the need to ensure a greater focus in other areas, such as addressing health inequalities. Reshaping their strategies for a post-pandemic work will also enable NHS bodies to reframe their Board Assurance Frameworks and refocus their risk management arrangements.
- **Focused, targeted, and integrated assurance** – adopting more efficient and leaner ways of working has enabled NHS bodies to provide focused, targeted, and in some cases, integrated assurance to their boards and committees. This has been particularly true in the context of quality assurance, with many bodies combining operational, financial, and workforce issues with core quality, safety, and experience issues. In reshaping their vision and priorities, we feel there is scope for NHS bodies to also consider redesigning their governance structures and build upon existing arrangements to provide more integrated assurance to their boards and committees in future. However, in doing so, NHS bodies should ensure sufficient attention is given to each area of assurance embedded within an integrated framework.
- **Enhanced communication** – the crisis has undoubtedly facilitated greater communication between NHS bodies and their partners, as well as enhanced communication with and between Independent Members. The use of online video platforms and official social media channels has also enabled NHS bodies to ensure visibility, provide information, and maintain ongoing engagement with their local populations and communities. We feel there is scope for NHS bodies to maintain, and enhance where possible, new forms and ways of communication introduced during the pandemic to sustain collaboration, partnership working, and public engagement in the post-pandemic world.

4.4 In conclusion, NHS bodies have adapted well to the many challenges and pressures posed by the pandemic. We have been assured that NHS bodies have largely maintained good governance throughout the crisis, with revised arrangements enabling them to govern in a lean, agile, and rigorous manner. The challenge now for each individual body is to fully evaluate their new ways of working, consider the opportunities outlined in this report, and maintain that sense of urgency and common purpose created during the crisis to establish and embed new approaches to governance in a post-pandemic world.

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Reference: AC/237/caf
Date issued: 15 December 2020

Dear Nick and Dai

Procurement and supply of PPE during the COVID-19 pandemic

I am writing to update you on work Audit Wales is carrying out looking at the procurement and supply of Personal Protective Equipment (PPE) during the COVID-19 pandemic.

There has been a good deal of interest in the issue of PPE since the outset of the pandemic. The Health, Social Care and Sport (HSCS) Committee commented on the supply of PPE in its July 2020 report on the impact and management of COVID-19 in health and social care. The Public Accounts Committee received evidence about PPE procurement, including domestic supply chains, in September 2020 as part of its inquiry into public procurement.

More recently, interest has been heightened by the publication of two reports by our colleagues in the National Audit Office. The first of these looked at UK Government procurement during the COVID-19 pandemic, which included a significant focus on procurement of PPE for health and social care in England. There was extensive media coverage of the NAO's findings in relation to a twin-track approach to identifying suppliers, a high-priority lane to assess and process potential PPE leads from government officials, ministers' offices, MPs and members of the House of Lords, senior NHS staff and other health professionals.

The second report looked more broadly at the supply of PPE in England, with extensive coverage of the large increase in the cost of PPE during the pandemic.

About our work

I thought it may be helpful to explain more about our work, which covers the same areas as the NAO: procurement and supply of PPE. We intend to build on the work of the HSCS Committee and to probe in more depth in some specific areas, notably procurement. We expect our work to have a forward-looking focus but based on a robust understanding of the lessons from the early phases of the pandemic.

Our scope takes in the procurement and supply of PPE for all public services. However, in practice, the primary focus will be the NHS and social care. Also, while recognising that there has been local procurement of PPE, this will not be a significant focus of our work. We will focus primarily on the national procurement, led by the Welsh Government and NHS Wales Shared Services Partnership (Shared Services).

We are currently in the fieldwork phase of the study. We have already interviewed several Welsh Government and Shared Services staff. We still have more interviews to carry out over the coming weeks. We have also gathered detailed documentary evidence.

In seeking evidence, we have also written to organisations that supplied evidence related to PPE as part of the HSCS Committee inquiry earlier this year. We have specifically asked for any new evidence or issues that they may wish to share with us.

Our fieldwork so far has focussed on the procurement of PPE. We still have a significant amount of work to do to complete our emerging picture on both procurement and supply. Our intention is to complete our fieldwork and issue our full findings in the spring.

Facts, figures and some emerging findings

In advance of our full report, I thought it would be helpful to share some facts and figures as well as some early emerging findings. I would emphasise that these are early findings and not set in stone. Nonetheless, given the high level of public interest and importance of these issues, I consider that there is merit in setting out the facts around some aspects of what we have found to inform any ongoing scrutiny.

At the start of the pandemic, the Welsh Government had a ‘pandemic stockpile’ of PPE, developed as part of UK wide arrangements, which it intended to distribute to health and social care bodies. The Welsh Government told us this equipment was crucial during the first wave. However, the stockpile was prepared for an influenza pandemic. Updated guidance on protecting NHS staff from coronavirus required some additional PPE, which was either not in the stockpile at all, or was not held in sufficient quantities to meet the extra demands posed by the

coronavirus. The Welsh Government, like other governments around the world, therefore needed to very quickly procure items such as fluid resistant gowns and respirators. Further, we understand that that some expected deliveries from existing suppliers did not materialise, exacerbating the pressure to quickly acquire more PPE.

The Welsh Government told us that it originally anticipated that there would be a UK-wide approach to PPE procurement. However, it agreed with the UK Government that, given the challenges, the Welsh Government would instead get funding via the Barnett formula and take on responsibility for procuring its own PPE. The Welsh Government told us it had continued to work with the UK Government and other devolved nations on procuring PPE, where opportunities have arisen.

The work to rapidly procure PPE for NHS Wales was led by the NHS Wales Shared Services Partnership and Welsh Government officials. Shared Services has taken on responsibility for providing PPE to services beyond the NHS, notably to social care and independent contractors in primary care.

Spend and distribution of PPE

As set out in our recent NHS Wales Finances Data Tool, at the end of September 2020 the NHS had spent £130 million on PPE for Wales. This includes £17 million in local procurement by health boards and trusts on top of £113 million spent by Shared Services on PPE. The Shared Services total includes £37 million for supply of PPE to social care and primary care services, such as GPs, pharmacists and opticians.

Shared Services expects to spend £239 million on PPE for Wales by the end of March 2021, with social care and primary care accounting for 43% (£104 million) of this expenditure.

In addition to the spend on PPE for Wales, as of the end of September, the Welsh Government had spent £37 million on PPE on behalf of other parts of the UK. It expects to recoup this expenditure. We have not yet examined the financial arrangements in place with the other nations.

The NAO's report on the supply of PPE highlights the significant increases in the cost of PPE at the outset of the pandemic. Shared Services told us that for many items it was a 'seller's market' with governments globally competing for scarce supply. We will be looking in more depth at the relative costs of items before the pandemic and during the pandemic. Where appropriate to do so, we will try to make comparisons with the prices paid by other parts of the UK.

As at 29 November 2020, Shared Services has distributed just under 480 million items of PPE since 9 March 2020[1] with around 240 million of these being issued to the social care sector. The 480 million items include 90.5 million aprons, 120 million masks[2], 4 million face visors, 255 million gloves and 2 million gowns[3].

The Welsh Government and Shared Services intended to build up a 24-week buffer stock of PPE by the end of November 2020. Shared Services told us that at the end of November the PPE buffer stock was largely in place. They were awaiting delivery of FFP3 Respirators made by a particular brand, which have been particularly difficult to source globally, and the receipt of orders that had been placed for gloves. We have visited the warehouse, where a proportion of the buffer stock is held. This visit reinforced to us the scale of the logistical operation. But we have not yet reviewed the modelling used to assess whether the buffer stock is sufficient for 24 weeks and we will do so as part of our fieldwork in the coming weeks.

Contracting approach

Under the Public Contract Regulations 2015 and related guidance[4] public bodies can enter contracts without competition or advertising so long as there are genuine reasons for extreme urgency. The Welsh Government, via Shared Services, has used these emergency exemptions for its procurement of PPE. Some details of contracts have been placed retrospectively on the Sell2Wales website. As part of our work we will be confirming that the correct contract notification procedures are being followed.

Shared Services has agreed contracts with around 100 different providers. However, many of these are for relatively low values. Around three-quarters of the suppliers have contracts valued at less than £1 million and around half are less than £150,000. Some 94% of the expenditure to the end of September 2020, including the expenditure on behalf of other parts of the UK, was with five suppliers.

While most of the PPE contracts are direct with suppliers, some of the larger contracts involve agents acting as intermediaries with overseas manufacturers. As

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[1] Data source – Stats Wales: Weekly number of PPE items issued by date. The reporting of PPE items issued is based on individual units, except for: gloves where a unit is reported based on the unit size of a pack and hand sanitiser where the unit is a bottle regardless of size.

[2] This figure includes: Type I and Type II mask, Type IIR masks, FFP2 masks, FFP3 masks.

[3] This figure includes: Gowns (fluid resistant) and Gowns (other).

[4] Regulation 32 and Procurement Policy Note 01/20: Responding to COVID-19 – March 2020

part of our fieldwork we are exploring further the use of agents and associated costs.

Although the bulk of PPE came from international suppliers, the Welsh Government and NHS worked with Welsh manufacturers to develop local supply chains. Welsh Government officials told us that this involved collaborative working within the Welsh Government, NHS and Industry Wales through the critical equipment requirements engineering team (CERET). We intend to explore this aspect of the procurement in more detail in the coming weeks.

Checks and approval arrangements

Shared Services and the Welsh Government told us that they have never had an equivalent to the twin-track ‘high priority lane’ approach to identifying potential suppliers described by the NAO in its report on COVID-19 procurement in England. In Wales, the Life Sciences Hub played a key role as a first point of contact for potential suppliers and manufacturers which, where appropriate, were referred to Shared Services. Shared Services told us that they also identified new suppliers through their existing networks, through suppliers getting in touch themselves and through other referrals. While there were referrals from politicians, Shared Services told us that these were subject to the same process, scrutiny and prioritisation as any other contacts. We are carrying out work to more fully understand how suppliers were identified and how referrals were managed.

The Welsh Government and Shared Services put in place revised governance arrangements around the letting of PPE contracts. All orders over £1 million in value already required the prior approval of the Welsh Government. In addition, a system of due diligence checks, scrutiny arrangements and a hierarchy of approvals were introduced involving the board of Velindre NHS Trust, which hosts Shared Services, and depending on the value and nature of the contract. Shared Services set up a new Finance Governance Group to support rapid decision making. This Group comprised senior managers from the NHS including specialists in areas like audit, fraud prevention, procurement, accountancy, and law.

The Welsh Government and Shared Services told us that the nature of the market during the pandemic meant that in some cases suppliers required an advance payment. To manage the risks, in a small number of instances, Shared Services made these payments though an independent escrow account. Shared Services and Welsh Government told us that this approach meant that the suppliers could see that the funding was in place but could not draw down the money until Shared Services had received the goods and checked that they met the required quality standards. All advance payments had to be approved by the Finance and Governance Group, with the Group referring advance payments more than 25% of a contract’s value to Welsh Government for prior approval. We will be exploring in more detail how this system worked in practice as well as the work to check quality, which involved the Surgical Materials Testing Laboratory (SMTL) based in Bridgend.

