Bundle Audit Committee 28 September 2021

1 10:00 - OPENING BUSINESS - OPEN SESSION

1.1 10:01 - AC21.51: Apologies for Absence

1.2 10:02 - AC21.52: Declarations of Interest

1.3 10:03 - AC21.53: Procedural Matters

1. confirm the Minutes of the last meeting of the Committee held on 10/06/21 as a correct record and to discuss any matter arising;
2. review the Summary Action Log;
3. note the details of breaches (in terms of publication of Board/Committee papers) to the Standing Orders;
4. To note that the Health Board Scheme of Delegation is currently being updated and will be submitted to Audit Committee via Chair's action prior to final approval at Board, together with the updated EASC and WHSCC Standing Orders and revisions to the Health Board's Standing Orders following the recent publication of an updated model issued by Welsh Government recently; and
5. To note that at the September Quality, Safety and Experience Committee the Chair had reflected that the Committee had previously raised the need to consider the consistency of scoring both for the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) - in particular regarding the impact to the service, should the risk be realised. She suggested that this be raised with the Audit Committee through her Chair's report to enable all Corporate Risks and Board Assurance Framework risks to be considered as a whole. This will be addressed by the Audit Committee at its next meeting when it will consider the next iteration of the BAF and CRR.

AC21.53a Draft Public Minutes Audit Committee 10.6.21 v0.1.docx

AC21.53c Breach log extract.docx

AC21.53b Public Summary Action Log_Audit Committee_live.docx

1.4 10:13 - AC21.54: Issues Discussed in Previous Private Session

The Audit Committee is asked to note the report.

AC21.54 Private Session Items Reported in Public_Sept_21.docx

1.5 10:14 - AC21:55: Chair's Assurance Report: Risk Management Group

The Audit Committee is asked to note the report

AC21.55 RMG Meeting - Chair`s Assurance Report - v1.1.docx

1.5.1 10:29 - AC21.56: Emergency Scheme of Reservation and Delegation (SORD)

The Committee is asked to recommend approval of the Emergency SORD to the Board.

AC21.56a Coversheet for Emergency SORD.docx

AC21.56b draft emergency SORD (003).docx

AC21.56c Appendix 2 to Emergency SORD - Abbreviated business case.xlsx

2.1 10:34 - AC21.57: Internal Audit Progress Report

The Audit Committee is asked to:
• Receive the progress report; and
• Approve the revised arrangements for the distribution of discussion and draft internal audit reports outlined at paragraph 14.

AC21.57a BCUHB Internal Audit Committee cover sheet September 2021.docx

AC21.57b BCUHB Audit Committee progress report September 2021.docx

2.2 10:54 - AC21.58: Wales Audit Progress Report

The Audit Committee is requested to:

** Receive and discuss the Audit Wales programme update;*
** Receive and discuss the following audit reports:*

Assessment of the Health Board's plans for the £297 million Welsh Government strategic financial allocation and;
Rollout of the COVID-19 vaccination programme in Wales

** Note the WHSSC management response*
** Note the verbal update on the approach for the Wellbeing of Future Generations report*

AC21.58a Audit Wales_Coversheet.docx

AC21.58b Audit Wales_BCU AC Update Sept 2021.docx

AC21.58c Use of additional Welsh Government allocation.pdf

AC21.58d Audit Wales_Vaccination-report.pdf

AC21.58e_Audit Wales WHSSC management response to recommendations for noting.pdf

2.5 11:14 - AC21.59: Schedule of Financial Claims (Public)

The Committee is asked to receive this report for assurance.

AC21.59 Schedule Financial Claims Public Report.docx

2.8 11:19 - AC21.60: Performance Accountability Framework

The Audit Committee is asked to note the report

AC21.60a Coversheet AC 28.09.21_PAF Impact and Effectiveness v 0.1.docx

AC21.60b Appendix 1 - PAF Impact and Effectiveness report.docx

AC21.60c Appendix 2 - Performance and Accountability Framework 1.09 - final.pdf

3.1 11:39 - AC21.61: Annual Review of Gifts & Hospitality and Declarations of Interest Registers

The Audit Committee is asked to receive and discuss the report.