The NHS Internal Audit service carried out a review of Financial Governance Arrangements during the COVID-19 Pandemic, with a focus on PPE, between March and August 2020. It found that the procedures around background checks, approvals and recording of decisions that the Welsh Government and NHS had put in place were complied with in all cases. It also noted that there were some improvements made to the financial governance arrangements and quality of documentation over the period. As part of our work we plan to test a sample of contracts. In doing so, we intend to place reliance on the work of Internal Audit in verifying compliance, while asking broader questions on value for money.

Next steps

Over the coming weeks, we intend to complete our work on procurement and then start to look in more depth at the issues around maintaining supply to the frontline staff. We will then start to form our conclusions, draft our report and go through our usual process of clearing it for factual accuracy with the Welsh Government and the other named parties.

In the meantime, if there is anything else we can do to help you and your committees on this matter please let me know.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee**
Cyhoeddus neu Breifat: Public or Private:	*Public*
Teitl yr Adroddiad Report Title:	**Well Being of Future Generations (Act) – reports received and BCUHB response.**
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Planning and Performance
Awdur yr Adroddiad Report Author:	Acting Assistant Director of Strategy and Planning
Craffu blaenorol: Prior Scrutiny:	On the 12th December 2019 the Audit Committee received the ***'Auditor General Wales (AGW) Wales Audit Office (WAO), Implementing the Well-being of Future Generations Act - Betsi Cadwaladr University Health Board (October 2019)'*** report and noted the progress made in applying the sustainable development principles and the recommendations for further development and improvement in this respect. The 12th December Audit Committee meeting also received and noted the Audit Wales response to the ***'Future Generations Report 2020'***.
Atodiadau Appendices:	***Appendix 1**: 'Auditor General Wales (AGW) Wales Audit Office (WAO), Implementing the Well-being of Future Generations Act - Betsi Cadwaladr University Health Board (October 2019)' report.* ***Appendix 2**: BCUHB Management Response to the AGW report.* ***Appendix 3**: Future Generations Report 2020. Please see https://www.futuregenerations.wales/wp-content/uploads/2020/07/Future-Generations-Report-2020-Easy-Read.pdf* ***Appendix 4**: Letter from Future Generations Commissioner to BCUHB Interim CEO.*

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive and note the BCUHB management response to the recommendations made in the AGW report.
- Note that the BCUHB management response will be submitted to the SPPH Committee, who will monitor progress via receipt and consideration of an annual update report.
- Receive the *"Future Generations Report 2020"*, note the action taken and further action planned.

Please tick as appropriate

Ar gyfer		**Ar gyfer Trafodaeth**		**Ar gyfer sicrwydd**	**X**	**Er gwybodaeth**	**X**

penderfyniad /cymeradwyaeth For Decision/ Approval		For Discussion		For Assurance		For Information	

Sefyllfa / Situation:

The Well-being of Future Generations (Wales) Act 2015 (WFG Act) requires the publication of two 5-yearly reports, one from the Future Generations Commissioner for Wales and other from the Auditor General for Wales (AGW); together these reports provide a periodic stock-take of the implementation of the Act.

Betsi Cadwaladr University Health Board – Implementing the Well Being of Future Generations Act 2019' (Appendix 1)

The AGW's report *'Betsi Cadwaladr University Health Board – Implementing the Well Being of Future Generations Act 2019'* fulfils the statutory requirement to assess the extent to which public bodies have acted in accordance with the sustainable development principle in setting their objectives and the action they have taken to meet them.

The report details findings on the Health Board's corporate approach to embedding the sustainable development principle and application of the five ways of working using an example selected by the WAO Team for this purpose, namely, the 'Healthy lifestyles – healthy weight' initiative.

The report concluded that the Health Board has made progress in applying the sustainable development principle and the five ways of working but noted that challenges remain. The report made five recommendations in the form of 'Opportunities for Learning'. which are detailed in the template included as Appendix 2 along with the Health Board Management response.

Future Generations Report 2020 (Appendix 3)

The Future Generations Commissioner published the first 'Future Generations Report 2020' in May 2020, the report seeks to provide practical advice, guidance and tools for public bodies implementing the Act. The report recommends how public bodies should operate, largely focused on the Act's five ways of working, and how the principles outlined in the Act should be applied to Public Bodies' decision making processes, implementation of policy and delivery of services. The report also provides advice on the setting and attainment of well-being objectives and provides examples of good practice in the form of 'Big Ideas'.

The Audit Wales response to the report was noted at the December 2019 Audit Committee meeting. Subsequently the Health Board has received a letter from the Future Generation Commissioner (Appendix 4) with recommendations that '***must be taken into account when setting or revising your well-being objectives'.***

Cefndir / Background:

Betsi Cadwaladr University Health Board – Implementing the Well Being of Future Generations Act 2019'

The report represents the fulfilment of the statutory requirement to examine public bodies to assess the extent to which they have acted in accordance with the sustainable development principle in setting objectives and taking steps to meet these. The report, whilst not requiring a formal management response, does include 5 'Opportunities for Learning' (set out on page 7) which need to be addressed.

In developing the report, the WAO team adopted a new approach to the examination, which involved:

- Evidence-based review of the corporate arrangements to embed the sustainable development principle (Part 1 of the report); and
- Examination of evidence and a participatory approach to the review progress on a specified step, which was identified by officers of the Health Board, **Healthy lifestyles – healthy weight** (Part 2 of the report.)

The more participatory approach was welcomed, allowing opportunity for stakeholders to contribute directly to the work, and the opportunity to examine in more depth some of the approaches being used to deliver the step.

The report should be taken in the context of other relevant external assurance mechanisms which contribute to the Board's overall understanding of progress against the WFG Act. This includes the Future Generations Commissioner's response to a self-assessment undertaken by the Health Board in December 2018; and other relevant reports such as the recent WAO report on Public Services Boards. Details of both can be made available if required.

The recommendations of the AGW and Future Generation Commissioners reports will be taken forward through development of Cluster, Health Community and the overarching Health Board plans. All recommendations will require work in partnership with other agencies, and more specifically so recommendations I4 and I5 of the AGW report where work will be taken forward through the North Wales Public Service Boards (PSBs) and the Regional Partnership Board (RPB) Transformation Programme.

Asesiad / Assessment & Analysis

Strategy Implications

Both reports are directly relevant to the Health Board's compliance with the WFG Act, which provided the foundation for the development of **'Living Healthier, Staying Well'** (LHSW) the Health Board's strategy to improve health, well-being and health care in North Wales.

There are two key pieces of work currently underway which present an opportunity for the Health Board to review and revise or recommit to its Well Being Objectives:

- ***PSB well-being assessments***: Five years have elapsed since the WFG Act came into law. PSBs are required to update their respective Well Being assessments.
- ***LHSW three years on***: It is three years since LHSW was approved and implementation of the strategy commenced. The Health Board Executive Team is currently considering options to refresh the strategy tied to the requirement to develop a specific Clinical Services Strategy for North Wales. A refresh of LHSW will necessitate a review of the Health Board's Well Being objectives and will provide an opportunity to take account of the recommendation in the 'Future Generations Report 2020' as well as the PSB assessments.

Financial Implications

There are no direct financial implications identified within either report. Where financial implications arise from the implementation of recommendations in the reports, these will be identified and assessed as part of our normal planning process.

The first recommendation of the AGW report is that the Health Board should "Explore opportunities to move towards a long-term funding model to help secure the implementation of new service models." (Recommendation I1.) This will need to be addressed in the context of the developing long-term financial strategy.

Risk Analysis
There are no directly identified risks arising from the report; however, there are significant risks to the Health Board in failing to comply with the requirements of the WFG Act and consequent risk of inability to achieve the levels of transformational change required to deliver the Health Board's strategic well-being objectives. These risks are included on the Corporate Risk Register.

Legal and Compliance
As above – compliance with the Well-being of Future Generations Act.

Impact Assessment
No specific impact assessments were undertaken in production of this report; however appropriate impact assessments, including Equality Impact Assessment, were undertaken in respect of the initiatives examined in the AGW report.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Implementing the Well Being of Future Generations Act – **Betsi Cadwaladr University Health Board**

Audit year: 2019

Date issued: October 2019

Document reference: 1459A2019-20

This document has been prepared as part of work performed in accordance with statutory functions, including s15 of the Well-being of Future Generations (Wales) Act 2015.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

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

The team who delivered the work comprised Philip Jones and Andrew Doughton.

Contents

The Health Board has made progress in applying the sustainable development principle and the five ways of working, although differences in stakeholder priorities remain.

Summary Report

Background

1 In accordance with the Well-being of Future Generations (Wales) Act 2015 (the Act) the Auditor General for Wales (the Auditor General) is statutorily required to examine public bodies to assess the extent to which they have acted in accordance with the sustainable development principle when:

a. setting their well-being objectives; and

b. taking steps to meet them.

2 The Act defines the sustainable development principle as acting in a manner: '…which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.'

3 The Auditor General must provide a report on his examinations to the National Assembly for Wales at least a year before each Assembly election. The first such report must be published by 2020, before the 2021 Assembly election.

4 In May 2018, the Auditor General published a preliminary report, 'Reflecting on Year One – How have public bodies responded to the Well-being of Future Generations Act (2015)'. He concluded that public bodies support the principles of the Act and are taking steps to change how they work.

5 During 2018 and 2019 the Auditor General is undertaking examinations across the 44 bodies covered by the Act to inform his 2020 report to the National Assembly. In developing our approach to undertaking the examinations, we engaged with a range of stakeholders and carried out pilot work during 2017-18. We have also worked closely with the Future Generations Commissioner.

6 The preliminary work we undertook in 2017 included a consideration of how public bodies had set their well-being objectives. The principal focus of this work is the way in which public bodies are taking steps to meet their well-being objectives.

7 We undertook our review at Betsi Cadwaladr University Health Board (the Health Board) during March to July 2019.

Focus of the work

8 We reviewed the extent to which the Health Board is:

- applying the sustainable development principle and the five ways of working in order to do things differently;
- embedding the sustainable development principle in core arrangements and processes; and
- involving and working with citizens and stakeholders to deliver its well-being duty.

9 We carried out a high-level review of how the Health Board has continued to develop its corporate arrangements since our baseline work in 2017, to inform the Auditor General's year one commentary in 2018. We also examined the extent to

which the Health Board is acting in accordance with the sustainable development principle and applying the five ways of working through a step being taken to meet a well-being objective. Specifically, we examined 'Healthy Lifestyles – Healthy Weight,' an initiative to support people to make the right choices to improve their health (described in Appendix 1).

10 Exhibit 1 summarises the five ways of working as defined in the Welsh Government's 'Well-being of Future Generations (Wales) Act 2015 – The Essentials' document[1]. Appendix 2 outlines positive indicators for each of the five ways of working that we have identified and used as part of our examination.

Exhibit 1: the 'five ways of working' as defined by the Welsh Government

The Five Ways of Working
Long-term - The importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs.
Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives.
Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies.
Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives.
Involvement - The importance of involving people with an interest in achieving the well-being goals and ensuring that those people reflect the diversity of the area which the body serves.

11 This report sets out our findings on the Health Board's corporate approach to embedding the sustainable development principle and how the five ways of working. have been applied through its work on 'Healthy lifestyles – healthy weight' (the step).

Main findings

12 Our examination found that **the Health Board has made progress in applying the sustainable development principle and the five ways of working, although differences in stakeholder priorities remain.**

13 We reached this conclusion because:

- the Health Board has made progress in embedding the sustainable development principle in order to do things differently, and this needs to be sustained to deliver the change it wants to see; and

[1] Well-being of Future Generations (Wales) Act 2015, The Essentials provides a summary of the key elements of the Act.