AC21.61a Gifts Hosp DOI report_Sep_2021. - for merge.docx

AC21.61b Appendix 1_Board Members DOI page from 2020-21 accounts (002).xlsx

AC21.61c Appendix 2_Gifts Hospitality Submissions 2020-21. v.1.xlsx

3.1 11:54 - AC21.62: Dental Assurance Report

The Audit Committee is asked to receive and discuss the report.

AC21.62 Audit Committee - Dental Services Assurance Report v3.docx

3.3 12:09 - AC21.63: Issues of Significance for reporting to Board

Members are asked to raise any issues of significance for reporting to the Board via the Chair's Assurance Report.

3.4 12:10 - AC21.64: Date of Next Meeting: 14/12/21

3.5 12:11 - AC21.65: 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."

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

AUDIT COMMITTEE PUBLIC MEETING DRAFT
Minutes of the Meeting Held on 10.06.21
Via Microsoft Teams - the Health Board has determined that the public are excluded from attending the Committee's meeting in order to protect public health during the pandemic.

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

In Attendance	
Louise Brereton	Board Secretary
Simon Cookson	Director of Audit and Assurance, NWSSP
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 AC21.31)
Dave Harries	Head of Internal Audit, NWSSP
Gill Harris	Deputy Chief Executive & Executive Director of Nursing
Sue Hill	Executive Director of Finance
Amanda Hughes	Financial Audit Manager, Audit Wales (for Minute AC21.29)
Matthew Joyes	Acting Associate Director of Quality Assurance (for Minute AC21.38)
Melanie Maxwell	Senior Associate Medical Director (for Minute AC21.32)
Simon Monkhouse	Finance Audit Lead, Audit Wales
Mark Polin	Chairman of the Board (part meeting)
Denise Roberts	Financial Accountant
Dawn Sharp	Deputy Board Secretary & Assistant Director
Tom Stanford	Finance Director, Operational Finance
Rod Taylor	Director of Estates (for Minute AC21.31)
Bethan Wassell	Statutory Compliance, Governance & Policy Manager (part meeting)
Simon Weaver	Head of Financial Control (part meeting)
Jo Whitehead	Chief Executive
Mark Wilkinson	Executive Director of Planning and Performance (for Minute AC21.31)

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AC21.24: Opening Business and Apologies for Absence. The Chair welcomed Members and attendees to the meeting. Apologies were received from Nicola Jones, Acting Deputy Head of Internal Audit and David Thomas, Engagement Director, Audit Wales.	
AC21.25: Declarations of Interest. No declarations of interest were made at the meeting.	
AC21.26: Procedural Matters. Reference was made to the breach log which captured all breaches in terms of late papers. One Member felt that there was an increasing pattern of late papers, coupled with Chair's Actions and stressed that this was not good governance. **RESOLVED:** That 1. the Minutes of the last meeting of the Committee held on 18.3.21 be confirmed as a correct record (subject to the correction of one minor typographical error); 2. the updates to the Summary Action Log be noted; 3. the details of breaches (in terms of publication of Board/Committee papers) to the Standing Orders be noted; 4. the approval (for onward submission to the May Board) via Chair's Action of the changes to Standing Orders, the Scheme of Reservation and Delegation and Standing Financial Instructions following the updates to the Models as issued by Welsh Government be noted; 5. following discussion at the Audit workshop on 25 May it be noted that the refined management response to the External Audit Wellbeing of Future Generations Report will be circulated to Members during June. 6. the Targeted Intervention Steering Group Terms of Reference (as presented to the May Board) be noted; and 7. following on from previous discussions it be noted that an Emergency Scheme of Reservation and Delegation has been drafted and will be presented to the September meeting.	
AC21.27: Issues Discussed in Previous Private Committee Session. **RESOLVED:** That the report on issues discussed in the previous Private Committee session be noted.	

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AC21.28 External Audit - Audit Wales Reports **AC21.28.1** The Performance Lead, Audit Wales presented he documents for Audit Committee which included the annual review of audited accounts and letter of representation (discussed as part of the next agenda item). The documents also included the regular audit update alongside reports finalised since the last Audit Committee. The update provided an overview of progress of the external audit programme and the performance audit reviews provided assurance and opinion on the effectiveness of arrangements in key areas as described within the reports, namely the Structured Assessment 2021 (Phase One) – Operational Planning Arrangements; Test, Trace, Protect in Wales: An Overview of Progress to Date; Welsh Health Specialised Services Committee Governance Arrangements; and Procuring and Supplying PPE for the COVID-19 Pandemic. **AC21.28.2** In considering the reports the following points were raised/noted:- • The performance audit work was progressing well • The follow up outpatients review was scheduled towards the end of the year due to capacity. • Funds held on Trust Audit work would start in the Autumn reporting into the December meeting of the Charitable Funds Committee. • The Structured Assessment report provided a high level summary focussed on Phase 1, with a focus on operational planning looking back at Q3/4. Members reflected that it was a very fair report. It was confirmed that the report had been shared with the full Executive Team and all recommendations were being taken forward. Members acknowledged the work of the governance review including revised templates. Members emphasised the importance of future plans needing to demonstrate the outputs. • The TTP report had been added to the programme as a result of the pandemic – it was acknowledged that the protect element of the programme was fragmented and varied across Wales and that the £500 payment to individuals who needed to isolate had generated a number of issues. The field work in relation to in-patient testing had been conducted remotely last autumn. Variances existed between sites from 20% - 50%. Independent Member Jackie Hughes queried how this compared with internal reporting and agreed to follow this up with the Deputy Chief Executive after the meeting. • WHSSC – the report had no recommendations for the Health Board and was yet to be presented to the Specialised Services Committee. The combined management response would be presented to the Audit Committee in September.	**JH/GH**

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• PPE – overall a report with positive findings – eight recommendations had been made to Welsh Government with none applicable to the Health Board. **RESOLVED**: That 1. the progress update together with the individual audit reports as detailed above be received; and 2. the report on the annual accounts be received.	
AC21.29 Executive Director Briefing on Financial Accounts **AC21.29.1** At its meeting on 20.5.21, the Board had delegated authority for approval of the 2020-21 annual financial statements to the Audit Committee (Minute 21.87 refers). The audited annual financial statements required approval by the Audit Committee prior to submission to Welsh Government and the Auditor General for Wales. **AC21.29.2** The Executive Director of Finance presented the report which provided members with a briefing on the Health Board's 2020-21 annual financial statements to ensure that members had sufficient and appropriate information to be able to approve the statements. The briefing outlined the Health Board's achievement against Welsh Government financial targets and provided an analytical review of in-year movements for both income and expenditure transactions and balance sheet balances. The Executive Director thanked both the Audit Wales Team and the Health Board's Finance Team for their commitment and hard work in preparing the accounts. **AC21.29.3** The Health Board had a statutory requirement to prepare a set of annual financial statements in a standard format provided by Welsh Government, with the approval of H M Treasury. The annual financial statements were completed in accordance with the National Health Services (Wales) Act 2006, the Welsh Government Health Board Manual for Accounts and HM Treasury's Financial Reporting manual (FReM) in order to reflect: • International Financial Reporting Standards (IFRS); • Accounting and disclosure requirements of the Companies Act 2006, where appropriate; • Any other pronouncements made, or endorsed by, the International Accounting Standards Board. **AC21.29.4** The unaudited annual financial statements for 2020-21 had been submitted to Welsh Government and Audit Wales on 30.4.21. Following completion of their financial audit, Audit Wales had prepared an Audit of Financial Statements Report providing a summary of amendments made to the unaudited financial statements along with	