- there are good examples of how the five ways of working are being applied, although differences in stakeholder priorities and long-term funding challenges remain.

14 Our findings are discussed in detail in the following sections of this report.

Opportunities for improvement

15 As the main provision of the Act came into force in 2016, it is inevitable that public bodies will need time to fully effect that change. We recognise that this is a transition period and that all public bodies are on a learning path.

16 We presented our findings to the Health Board at a workshop of key representatives involved in the work on 'Healthy lifestyles – healthy weight' in July 2019. At this workshop the Health Board considered our findings on the 'step', identified opportunities for improvement and began to consider a more detailed response.

17 Exhibit 2 sets out the Health Board's opportunities for improvement (I), which are intended to support continued development and embedding of the sustainable development principle and five ways of working.

Exhibit 2: opportunities for improvement.

Opportunities for improvement
Long-term
I1 Explore opportunities to move towards a long-term funding model to help secure the implementation of new service models.
Prevention
I2 Continue to support primary care clusters so that they can lead and drive population health improvement, wellbeing and prevention goals.
I3 Continue to monitor and review existing and future outcome measures for the 'Healthy lifestyles – healthy weight' programme to ensure ongoing effectiveness as the programme develops.
Integration
I4 Systematically identify ways in which the different stakeholders in 'Healthy lifestyles – healthy weight' can align and integrate their respective work.
Collaboration
I5 Define the impact of unhealthy weight in a broader sense to stakeholders so that they are aware of the possible future impact on demand for their services.

18 The Health Board's management response will be inserted as Appendix 3 once developed and agreed. The final report will be published on the Wales Audit Office website after consideration by the Board or a relevant board committee.

Detailed Report

Part 1 – Corporate arrangements

The Health Board has made progress in embedding the sustainable development principle in order to do things differently, and this needs to be sustained to deliver the change it wants to see

19 Prior to examination of work in relation to 'Healthy lifestyles – healthy weight' we wanted to understand how the corporate arrangements support delivery of that work.

20 The Health Board's Annual Progress Report on the Well-being of Future Generations Act was presented to the Board in July 2018. It was developed to be read alongside other progress reports for the Board, including the Living Healthier, Staying Well strategy; the Board Annual Report for 2017-18; the Annual Quality Statement; and the partnership plans published by the Regional Partnership Board and the four Public Services Boards. The Board intends that the Annual Progress Report will be complementary to these other documents, to help illustrate progress in the alignment of objectives and general consistency of approach.

21 The Health Board presented an updated view of progress towards its well-being objectives in its submission of a self-reflection tool for the Future Generations Commissioner's Office in early 2019. It gives positive examples of progress and acknowledges areas where there is more to do (see examples in Exhibit 3).

22 In particular we wanted to understand whether the Health Board is responding to the sustainable development principle and the five ways of working by:

- doing things differently to deliver change;
- developing core arrangements and processes; and
- involving citizens and stakeholders.

23 Our findings are set out in Exhibit 3.

Exhibit 3: embedding the sustainable development principle and the five ways of working

Doing things differently to deliver change
The Health Board was able to provide examples that show it is making progress towards applying the sustainable development principle but recognises that this progress needs to be sustained to deliver the change it wants to see • Attention is given to the Future Generations agenda by the Health Board's chairman and the executive team is helping to embed the approach. Senior staff described how the five ways of working is becoming a routine part of work at the corporate level. Papers received by the Finance and Performance Committee and the Quality, Safety and Experience Committee provided examples of where this has taken place.

- The Public Health outcomes framework is focussed, amongst other things, on prevention and the long-term. Directors work with staff in teams across the Health Board area in North Wales to reinforce this focus. We saw this reflected in the Health Board's Sustainability Report (2019) and the interim LiveLab Report (February 2019).
- Interviewees told us that changes of approach in response to the Well-being of Future Generations Act in the Health Board and at a national level in Wales are having a positive impact on how well the sustainable development principle and the five ways of working are applied. They regarded the approval of allocations from the Transformation Fund as a positive step in this respect.
- Some organisational objectives are moving closer together across partner organisations, although difference remain and it was acknowledged that there is more to do. This issue is discussed further in Part 2 of this report.

Developing core arrangements and processes

There are tangible examples of how the Health Board is developing its core arrangements and processes in support of the sustainable development principle

- The Health Board has established a requirement for the five ways of working to be considered as part of:
  - the terms of reference for formal committees,
  - papers submitted to committees; and
  - procedures and policies.
- The Health Board reported that partnership arrangements are focussing increasingly on the sustainable development principle.
- The Well-being of Future Generations approach has been accounted for in a full revision of the Health Board's annual report and annual performance report.
- The Health Board has further embedded sustainable development as an enabling principle in its clinical strategy, 'Living Healthier, Staying Well'. This has been made explicit during the progress made with the step, as set out in Part 2 of this report.
- The need to invest to save, as an approach to planning, is clearly supported by the executive team. This has resulted in the inclusion of preventative elements in the Orthopaedic Plan and a focus on upstream preventative work as part of the development of stroke services.

Involving citizens and stakeholders

The Health Board recognises the need for innovative approaches to involving and working with citizens and stakeholders in relation to the requirements of the Well-being of Future Generations Act, and there are examples of how this is developing

- Interviewees commented that consideration of the Well-being of Future Generations Act is expected as part of conversations with citizens and stakeholders. A wide array of well-being 'assets' have been included as part of involvement activities and conversations.
- An extensive engagement programme is ongoing, with Health Board representatives going out to existing groups and meeting places to engage on service developments. The engagement team has undergone training on best practice, along with staff in the planning and strategy team. The engagement team has developed engagement practitioners' networks to which anyone involved in engagement is invited.
- The four PSBs across the Health Board area are developing their role in this respect. Each has environment on their agenda, and they are starting to work more closely together on these issues. There are some shared members across the RPB and PSBs, which assists with communication. There is a view that this needs to go further.
- Under the Social Services Well Being Act the Health Board has developed the "what matters" conversation with individuals, enabling greater collaboration on service development. In

addition, the North Wales Social Value Forum is working to support and enable the promotion of social value, in line with the duties of Social Services Well-being Act.

- The development of stroke services is being achieved through co-production with stakeholders and other partners.

Part 2 - Examination of the work in relation to 'Healthy lifestyles – healthy weight'

There are good examples of how the five ways of working are being applied, although differences in stakeholder priorities and long-term funding challenges remain

24 We examined the Health Board's work on the step 'Healthy lifestyles – healthy weight' to demonstrate how the Health Board is acting in partnership with other local stakeholder organisations to support people to make informed choices in relation to their own health, and to promote better population health overall. The work aims to reduce health inequalities, particularly by focussing support on the communities that need it most. One of the priorities of the partnership work is to establish lifestyle services to support health and well-being, a key element of which is to help people achieve a healthy weight and to stay active. Further information on the step is set out in Appendix 1.

Long-term: There is a clear focus on short term and long-term needs, but the existing funding model is not based on a long-term approach

25 We looked for evidence of:

- a thorough understanding of current and long-term needs and the associated challenges and opportunities;
- planning over an appropriate timescale;
- resources allocated to ensure long-term benefits; and
- appropriate monitoring and review.

26 We identified the following strengths:

- the Public Health Team and the Health Improvement & Inequalities Team are planning to deliver long-term outcomes in relation to healthy weight through a programme of work; for example, maternal obesity, Healthy School, Let's Get North Wales Moving; and
- solutions have involved engaging people to make changes to individual and community behaviour, which are intended to translate into enduring improvements in well-being.

27 We identified the following learning points:

- short term funding for pilot projects often means that there is a lack of certainty about the potential to mainstream the work; for example, the third sector funding model is variable (e.g. over 1, 2, or 3 years);

- the Health Board recognised that there are opportunities to get more value from the third sector (20,000 third sector organisations in North Wales), perhaps by ensuring their contribution to pooled funding discussions;
- few third sector organisations focus on 'healthy weight' but this is evolving with social prescribing and the Conwy connect 3rd sector breast feeding initiatives given as examples; and
- there is a need to drive collective longer-term planning through support from all relevant stakeholders at regional or sub-regional levels. Clusters are providing opportunities to work across sectors.

Prevention: Healthy lifestyles – healthy weight is based on prevention, and clusters will need to be fully supported to implement this approach

28 We looked for evidence of:

- a thorough understanding of the nature and type of problem the step could help prevent from occurring or getting worse;
- resources allocated to ensure preventative benefits will be delivered; and
- monitoring and review of how effectively the step is preventing problems from occurring or getting worse.

29 We identified the following strengths:

- corporate and project staff understand the root causes of obesity and the relationships between them, and their work is firmly evidence-based;
- the life-style programme is improving outcomes for pre-operative patients with evidence of reductions in surgery as a result of healthier behaviours;
- recognition of the importance of the WFGA in developing preventative measures; and
- the Transformation Fund role in enabling this preventative approach.

30 We identified the following learning points:

- clusters have a key role in supporting preventative work, although they are not yet fully supported to deliver this approach; and
- monitoring and review of outcome effectiveness will be essential as the programme of work develops.

Integration: The Live Lab approach has identified potential shared actions to help the Health Board and its partners to address obesity, although the overall approach to integration is not yet systematic

31 We looked for evidence of consideration of:

- how this step could contribute to the seven national well-being goals;
- how delivery of this step will impact on the Health Board's well-being objectives and wider priorities; and
- how delivery of this step will impact on other public bodies' well-being objectives.

32 We identified the following strengths:

- local stakeholders are learning together and thinking about how services can be integrated; and
- the Health Board, its partners and the public worked on the 'Live Lab'[2] approach and have issued an interim report which sets out shared actions to address obesity and the well-being agenda.

33 We identified the following learning point:

- integration is not yet being systematically considered by stakeholders, and has to some extent been opportunistic rather than planned.

Collaboration: Despite effective collaboration, tensions have arisen when organisational priorities are not aligned

34 We looked for evidence that the Health Board:

- has considered how it could work with others to deliver the step (to meet its well-being objectives, or assist another body to meet its well-being objectives);
- is collaborating effectively to deliver the step; and
- is monitoring and reviewing whether the collaboration is helping to meet its well-being objectives and those of other stakeholders.

35 We identified the following strengths:

- Let's Get Moving North Wales establishes a shared physical activity agenda with individual organisational priorities;
- stakeholders have started to recognise that they have a part to play in the 'healthy weight' agenda, for example, through sports and leisure activities; and

[2] Live Labs are one of the ways in which the Future Generations Commissioner for Wales is providing advice and assistance to public bodies.

- collaboration is particularly forthcoming where stakeholders can clearly see a role for themselves.

36 We identified the following learning points:

- while collaboration has increased, it is not yet embedded at all levels of working;
- the Health Improvement and Inequalities Transformation Group is focussing on addressing 'Level 1' obesity with a multi-partner approach. However, there is a need to consider whether 'healthy weight' is the best way to frame the work in this area. For example, the focus could be around economic impact, pensions, environmental impact etc; and
- the Health Board's traditional focus has been towards acute and clinical interventions once obesity has become a problem. It still needs to use its resources to address the latter and this creates some tension when trying to collaborate with other stakeholders around prevention.

Involvement: The Health Board recognises the importance of involvement in addressing obesity and that the NHS cannot do so alone

37 We looked for evidence that the Health Board has:

- identified who it needs to involve in designing and delivering the step;
- effectively involved key stakeholders in designing and delivering the step;
- used the results of involvement to shape the development and delivery of the step; and
- sought to learn lessons and improve its approach to involvement.

38 We identified the following strengths:

- the involvement of previous service users in the delivery of the programme has received very positive feedback, as they can use their personal experience to make the approach more relatable to other service users;
- Live Lab identified a 'hotspot' in Llanrwst. As a result, the Health Board plans to develop a local partnership of public, private, voluntary and community organisations and local people to create and launch Llanrwst as a "Healthy Village and Community" with a campaign to change the narrative around healthy living; and
- the Health Board is targeting a cross-section of the community to train groups to act as champions and to disseminate and promote information about the 'Healthy living – healthy weight' agenda.

39 We identified the following learning points:

- the challenge of balancing large-scale population-based programmes versus those focussed on individuals;

- in addition to doing their job, staff members can have a wide personal impact on their communities so their involvement in initiatives can be a powerful means of promotion; and
- there is scope for further championing of the WFGA approach amongst medical staff.

Appendix 1

The Step

Information provided by the Betsi Cadwaladr University Health Board on the step: Work in relation to 'Healthy lifestyles – healthy weight'

Explanation of the step

We want to work in partnership to support people to make the right choices and to promote population health. Reducing health inequalities is an important part of this plan. We want to support the communities that need it the most.

One of our priorities is to establish lifestyle services to support the people of North Wales to make informed choices about their health and well-being. Within this, supporting people to achieve a healthy weight and stay active is a key element. The Five Ways to Well-being[3] provide another approach through which to frame the importance of this work.

Why is the Health Board doing this?

In our long-term strategy, Living Healthier, Staying Well, we identified the need to focus on helping people make healthy lifestyle choices. We looked at the evidence in Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales (Public Health Wales, 2016). People told us in the discussions we had about what's important that we should focus more on supporting people to manage their own health and well-being.

What is the Health Board doing to achieve this step?

We established a Health Improvement and Inequalities Transformation Group. This group has been working to identify and lead a programme of work to support healthy weight. Some examples are as follows:

Area	Examples of work
Being active	Let's Get Moving North Wales, partnership work with Sports North Wales, Local Authorities and others
	Work with Disability Sport Wales
Green health	Looking at the links between green and open spaces, and health & well-being

[3] The Five Ways to Well-being are a set of evidence-based messages aimed at improving the mental health and well-being of the whole population. They were developed by the New Economics Foundation from evidence gathered in the Foresight Mental Capital and Wellbeing project (2008).

Social prescribing	The Made in North Wales network developed an asset-based approach to well-being
Healthy diet and healthy weight	Healthy Schools initiatives, a “Live Lab” initiative supporting children and young people, weight management services, the Lifestyle Programme supporting the orthopaedic pathway
	Training of midwives and health visitors to support families around health lifestyles
	Launch of infant feeding programme and child measurement programme
Supporting our staff	Staff health and well-being initiatives, and achievement of the Gold and Platinum Health at Work

Appendix 2

The Five Ways of Working

The table sets out 'positive indicators' for each of the five ways of working that we have identified and used to help inform our assessments of the extent to which bodies may be applying the sustainable development principle. We do not intend the indicators to be used as a 'checklist'. We have used them as 'indicators' to help us to form conclusions, rather than 'determinants' of the extent to which a body is acting in accordance with the sustainable development principle in taking steps to meet its well-being objectives.

What would show a body is fully applying the long-term way of working?
• There is a clear understanding of what 'long-term' means in the context of the Act. • They have designed the step to deliver the well-being objectives and contribute to their long-term vision. • They have designed the step to deliver short or medium-term benefits, which are balanced with the impact over the long-term (within the project context). • They have designed the step based on a sophisticated understanding of current and future need and pressures, including analysis of future trends. • Consequently, there is a comprehensive understanding of current and future risks and opportunities. • Resources have been allocated to ensure long-term as well as short-term benefits are delivered. • There is a focus on delivering outcomes, with milestones/progression steps identified where outcomes will be delivered over the long-term. • They are open to new ways of doing things which could help deliver benefits over the longer term. • They value intelligence and pursue evidence-based approaches.
What would show a body is fully applying the preventative way of working?
• The body seeks to understand the root causes of problems so that negative cycles and intergenerational challenges can be tackled. • The body sees challenges from a system-wide perspective, recognising and valuing the long-term benefits that they can deliver for people and places. • The body allocates resources to preventative action that is likely to contribute to better outcomes and use of resources over the longer-term, even where this may limit the ability to meet some short-term needs. • There are decision-making and accountability arrangements that recognise the value of preventative action and accept short-term reductions in performance and resources in the pursuit of anticipated improvements in outcomes and use of resources.

What would show a body is taking an 'integrated' approach?
• Individuals at all levels understand their contribution to the delivery of the vision and well-being objectives. • Individuals at all levels understand what different parts of the organisation do and proactively seek opportunities to work across organisational boundaries. This is replicated in their work with other public bodies. • Individuals at all levels recognise the cross-organisation dependencies of achieving the ambition and objectives. • There is an open culture where information is shared. • There is a well-developed understanding of how the well-being objectives and steps to meet them impact on other public sector bodies. • Individuals proactively work across organisational boundaries to maximise their contribution across the well-being goals and minimise negative impacts. • Governance, structures and processes support this, as do behaviours.
What would show a body is collaborating effectively?
• The body is focused on place, community and outcomes rather than organisational boundaries. • The body has a good understanding of partners' objectives and their responsibilities, which helps to drive collaborative activity. • The body has positive and mature relationships with stakeholders, where information is shared in an open and transparent way. • The body recognises and values the contributions that all partners can make. • The body seeks to establish shared processes and ways of working, where appropriate.
What would show a body is involving people effectively?
• Having an understanding of who needs to be involved and why. • Reflecting on how well the needs and challenges facing those people are currently understood. • Working co-productively, working with stakeholders to design and deliver. • Seeing the views of stakeholders as a vital source of information that will help deliver better outcomes. • Ensuring that the full diversity of stakeholders is represented, and they can take part. • Having mature and trusting relationships with its stakeholders where there is ongoing dialogue and information is shared in an open and transparent way. • Ensure stakeholders understand the impact of their contribution. • Seek feedback from key stakeholders which is used to help learn and improve.

Appendix 3

The Health Board's management response to improvement opportunities

The Health Board's management response will be inserted here. This appendix will form part of the final report to be published on the Wales Audit Office website once the report has been considered by the Board or a relevant board committee.

40 The Health Board considered our findings at the workshop held in July 2019 and agreed a number of improvement opportunities regarding work in relation to Healthy lifestyles – healthy weight'. The following table presents the actions that the Health Board has identified in response.

Opportunities for improvement	Actions, responsibilities, timescales
Long-term	
I1 Explore opportunities to move towards a long-term funding model to help secure the implementation of new service models.	
Prevention	
I2 Continue to support primary care clusters so that they can lead and drive population health improvement, wellbeing and prevention goals.	
I3 Continue to monitor and review existing and future outcome measures for the 'Healthy lifestyles – healthy weight' programme to ensure ongoing effectiveness as the programme develops.	
Integration	
I4 Systematically identify ways in which the different stakeholders in 'Healthy lifestyles – healthy weight' can align and integrate their respective work.	
Collaboration	
I5 Define the impact of unhealthy weight in a broader sense to stakeholders so that they are aware of the possible future impact on demand for their services.	

41 We will monitor the Health Board's progress in implementing these actions, and the extent to which they address the issues we have identified in our findings, through our future programmes of work.

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Audit Management Response

Audit Details

Audit Title: Implementing the Well-being of Future Generations Act - BCU HB	**Audit Source**: Welsh Audit Office
Executive Lead Title: Director of Planning & Performance	**Executive Lead name**: Mark Wilkinson
Operational Lead Title: Assistant Director - Health Strategy	**Operational Lead name**: Sally Baxter
Date of Audit Issue: 01/10/2019	**Date of Management Response**: 12/03/2020

Audit Summary	The Health Board, as one of the specified public bodies covered by the Well-being of Future Generations (Wales) Act 2015, is required to respond to the principles of the Act and change the way we work to address these. This includes the setting of well-being objectives to contribute towards the achievement of all seven of the national well-being goals, and the adoption of the sustainable development principle, enabled by the five ways of working (long term; prevention; integration; collaboration; involvement.) The report represents the fulfilment of the statutory requirement to examine public bodies to assess the extent to which they have acted in accordance with the sustainable development principle in setting objectives and taking steps to meet these. In developing the report, the Wales Audit Office team adopted a new approach to the examination, which involved: - evidence-based reviewing of the corporate arrangements to embed the sustainable development principle (Part 1 of the report); and - examination of evidence and a participatory approach to the review progress on a specified step, which was identified by officers of the Health Board, Healthy lifestyles – healthy weight (Part 2 of the report.) The more participatory approach was welcomed, allowing opportunity for stakeholders to contribute directly to the work, and the opportunity to examine in more depth some of the approaches being used to deliver the step. We are grateful to the WAO team for leading the workshops and their support to the Health Board in working with the new approach. It was felt by some Health Board participants that there could have been greater clarity over the balance of focus between the two parts. However, this has been discussed with the WAO team and the learning from the approach will be taken forward in future work. The report should be taken in the context of other relevant external assurance mechanisms which contribute to the Board's overall understanding of progress against the WFG Act. This includes the Future Generations Commissioner's response to a self-assessment undertaken by the Health Board in December 2018; and other relevant reports such as the recent WAO report on Public Services Boards. Details of both can be made available if required.

Audit Management Response

	The recommendations will be taken forward through development of cluster, health economy and the overarching Health Board plans. All recommendations will require work in partnership with other agencies, and more specifically so recommendations I4 and I5, for which work will be taken forward through the North Wales PSBs and the RPB transformation programme. A response was presented in narrative form to the Audit Committee in December 2019 on the understanding that a formal management response was not required; however it has since been clarified that a management response should be completed using the formal template. This management response captures the essence of the December report and provides trackable milestones.

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

Audit Management Response

Rec ID	Audit Finding	Audit Recommendation	Management Response	Owner	Contributors	Deadline
R1	There are good examples of how the five ways of working are being applied, although differences in stakeholder priorities and long-term funding challenges remain Long-term: There is a clear focus on short term and long-term needs, but the existing funding model is not based on a long-term approach	I1 Explore opportunities to move towards a long-term funding model to help secure the implementation of new service models.	The development of the clinical services strategy and three year plan will facilitate a greater focus on long term sustainability and a population health approach, in accordance with the aims of A Healthier Wales. The plans will factor in the need for long-term funding to enable this shift in approach and targeting of resource. The evaluation of initiatives funded under short term grant including BAHW and Transformation Funds will support the prioritisation and mainstreaming of effective evidence-based population health programmes.	Executive Director of Planning & Performance	Stategic Planning leads	31/03/2022
R2	Prevention: Healthy lifestyles – healthy weight is based on prevention, and clusters will need to be fully supported to implement this approach	I2 Continue to support primary care clusters so that they can lead and drive population health improvement, wellbeing and prevention goals.	Area Teams are working with clusters to develop existing and new initiatives through cluster planning and there are examples of prevention and population health within current cluster plans. Clusters are however maturing at different pace and capacity is a constraint. Further emphasis to be placed on leading and driving population health improvement as cluster planning develops.	Executive Director, Primary Care and Community Services	Assistant Directors - Primary Care	31/03/2022

Audit Management Response

R3	Integration: The Live Lab approach has identified potential shared actions to help the Health Board and its partners to address obesity, although the overall approach to integration is not yet systematic	I3 Continue to monitor and review existing and future outcome measures for the 'Healthy lifestyles – healthy weight' programme to ensure ongoing effectiveness as the programme develops.	The Health Board will continue to develop a partnership and population health based approach to prevention and early intervention. Within this, the Healthy Lifestles - Healthy Weight programme will continue as one of the priorities within the annual plan and the outcomes achieved will be evaluated	Executive Director - Public Health	Public Health Assurance & Development Manager	31/03/2021
R4	Collaboration: Despite effective collaboration, tensions have arisen when organisational priorities are not aligned	I4 Systematically identify ways in which the different stakeholders in 'Healthy lifestyles – healthy weight' can align and integrate their respective work.	The PSB Well-being Plans already include a range of priorities in relation to healthy lifestyles. HB representatives to continue to develop shared priorities with partners in the RPB and PSBs. Further work is required to strengthen partnership governance arrangements and ensure a closer alignment of priorities at corporate level	Executive Director - Public Health	Area Directors, Public Health Team	31/03/2022
R5	Involvement: The Health Board recognises the importance of involvement in addressing obesity and that the NHS cannot do so alone	I5 Define the impact of unhealthy weight in a broader sense to stakeholders so that they are aware of the possible future impact on demand for their services.	The publication of the Healthy Weight, Healthy Wales strategy (October 2020) supports this recommendation and sets out clearly the need for a "wellness" system for healthy weight. The Health Board will work with partners through the PSBs and RPB to implement the strategy.	Executive Director of Public Health	Area Directors, Public Health Team	31/03/2022

Comisiynydd Cenedlaethau'r Dyfodol Cymru
Future Generations Commissioner for Wales

Trwy e-bost

28 Gorffennaf 2020

Annwyl Simon,

Adroddiad Cenedlaethau'r Dyfodol 2020

Diolch am eich cefnogaeth i ddatblygiad yr Adroddiad Cenedlaethau'r Dyfodol cyntaf, fel sy'n ofynnol o dan y Ddeddf Llesiant Cenedlaethau'r Dyfodol. Cyhoeddwyd fy adroddiad ym mis Mai 2020 ac mae wedi bod yn ddarn arwyddocaol o waith, yn pontio'r pedair blynedd yr wyf wedi eu treulio yn fy swydd. Tra nad oedd cyhoeddi'r adroddiad yng nghanol pandemig byd eang yn amseru delfrydol, roedd yn angenrheidiol i mi gwrdd â'r dyddiad cau statudol ar gyfer ei gyhoeddi un flwyddyn cyn yr Etholiadau Senedd nesaf.

Canfuwyd y casgliadau a'r argymhellion o fewn yr adroddiad yn ystod fy mhedair blynedd fel Comisiynydd Cenedlaethau'r Dyfodol. Mae'r adroddiad yn rhoi fy asesaid o gynnydd a fy nghyngor i Lywodraeth Cymru a chyrff cyhoeddus ar weithredu cenhadaeth genedlaethol y Ddeddf. Gellir cael crynodeb o'r casgliadau cyffredinol hyn a'r argymhellion yma a gellir dod o hyd i ddadansoddiad mwy manwl o wahanol nodau a meysydd polisi drwyddi draw yn yr adroddiad ac adnoddau cysylltiedig (gweler isod). Mae'r casgliadau a'r argymhellion wedi ystyried fy ngwaith monitro gyda chyrff cyhoeddus a'r archwiliadau perthnasol a wnaethpwyd gan Archwilydd Cyffredinol Cymru. Maent hefyd wedi eu trwytho drwy ennyn ymgyfraniad a gwrando ar 5,000 o bobl, grwpiau cymunedol a sefydliadau drwy fy ymgysylltiad i fy hunan, llwyfannau arlein, cyfarfodydd cymunedol, sgyrsiau mewn mannau cyhoeddus, sgyrsiau manwl, grwpiau ffocws ac ymatebion ysgrifenedig.

Casgliadau Allweddol

Rwyf wedi nodi nifer o feysydd lle mae cynnydd cadarnhaol yn cael ei wneud:

- Mae'r Ddeddf wedi arwain at beth arloesi ardderchog.
- Mae Byrddau Gwasanaethau Cyhoeddus yn dangos pŵer cydweithredu, a llawer o gyrff cyhoeddus yn mynd tu hwnt i'w cylchoedd gwaith traddodiadol i weithio gydag eraill. Mae angen yn awr i gydweithio symud tu hwnt i'r partneriaid amlycaf a symud ymlaen o 'rannu gwybodaeth' tuag at gronni adnoddau.
- Mae'r rhan fwyaf o gyrff cyhoeddus yn dangos cynnydd wrth weithredu'r Ddeddf ond mewn gwahanol ffyrdd. Yn y cyfnod nesaf, mae angen iddynt gymhwyso holl ddyheadau a gofynion cyfreithiol y Ddeddf.
- Wrth weithredu'r Ddeddf, mae rhai cyrff cyhoeddus yn defnyddio'r Ddeddf yn effeithiol i benderfynu 'beth' y maent yn ei wneud ac eraill yn talu mwy o sylw i 'sut' y maent yn mynd ati i wneud pethau yr oeddent eisoes wedi penderfynu eu gwneud. Fodd bynnag, mae angen i gyrff cyhoeddus wneud gwaith pellach i ddangos o ddifrif 'brawf dwbwl' y Ddeddf - gan weithredu'r ddau.

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- Mae'r Ddeddf yn hwyluso meddwl mwy integredig, gyda nifer o Fyrddau Gwasanaethau Cyhoeddus yn gweithio gyda'i gilydd yn effeithiol i fynd i'r afael â materion o bwys, a chyrff cyhoeddus yn gweithio tu hwnt i ffiniau gweithdrefnol traddodiadol a daearyddol. Ond weithiau mae cyfleoedd i gyflawni manteision ataliol ehangach drwy integreiddio eu hamcanion a chydweithio gydag eraill yn cael eu colli.

Mae'r adroddiad yn tynnu sylw at waith da iawn sy'n digwydd yng Ngogledd Cymru, sy'n cyfrannu at nifer o'r nodau llesiant. Er enghraifft, mae'r Hybiau Cymunedol newydd MI FEDRAF a ariennir gan y Gronfa Drawsnewid yn enghraifft dda iawn o ymagweddau integredig tuag at gadw'n iach, gan gydnabod penderfynyddion ehangach iechyd. Rwyf wedi tynnu sylw at waith Cydweithfa Gofal Cymunedol yn Wrecsam fel un o'r enghreifftiau gorau o'r math hwn o ymagwedd yng Nghymru.

Byddai fy swyddfa'n hapus i'ch cynorthwyo i roi cyhoeddusrwydd i'r rôl yr ydych wedi ei chwarae yn y gwaith o drwytho'r adroddiad a lle'r ydyn ni wedi dyfynnu eich gwaith fel arfer da. Os hoffech gael dyfyniad neu os hoffech drafod sut i ennyn sylw'r cyfryngau, os gwelwch yn dda ebostiwch cysywlltwchani@cenedlaethaurdyfodol.cymru.

Fodd bynnag mae yna feysydd lle mae cynnydd yn cael ei rwystro:

- Mae rhai nodau llesiant cenedlaethol nad ydynt yn cael eu deall gystal ag eraill, yn benodol nodau Cymru gydnerth, lewyrchus a Chymru sy'n gyfrifol yn fyd-eang, ac mae eglurder ar y modd y mae cyrff yn cyflawni'r rhain yn absennol.
- Mae cyrff cyhoeddus a Byrddau Gwasanaethau Cyhoeddus yn ystyried yr hirdymor ac atal yn fwy nag erioed o'r blaen, ond mae angen i'r system gyfan symud tuag at feddwl a gweithredu a buddsoddi yn y dull hwn.
- Mae rhai o ofynion cynllunio corfforaethol, rheoli perfformiad ac adrodd a osodwyd gan Lywodraeth Cymru ar gyfer cyrff cyhoeddus yn rhwystro cyrff cyhoeddus eraill rhag gweithredu'r Ddeddf yn effeithiol.
- Mae cynllunio ariannol ac ariannu tymor byr yn rhwystro gallu cyrff cyhoeddus i gyflawni eu hamcanion llesiant ac yn peri i gyfleoedd i gydweithredu, atal, meddwl yn yr hirdymor ac integreiddio fod yn fwy heriol.
- Mae meysydd newid corfforaethol (h.y. cynllunio corfforaethol, cynllunio ariannol, cynllunio gweithlu, caffael, asedau, rheoli risg a rheoli perfformiad) - a amlinellwyd yn yr arweiniad statudol ar weithredu'r Ddeddf – yn berchen ar y gallu a'r potensial i sbarduno newid, ond mae'n rhaid i gyrff cyhoeddus eu defnyddio'n well.

Buaswn yn eich cyfeirio'n arbennig at dudalen 19 yn y crynodeb gweithredol lle'r wyf wedi dangos y categorïau bras y credaf fod cyrff cyhoeddus yn syrthio iddynt yn nhermau'r ymagwedd a fabwysiedir tuag at weithredu eu dyletswyddau o dan y Ddeddf. Er nad wyf wedi enwi sefydliadau buaswn yn eich annog i fyfyrio ar ble y gallai eich sefydliad chi fod, a byddai fy nhîm a minnau'n hapus i drafod hyn gyda chi ymhellach.

Argymhellion

Comisiynydd Cenedlaethau'r Dyfodol Cymru | Future Generations Commissioner for Wales

Rwy'n cydnabod nad yw newid diwylliannol yn digwydd dros nos. Fodd bynnag, mae Adroddiad Cenedlaethau'r Dyfodol 2020 yn ddogfen statudol y mae'n rhaid i chi ei hystyried wrth osod neu adolygu eich amcanion llesiant. Buaswn yn tynnu eich sylw at yr argymhellion ym mhob pennod o'r adroddiad sydd wedi'u hanelu at eich corff cyhoeddus chi, gyda'r bwriad o ddod â'r Ddeddf yn fyw yng nghyd-destun gwasanaethau cyhoeddus Cymru a symud pob corff cyhoeddus tuag at y categori *'Credinwyr a Chyflawnwyr'.*

Mae argymhellion yn yr adroddiad yn ymwneud â chynnydd cyffredinol, pob nod llesiant a fy meysydd ffocws - tai, cynllunio, trafnidiaeth, Profiadau Niweidiol yn ystod Plentyndod, sgiliau, ffyrdd gwell o gadw pobl yn iach a datgarboneiddio. Gellir cyrchu pob pennod ar wahân ar-lein ac felly buaswn yn eich annog i sicrhau bod penodau perthnasol yr adroddiad yn cael eu rhannu gyda chydweithwyr perthnasol ledled eich sefydliad. Nodir yr argymhellion y mae'n ofynnol i gyrff cyhoeddus eu hystyried fel a ganlyn:

Argymhellion polisi – Wedi eu hanelu at gyflawni'r nodau llesiant a nodir yn y Ddeddf. Mae'r rhain wedi eu *cyfeirio i raddau helaeth at Lywodraeth Cymru* ond maent hefyd yn berthnasol i rai cyrff cyhoeddus. Gallwch ddod o hyd i'r 20 prif argymhelliad yma.

Argymhellion proses – Mae'r rhain yn cyfeirio'n uniongyrchol at 'sut' ddylai cyrff cyhoeddus wneud pethau. Maen nhw'n ffocsysu i raddau helaeth ar y pum dull o weithio, y broses o wneud penderfyniadau, gweithredu polisi a chyflwyno gwasanaethau, a sut mae peirianwaith y sector cyhoeddus yn gweithio. *Mae rhai'n benodol ar gyfer Llywodraeth Cymru a rhai i bob corff cyhoeddus lle mae eu cylch gwaith yn berthnasol.*

Cyngor ar osod a chyflawni amcanion llesiant – Mae'n ofynnol i gyrff cyhoeddus ystyried y cyngor hwn y tro nesaf y byddant yn gosod neu'n adolygu eu hamcanion llesiant. *Mae'r cyngor hwn yn berthnasol i bob corff cyoeddus sy'n dod o dan y Ddeddf yn cynnwys Llywodraeth Cymru.*

Syniadau Arloesol – Drwy'r holl adroddiad hwn byddwch yn darganfod Syniadau Arloesol am y modd y gallwn wneud pethau'n wahanol. Maent wedi eu cymryd o rai o'r enghreifftiau gorau o Gymru a'r byd, ac mae llawer wedi eu cyfrannu gan bobl Cymru. Eu nod yw ysbrydoli cyrff cyhoeddus, y sector gwirfoddol, busnesau a chymunedau i roi cynnig ar bethau newydd. Mae'r rhain yn rhoi syniadau y gellid eu mabwysiadu gan bob corff cyhoeddus.

Yr Adroddiad ac adnoddau eraill

A chadw mewn golwg ehangder a dyfnder y Ddeddf Llesiant Cenedlaethau'r Dyfodol, mae'r adroddiad yn adnodd eang. Felly, rwy'n falch i rannu gyda chi nifer o adnoddau cyflenwol yr wyf wedi eu cyhoeddi i wneud fy nghasgliadau a'm hargymhellion yn fwy hygyrch:

- fersiwn rhyngweithiol arlein
- fersiwn 'yn fras'
- crynodebau gweithredol o bob pennod

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- fersiwn hawdd ei ddarllen a fersiwn Iaith Arwyddion Prydain (yn ychwanegol at y fersiwn lawn ar gael gyda thechnoleg gynorthwyol ac ymarferoldeb testun-i-leferydd ar y wefan)
- mae fersiwn ymateb creadigol pobl ifanc i'r adroddiad eto i ddod gyda fy nhîm ar hyn o bryd yn gweithio i greu hwn gyda grŵp o blant a phobl ifanc.

Ochr yn ochr â'r adnoddau hyn hoffwn eich cyferio'n benodol ar y fframweithiau canlynol

- Fframwaith ar gyfer Prosiectau y dylid eu defnyddio i ystyried sut y gallwch wneud penderfyniadau ar seilwaith yn unol â'r Ddeddf
- Fframwaith ar gyfer Dylunio Gwasanaeth y dylid eu defnyddio ar gyfer ystyried sut mae gwasanaethau'n alinio â gofynion y Ddeddf
- Fframwaith ar gyfer Craffu y dylid eu rhannu gyda'ch pwyllgorau craffu ac/neu Fyrddau i'w helpu mewn cyfarfodydd.

Beth nesa

Wrth i Lywodraeth Cymru a chyrff cyhoeddus symud o'u hymateb yn y fan a'r lle i'r argyfwng tuag at gynllunio ar gyfer adferiad rhaid i mi eich atgoffa o'ch dyletswyddau i ddefnyddio'r Ddeddf yn eich holl benderfyniadau wrth i ni ystyried ein hymagwedd tuag at adferiad. Gan adeiladu ar argymhellion Adroddiad Cenedlaethau'r Dyfodol, rwyf hefyd wedi cyhoeddi pum argymhelliad ar gyfer adferiad Cymru. Mae'n galonogol i nodi bod y cynllun pum pwynt hwn wedi derbyn cefnogaeth eang o'r CBI, WWF, TUC ac eraill. Mae gennym gyfle unwaith-mewn-cenhedlaeth i ailosod economi Cymru, ac adeiladu system economaidd sy'n mynd i'r afael ag argyfyngau parhaus iechyd, hinsawdd a natur y byddwn yn parhau i'w hwynebu.

Yn y cyfamser, rwy'n awyddus i ddeall sut y gall cynnwys yr adroddiad gefnogi eich gwaith. Os hoffech drafod unrhyw ran o'r wybodaeth a gynhwysir gyda'r llythyr hwn, rhoi gwybod i ni am waith yr ydych yn ei wneud, yn cynnwys y defnydd o'n hargymhellion, neu dynnu sylw at ble'r ydych wedi cael eich amlygu o fewn yr adroddiad, neu gofrestru ar gyfer y wybodaeth ddiweddaraf yn ein cylchlythyr misol, os gwelwch yn dda ebostiwch cysylltwchani@cenedlaethaurdyfodol.cymru.

Unwaith eto hoffwn ddiolch i chi am eich cyfraniad i Adroddiad Cenedlaethau'r Dyfodol ac rwy'n edrych ymlaen at weithio gyda chi i adeiladu mudiad dros newid i gyflawni'r Gymru a garem.

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Dear Simon,

Future Generations Report 2020

Thank you for your support in developing the first Future Generations Report, as required under the Well-being of Future Generations Act. My report was published in May 2020 and has been a significant piece of work, spanning

the four years I have been in post. Whilst publishing the report during a global pandemic was not ideal timing, it was necessary to meet the statutory deadline of publication one year prior to the next Senedd Elections.

The findings and recommendations within the report have been identified during my four years as Future Generations Commissioner. The report provides my assessment of progress and my advice to Welsh Government and public bodies on implementing the national mission of the Act. A summary of these overall findings and recommendations can be found here. More detailed analysis of different goals and policy areas can be found throughout the main report and related products (see below). The findings and recommendations have been taken into account my monitoring work with public bodies and the related examinations undertaken by the Auditor General for Wales. They have also been informed by involving and listening to at least 5,000 people community groups and organisations through my own engagements, online platforms, community meetings, conversations in public spaces, in-depth conversations, focus groups and written responses.

Key findings

I have identified a number of areas where positive progress is being made:

- The Act is bringing about some excellent innovation.
- Public Services Boards are showing the power of collaboration, and many public bodies are going beyond their traditional functions to work with others. Collaboration now needs to move beyond involving the most obvious partners and from 'information sharing' towards pooling resources.
- Most public bodies are making progress on implementing the Act but in different ways. In the next phase, they need to apply the Act across all its aspirations and legal requirements.
- In implementing the Act, some public bodies are using the Act effectively to decide 'what' they do and others are more considering 'how' they go about doing things they had already decided to do. However, there is further work needed for public bodies to fully demonstrate the 'double test' of the Act – applying both.
- The Act is facilitating more integrated thinking, with many Public Services Boards working together effectively to tackle issues and public bodies working beyond traditional organisational and geographical boundaries. But sometimes opportunities are being missed to achieve wider preventative benefits through integrating their objectives and collaborating with others.

The report highlights really good work happening in North Wales, which contributes to a number of the well-being goals.

For example, the new I CAN Community Hubs funded by the Transformation Fund are a really good example of integrated approaches to keeping well, recognising the wider determinants of health. I have highlighted the work of Community Care Collaborative in Wrexham as one of the best examples of this type of approach in Wales. My office would be happy to support you in publicising the role you have played in informing the report and where we have citied your work as good practice. If you would like a quote or to discuss media coverage please email: contactus@futuregenerations.wales.

However, there are areas where progress is being hindered:

- There are some national well-being goals that are less understood specifically the goals of a resilient prosperous and globally responsible Wales and clarity is lacking on how public bodies are meeting them.
- Public bodies and Public Services Boards are considering the long-term and prevention more than ever before, but the whole system needs to move to thinking and acting and investing in this way.
- Some of the corporate planning, performance management and reporting requirements set by Welsh Government for public bodies are hindering effective implementation of the Act by other public bodies
- Financial planning and short-term funding inhibit the ability of public bodies to meet their well-being objectives and make collaborations, prevention, long-term thinking and integration more challenging.
- The corporate areas of change (i.e. corporate planning, financial planning, workforce planning, procurement, assets, risk management and performance management) outlined in the statutory guidance on implementing the Act are potential levers to drive change, but public bodies must make better use of them.

I would refer you in particular to page 19 of the executive summary in which I have illustrated the broad categories that I believe public bodies are falling into in terms of the approach taken to implementing their obligations under the Act. Although I have not named organisations I would encourage you to reflect on where your organisation might be and my team and I would be happy to discuss this further with you.

Recommendations

I acknowledge that cultural change doesn't happen overnight. However, the Future Generations Report 2020 is a statutory document that you must take into account when setting or revising your well-being objectives. I would draw your attention to the recommendations in each chapter of the report aimed at your public body, with the aim of bringing the Act to life in the context of Welsh public services and moving all public bodies towards the category of '*Believers and Achievers.'*

Recommendations in the report relate to overall progress, each well-being goal and my areas of focus – housing, planning, transport, Adverse Childhood Experiences, skills, better ways of keeping people well and decarbonisation. Each chapter can be accessed separately online and I would therefore encourage you to ensure that the relevant chapters of the report are shared with relevant colleagues throughout your organisation.

Recommendations which public bodies are required to take into account are set out as follows:

Policy recommendations - aimed at achieving the wellbeing goals set out in the Act. These are *directed largely at Welsh Government* but also relevant for some public bodies. You can find the top 20 recommendations here.

Process recommendations – These are directly related to 'how' public bodies should do things. They largely focus on the five ways of working, the process for decision making, for implementing policy and delivering services, and how the machinery of the public sector works. *There are some specifically for Welsh Government and some for all public bodies where their remit is applicable*

Comisiynydd Cenedlaethau'r Dyfodol Cymru
Future Generations Commissioner for Wales

Advice on the setting and meeting of well-being objectives - Public bodies are required to take this advice into account when next setting or revising their well-being objectives. *This advice applies to all public bodies covered by the Act including Welsh Government.*

Big Ideas - Throughout this report you will find Big Ideas of how we could do things differently. They are taken from some of the best examples from Wales and across the world, and many have been fed in by the people of Wales. They aim to inspire public bodies, the voluntary sector, businesses and communities to try new things. These provide ideas which could be taken on board by all public bodies.

Report and other resources

Given the breadth and depth of the Well-being of Future Generations Act, the report is an extensive resource. So, I am pleased to share with you a number of complementary resources that I have published to make my findings and recommendations more accessible:

- an interactive online version
- an at a glance version
- executive summaries of each chapter
- an easy read and multiple British Sign Language versions (in addition to the full version being available with assistive technology and text-to-speech functionality on the website)
- a young person's creative response version of the report is still to come, with my team currently working with a group of children and young people to create it.

Alongside these resources I would refer you specifically to the following frameworks:

- Framework for Infrastructure which should be used to consider how you can take decisions on infrastructure in line with the Act
- Framework for Service Design which should be used for considering how services are aligned with the requirements of the Act
- Framework for Scrutiny which should be shared with your scrutiny committees and/or Boards to assist them in meetings

What next

Much has changed over the last four months and the new challenges and opportunities that have emerged in front of us as a result of COVID-19 are at the forefront of everyone's minds. However, it is clear to me that the recommendations I have made are now even more important in the context of COVID recovery.

As Welsh Government and public bodies move from their immediate crisis response to recovery planning, I must remind you of your obligations to apply that Act to all of your decision making as we consider how we will

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approach recovery. Building on the recommendations in the Future Generations Report, I have also published five recommendations for Wales' recovery. It is pleasing to note that this five point plan has received widespread support from the CBI, WWF, TUC and others. We have a once-in-a-generation opportunity to reset Wales' economy, and build an economic system that tackles the ongoing health, climate and nature crises we will continue to face.

In the meantime, I am keen to understand how the contents of the report can support your work. If you would like to discuss any of the information contained with this letter, inform us of work you are undertaking, including the use of our recommendations or publicising where you have been highlighted within the report, or sign up for further updates to our monthly newsletter, please email: contactus@futuregenerations.wales.

Once more I would like to thank you for your contribution to the first Future Generations Report and look forward to working with you to build a movement of change to achieve the Wales we want.

Yn gywir / Yours sincerely,

Sophie Howe
Comisiynydd Cenedlaethau'r Dyfodol Cymru / Future Generations Commissioner for Wales

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Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 18.03.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Schedule of Closed Claims Over £50,000 - Quarter Three 2020/21
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Acting Associate Director of Quality Assurance / 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 three of 2020/21 (over £50,000). Specific details of claims are contained within a second appendix to be received in Private Committee to ensure patient/staff identifiable information is protected.

Argymhelliad / Recommendation:

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 of over £50,000 closed during Quarter 3 (October -December) of the 2020/21 financial year. This report formally summarises to the Audit Committee, the authorities given by the Health Board's Claims Managers, 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.

The report includes two tables – one containing summary information for the public report and a more detailed tab for the private report which includes additional information that may be patient/staff identifiable.

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 1 October 2019. The 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. The audit for 2020/21 has commenced.

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	Region	Specialty	Incident Date	Total (Payment summary)
W16-2234	Clinical Negligence	BCUHB West	Emergency Department (Secondary)	02/07/1996	£452,272.88
E15-2041	Clinical Negligence	BCUHB East	Day Surgery (Secondary)	01/01/2009	£179,232.40
CLA16-2248	Clinical Negligence	BCUHB East	Emergency Department (Secondary)	04/04/2014	£857,630.90
					£1,738,367.92

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 18th March 2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Primary Care Dental Services Assurance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport, Executive Director for Primary Care and Community Services
Awdur yr Adroddiad Report Author:	Mike Buckle, Assistant Director for North Wales Dental Services
Craffu blaenorol: Prior Scrutiny:	Executive Director for Primary Care and Community Services / Area Director Central
Atodiadau Appendices:	N/A

Argymhelliad / Recommendation:

The Audit Committee is asked to note the contents of this paper and the actions implemented to provide assurance of the maintenance of an effective dental service during the Covid-19 pandemic and other processes to protect the public purse expenditure the management and commissioning of General Dental Services.

Please tick as appropriate

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

Sefyllfa / Situation:

The purpose of the paper is to provide Members with an overview of the risks and assurance processes that are applied by the Dental Directorate of the Health Board (HB) in its management of primary care dental service contractors during the Red and Amber phases of the current Covid-19 pandemic.

Cefndir / Background:

The previous report to the Audit Committee (17 September 2020) outlined how dental contracts were performance monitored and managed via a system of Units of Dental Activity (UDA) and the mechanisms in please to manage risk and provides assurance

The Welsh Government issued notification 23 March 2020 that dental services had entered Red Alert phase and that all face to face treatment in dental practices, with the exception of limited treatment in absolute urgent circumstances, was suspended.
The Chief Dental Officer Wales (CDO) subsequently wrote to all Health Boards and Dental Contractors 26 March 2020 suspending the monitoring of UDA and setting out the conditions and

expectations for continued contract payments at 80% of full contract value initially for the 3 month period to end June 2020.

The conditions and expectations were:

- all staff in post in March 2020 will be retained and their pay will be protected at previous levels to reflect their NHS work, with no redundancies being made.
- Practices will remain ‘open for contact’ and will commit to providing Health Boards with details of activity every fortnight.
- Practices are required to ensure a dentist is available, during normal practice opening hours, to give telephone advice and direction to patients including remote prescriptions.
- Practices may need to undertake certain urgent treatments for patients that do not have any symptoms of COVID-19 and that cannot be delayed
- Practice staff may be asked by their Health Board to assist in the provision of services at the Urgent/Emergency dental care centres or to undertake other tasks to assist the wider NHS.
- Practices will cooperate to ensure sufficient cover for emergency work is provided to Health Boards. This will include staff and resources being shared between practices.
- Practices are advised to consider paying a stipend or retainer is paid to labs based in Wales that is proportionate to their level of supply of NHS lab work to the practice.

The conditions and expectations effectively replaced the UDA system and meant that previously described mechanism for UDA performance monitoring practices became unavailable.

Subsequent Welsh government guidance updates have been implemented by the contracting team and now run into quarter 1 & 2 of the 2021/22 financial year.

This paper describes the additional actions taken by the Dental Directorate to maintain adequate levels assurance and risk management regarding dental services following the suspension of the UDA system and further processes that have been put in place to improve the engagement and management of contractor activity.

Asesiad / Assessment & Analysis

Strategy Implications

General Dental Services is a key primary care service commissioned by the Health board for its residents. This supports Care Closer to Home, a key area of the HB's strategy by delivering preventative oral healthcare to both adults and children at convenient and appropriate locations.

Financial Implications

The assessment is that there are no financial implications to this report. The report is intended to provide Members with a background to actions implemented during the COVID pandemic to provide assurance that contract payments are being utilised for continued effective delivery of dental services.

Risk Analysis

The assessment of risk is that, following the suspension of UDA, there is limited NHS/BSA or BCUHB oversight of the risk management processes. This risk is not currently registered on the Risk Register as BCU has adopted the new way of working following guidance from the Chief Dental Officer

The additional actions over and above those in the last paper to manage risk and provide assurance over and above the last submission to this committee are:

Assurance Action 1 - Clinical risk management

The contracting team are supported by the NHS Business Services Authority with detailed clinical data on service provision to individual performer level. Quarterly meetings are held to discuss and action the necessary activities to challenge poor clinical behaviour. BCU Dental Practice Advisers provide additional clinical support to the contracting team to redress poor performance and encourage change in behaviours. The new clinical system, EDEN is new to the UK and all Health Boards will struggle for comparative data to compare and contrast performance in the new ACORN arena.

Assurance Action 2 - Patient expectations

The contracting team have produced a series of press releases for the public so that they are aware of the type of services they can expect during these challenging times. There is a focus on urgent and emergency service provision. There are processes in place to issue undated press releases as and when Welsh Government advice the Health Board of and significant change to service provision. Dental practices are also contacted accordingly.

Assurance Action 3 - Care home provision

The Community Dental Service (CDS) continue to provide an urgent and emergency service to care home residents within the current confines of the COVID impact. This is not dissimilar to current Urgent/Emergency Designate Dental Centre (UEDDC) provision for the general public. Risk assessments and prioritisation processes are in place to mitigate any unnecessary harm to this cohort.

Assurance Action 4 - Non-treatment and antibiotic prescribing

The Out of Hours (OOH) service picks up patients who are unable to see a high street dentist. Working through NHS111 and BCU's helpline, patients are triaged and referred to an appropriate clinic for treatment. Data is comprehensively reviewed on a quarterly basis. It should be noted that COVID protocols have significantly restricted the numbers of patients that could be seen but this is improving.
The contracting team are supported by the NHS Business Services Authority with detailed clinical data on antibiotic prescribing to practice and individual performer level. Quarterly meetings are held to discuss and action the necessary activities to challenge poor clinical behaviour. BCU Dental Practice Advisers provide additional clinical support to the contracting team to redress poor performance and encourage change in behaviours with clinical visits to practices.

Assurance Action 5 - Voluntary support

The CDS service has utilised voluntary support from high street dentists with the provision clinical services at its UEDCC sites across the geography. The driver behind this was BCU clinical staff were being seconded to work on e.g. testing sites so additional capacity was needed. Working with workforce colleagues, honorary contracts were issued to cover indemnity concerns and this has been successful. This is now being stepped down according to service demand and increased BCU workforce availability.

Assurance Action 6 – Financial management

The financial position is discussed fully between finance colleagues and the contracting team on a monthly basis, highlighting outlying positions and recommendation to redress any concerns. The contracting team monitor GDS dental activity, referrals for tier two and secondary care provision by individual provider level. Outlier performance is redressed contractually and recovery takes place in accordance with GDS regulations.

Non-Compliance

In circumstances that the contractor is unable or unwilling to provide satisfactory assurance of compliance with the conditions and expectations of continued payment the contracting team engage with the contractor to discuss the issue and agree a resolution (e.g. cooperate with nearby practices). If serious non-compliance by the contractor persists the Welsh Government have confirmed the option to revert the management of the contract back to UDA monitoring. Such a reversion has potentially serious consequences for the payment levels to the Contractor so would not be triggered lightly by either party. The current case is still under review.

Further Assurance with Contract Management

The Assistant Director developed an additional process to further aid performers and practices who may be experiencing lower levels of performance or issues with processes, governance or reporting of activity which the contracting team have been unable to resolve through discussion.

The process is known as the Support and Assurance process. The ideology behind the approach is to invite individuals into a formal meeting to discuss and asking them to present their cases for not achieving compliance.

The panel is made up of the Assistant Director and the interim North Wales Dental Clinical Director where they consider presentations from the contracting team and the provider. A solution is actively sought, hopefully without having to formerly escalate concerns to Quality and Safety or Performance Concerns Group.

The process has now been formerly adopted through our normal governance route of the Central Area Leadership Team. To date, one dental contractor has gone through the process.

Legal and Compliance

GDS services are covered by the NHS GDS (Wales) Regulations 2006. Since the declaration of Red Alert 23 March 2020 and the subsequent progression to Amber Alert 22 June 2020 services are covered by a number of specific guidance documents issued by the CDO:

- Red Phase Guidance (23/3/20)
- Covid-19 Business Continuity and Financial Support (26/3/20)
- Red Alert Escalation (3/4/20)
- De-escalation SOP (21/5/20)
- Restoration of Dental Services (22/5/20)
- SOP for AGPs for non-COVID patients (10/6/20)
- Expectation Document – Amber Phase (13/7/20)
- Covid-19 Progress through Amber Update & Guidance – CDO Letter - 27/08/20
- SOP - Dental Service Provision updated version – 27/08/20
- SOP – Orthodontic Services – 27/08/20
- Guidance on Ventilation & Q3 – CDO Letter 25/09/20
- Firebreak Guidance – CDO Letter - 22/10/20
- Progress and Guidance Update Q4 – CDO Letter 17/12/20
- SOP - Dental Service Provision updated version – 17/12/20
- Guidance for Q1 & Q2 – CDO Letter – 18/02/21

Impact Assessment

No impact assessment has been completed as the paper describes the additional assurance processes in place for an existing service.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 18/03/21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Legislation Assurance Framework (LAF)
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Board Secretary
Atodiadau Appendices:	Appendix one: Legislative Developments

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Note/discuss the contents of this report and the current position in respect of the LAF development and;
- Note/discuss the contents of appendix one: Legislative Developments

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:

This paper details a summary of the work undertaken in the development of the BCUHB Legislation Assurance Framework (LAF) including:

- Operational engagement in developing the LAF and the collation of assurances.
- Legislative developments (legislation enacted since the previous report)

Cefndir / Background:

The LAF system provides the Board with an oversight of legislative obligations/liabilities, the assurance level, the impact of non-compliance and the control measures in place for each. Members are also asked to note that the LAF has proven to be a useful tool for supporting the review and implementation of the Policy on Policies (as per the HASCAS and Ockenden external review recommendations); acting as a reference point to ensure that legislation cited is correct.

The Legislation Assurance Framework (LAF) previously formed Part B of the Health Board's Assurance Map (reflecting the approach in Wales of three distinct products (narrative Board Assurance Framework, Assurance Framework Map and the Corporate Risk Register)). Following the approval of the Health Board's Board Assurance Framework (BAF) at the January Board Meeting, the LAF is now a standalone product presented bi-annually to Audit Committee.

Operational engagement in developing the LAF and the collation of assurances.

Due to significant staffing / capacity issues within the Office of the Board Secretary (OBS) and the requirement of operational leads to focus on the COVID-19 response, the LAF development has generally been limited to basic monitoring and updates. This means that all newly enacted legislation and/or amendments are reviewed for applicability and impact, disseminated to governance leads for information and input/updated in the main database where applicable. Members can be assured that the master database is continuously updated though engagement with the relevant leads to confirm allocation and complete the assurance criteria has been limited overall. For this reason, appendix two, 'Items of limited or no assurance', is omitted from this iteration of the report.

Following the appointment of a substantive Board Secretary in January 2021, it is anticipated that the work to develop the LAF will resume pending operational staff prioritisation of the COVID-19 response and that appendix two will be reinstated for the September meeting of the Audit Committee as per the committee cycle of business.

Legislative developments (legislation enacted since the previous report)

Members should note that the report does not detail new legislation that has been enacted in order to address failures of retained EU law to operate effectively arising from the withdrawal of the United Kingdom from the European Union. The majority of amendments have no practical application and generally remove EU references that are no longer appropriate. For example, 'The Planning (Hazardous Substances and Miscellaneous Amendments) (EU Exit) Regulations 2018 amended the Planning (Hazardous Substances) Regulations 2015 and would not be included unless the amendment introduced changes in the legislation's application to the BCUHB. Similarly, the Health Protection (Notification) (Wales) (Amendment) Regulations 2020 which place obligations on various persons for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination have been enacted to amend/include Coronavirus Disease 2019 (COVID-19) into Schedule 1 of the existing 2010 Regulations and would therefore not be incorporated into the LAF.

Due to the current political landscape (COVID-19 response and prioritisation / withdrawal of the United Kingdom from the European Union.), the volume of legislation enacted has been reduced. Detailed at Appendix 1 is a summary of relevant legislation enacted since the previous report.

Asesiad / Assessment & Analysis

Strategy Implications

The LAF contains approximately 600 pieces of legislation. These include items that impact on strategic goals and plans. For example, the Social Services and Wellbeing (Wales) Act 2014, the Well-being of Future Generations (Wales) Act 2015 or specific environmental obligations to improve air quality / reduce waste etc. or general sustainability such as Public Services (Social Value) Act 2012.

Financial Implications

The LAF contains approximately 600 pieces of legislation. These include items that impact on financial regulation or operational finance requirements, for example – Bribery/Money Laundering/Modern Slavery, Charities, Consumer Credit, Late Payment of Commercial Debts Regulations/Public Contracts Regulations, Incidental lotteries, Government financial reporting manuals, tax and pensions and the duties under the National Health Service Finance (Wales) Act 2014.

Risk Analysis

Where there is evidence of limited or no assurance, items are included in appendix 2 (*omitted from this report iteration*). Directorate Governance Leads / Owners are directed that areas of non-compliance should be reflected in the appropriate risk register as appropriate. This supports the triangulation of data analysis. The LAF also details mitigating controls in place. The Health Board has committed to ensuring that there is a managed system in place to capture compliance information in accordance with the Board's Risk Appetite. This includes risks which could be identified from the Health Board's inability to comply with legislation, regulation, policies and procedures including professional standards.

Legal and Compliance

NHS bodies in Wales must operate within the law in relation to all aspects of their business. The Health Board has a responsibility to ensure that its governance arrangements encompass an assessment of compliance with all applicable legislative obligations. These will include, but not be restricted to the following categories:

- Accreditation, registration or licensing requirements
- Reporting requirements (the provision of statistics or information)
- Complying with timeframes for performing activities
- A requirement to provide a specified service or range of services
- Restrictions or limitations on how these services can be offered
- Financial obligations
- Employer duties
- Powers of inspection or review
- Data protection
- Professional regulation
- Other key pieces of legislation such as health & safety or environmental obligations

Impact Assessment

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

Appendix 1: Legislative Developments

Title	Explanatory Note	Divisional Assignment	Additional information
Restriction of Public Sector Exit Payments Regulations 2020 **And** HM Treasury: Restriction of Public Sector Exit Payments Guidance on the 2020 Regulations	The Regulations introduced changes to: • Restrict a body listed in the Schedule (includes a Local Health Board established under section 11 of the National Health Service (Wales) Act 2006) from making a payment of a prescribed description ("exit payment") exceeding the amount specified in section 153A Small Business, Enterprise and Employment Act 2015 to an employee or office holder in consequence of leaving employment or office except in the circumstances set out in these Regulations. The cap amount is currently £95,000. • Following the enactment of the regulations, the Treasury concluded that the Cap may have had unintended consequences and that the Regulations should be revoked as of 12/02/21. However, the Treasury has stated that further proposals will be brought forward at pace to tackle unjustified exit payments.	Workforce & Organisational Development	The BCUHB are awaiting further information from Welsh Government / NHS Employers. The BCUHB do not currently have any members of staff impacted by the legislative changes.
Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020	The Regulations were introduced to support the rollout of COVID-19 vaccines. Key changes include: • strengthen existing regulations that allow for the temporary licencing of medicines and vaccines, on an exceptional basis, pending the grant of a full licence • extend the current immunity from civil liability to companies producing the vaccine, rather than just healthcare workers and manufacturers. This will protect individuals from legal liability in civil cases but does not give them blanket immunity from civil liability • allow a wider range of trained personnel to administer COVID-19 or flu vaccines • ensure that the vaccines and treatments used in response to certain specific types of public health threat, such as a COVID-19 vaccine, can be promoted as part of national vaccination or treatment campaigns • make short-term provisions to facilitate the swift and safe transfer of COVID-19 and flu vaccines under NHS or armed services' authorised arrangements by providing an exemption from the need for a wholesale dealer's licence	Public Health	The Regulations are of an administrative nature, mainly applicable to manufacturers. Details of the changes have been shared with the Executive Director of Public Health, Immunisation Coordinators, Chief Pharmacist and the Lead Governance Pharmacist. The COVID-19 Vaccination programme is overseen by the Quality, Safety & Experience Committee, an update will be provided on the 2nd March 2021.

Title	Explanatory Note	Divisional Assignment	Additional information
Smoke-free Premises and Vehicles (Wales) Regulations 2020	The Regulations implement Chapter 1 of Part 3 of the Public Health (Wales) Act 2017. Key changes include: • extension of the smoking ban to outdoor areas of hospital grounds, school grounds, and local authority playgrounds. Part 2 (1), 11(1)-(6), *Hospital Grounds: Designated Areas* came into force on the 1st of March	Public Health	The Board on 11th March 2021 was asked to note the actions being taken in support of introduction of the Smoke Free Regulations (including the decision not to provide designated smoking areas within hospital grounds, to ensure all hospital sites become smoke-free). The paper to the Board provides an update on the implementation of Smoke Free Premises and Vehicles (Wales) Regulation 2020 which came into force on 01/03/2021. This includes the decision (agreed by the Executive Team and endorsed by the Strategy, Partnerships & Population Health Committee) – not to use designated smoking shelters in Hospital grounds as per the Smoke Free Premises Regulations.
Medicines and Medical Devices Act 2021	The Act provides for four key areas: • to provide the UK with means to depart from the EU rules that regulate these areas. • to facilitate simpler amendments of existing laws through statutory instruments. • to ensure the benefits of innovation do not compromise patient safety. • to establish a new Commissioner for Patient Safety (England).	Executive Medical Director (Medicines and Clinical Trials) Executive Director of Therapies & Health Sciences (Medical Devices)	The majority of the Act is not yet in force. Areas in force are enabling sections that allow the Secretary of State (England) to amend the existing regulatory framework for medicines and medical devices, namely: • Certain sections of the Medicines Act 1968 • Human Medicines Regulations 2012 • Medicines for Human Use (Clinical Trials) Regulations 2004 • Medicines (Products for Human Use) (Fees) Regulations 2016. • Medical Devices Regulations 2002 The appointment of a Patient Safety Commissioner (PSC) for England follows a recommendation made in the final report of the Independent Medicines and Medical Devices Safety review (July 2020). The PSC's statutory functions include the power to make reports or recommendations and the power to request and share information with relevant persons. The Department of Health and Social Care has developed a fact sheet available here. Clarification from Welsh Government will be required as to the impact/powers in Wales. Details of the changes have been shared with the Acting Executive Medical Director, Executive Director of Therapies & Health Sciences, Chief Pharmacist, Deputy Director Medical Physics, and the Acting Associate Director of Quality Assurance. Amendments and developments will be monitored and reported as part of future iterations of the LAF and via the appropriate divisional governance groups.
Equality Act 2010, s.1 as amended by the Wales Act 2017, s. 45	The Equality Act, section 1 provides a framework under which public authorities are required to comply with a more specific and targeted duty to have due regard to exercising public functions 'in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage'. Section 45 of the Wales Act 2017 amended the Equality Act meaning that the 'socio economic duty' has lain dormant on the statute book. However, section 2 of the Equality Act 2010, confers a power on Welsh Ministers to make regulations, naming those relevant public bodies to which the duty will apply. Following the consultation, A More Equal Wales –	Workforce & Organisational Development	The Socio-economic duty will have a significant impact on the way in which the BCUHB make strategic decisions such as 'deciding priorities and setting objectives'. Considerable work has been undertaken in preparation for the commencement: • Establishment of a Task & Finish Group with representation from the Equalities team, Strategy & Planning, Public Health, Staff side Representative/Independent Board Member, Corporate Communications & Engagement, Finance, MH&LD and the Office of the Board Secretary. • Development of a Procedure for the Socio-economic Impact Assessment / template impact assessment form. • Dedicated information page on the staff intranet. • Board Awareness session / presentation 8th April 2021 • Updated Board & Committee report template

Title	Explanatory Note	Divisional Assignment	Additional information
	Commencing the Socio-economic Duty, the Welsh Government directed that the duty would commence on the 29th September 2020. A revised date, due to the COVID-19 pandemic, has been agreed for the 31st March 2021.		• Situation-Background-Assessment-Recommendation (SBAR) circulated to the Executive Team and a briefing paper for the Strategy, Partnerships and Population Health Committee (SPPH) 10/12/20.