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recommendations arising from their audit work. The Financial Audit Manager, Audit Wales discussed the key findings from the audit, noting that they intended to issue an unqualified opinion. She thanks the Finance Team for their support during the audit. Reference was made to pension liabilities and that it was still not possible to assess what the liability might be, and as a result their opinion was required to include an 'emphasis of matter'. She noted the need in future years to improve and simplify the way the remuneration report was concluded and that Audit Wales would be working with the Finance Team over coming months to improve reporting going forward. Whilst they would be making a number of recommendations for the Finance Team to address there was nothing significant to flag as an area of concern for the Committee. **AC21.29.5** Reference was made to Board Members' Declarations of Interests and the fact that during the audit it had become apparent that a number of declarations relevant to the financial statements had not been made. It was confirmed that all the declarations had been made but that certain information had been omitted from some Members' declarations and had to be followed up. The Financial Audit Manager confirmed that all information necessary had been submitted prior to the closure of the audit. The Board Secretary confirmed that further check and challenge would be instigated for future submissions. **AC21.29.6** Members noted that this was to be the Financial Audit Manager's last meeting and wished her well in her future career. **RESOLVED:** That the Health Board's 2020-21 annual financial statements together with the Letter of Representation following consideration of the Audit Wales Audit of Financial Statements Report and confirmation of the Auditor General's intended opinion on the financial statements, be approved.	
AC21.30 End of Year Reporting **AC21.30.1** The Annual Governance Statement (AGS) was part of the Health Board's statutory Annual Report to Welsh Government. Its content was in a standard format in accordance with the reporting arrangements prescribed in the Manual for Accounts. The Audit Committee had delegated authority to grant approval from the Board to submit the Statement, and all other elements of the annual report and accounts, to Welsh Government. The Annual Report would then be presented to the Annual Meeting scheduled for 29th July 2021. **AC21.30.2** The Chief Executive thanked colleagues for their work on compiling the AGS and Annual Report and referenced the ongoing work to improve governance arrangements across the organisation, outlining	

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that her ambition was to achieve substantial assurance next year rather than satisfactory assurance as part of the Audit Opinion. **AC21.30.3** In accordance with Standing Orders, all Board Committees were required to produce Annual Reports, these had been reviewed in detail by Audit Committee Members at a workshop held on 25th May 2021. The audited Charity Annual Report and Financial Statements, providing the formally reported position for the charity for 2019-20 had been approved by the Charitable Funds Committee on 8th December 2020, signed by the Auditor General on 9th December 2020 and reported to the Audit Committee for information at its 17th December 2020 meeting. **RESOLVED**: That 1. the Annual Report be approved for submission to Welsh Government; and 2. the suite of Committee Annual Reports be received and approved.	
AC21.31 Internal Audit Report **AC21.31.1** The Head of Internal Audit presented the progress report which had been 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. **AC21.31.2** The annual report and opinion was also presented to the Committee and had been produced in accordance with the Public Sector Internal Audit Standards: Standard 2450 – Overall Opinions. **AC21.31.3** The progress report summarised eleven assurance reviews finalised since the last Committee meeting in March 2021, with the recorded assurance as follows: • Reasonable assurance (yellow) – four; • Limited assurance (amber) – five; and • Assurance not applicable (blue) – two. **AC21.31.4** The report also detailed reviews issued at draft reporting stage, work in progress and recommendations subject to follow-up in the period. In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit (HIA) was required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the Health Board's risk management, control and governance processes (i.e. the system of internal control). The outcomes of the reviews had been shared with management, however at the time of the report, some of these were still to be finalised although the draft report opinion had been used to inform the HIA opinion.	

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AC21.31.5 The report also appended five limited assurance reviews and discussion followed on each. The question of benchmarking with other Health Boards in terms of limited assurance reports arose. Whilst the Health Board did have more than others, Members acknowledged that a number of reports had been commissioned at the request of the relevant Executive. **Interim Staffing** **AC21.31.6** The Executive Director of Workforce and Organisational Development joined the meeting to respond to the findings following an introduction by the Chair, who set out the context to the report in terms of why he commissioned the review specifically in the light of the earlier Audit Wales report on Interims. A long and detailed discussion took place with the following points being highlighted:- • A new Standard Operating Procedure had been approved in March 2020, days before the pandemic was declared. • In view of the pandemic a fast track recruitment process was established which also applied to interim appointments • Significant pressures had been experienced by the Workforce Team as a result of the pandemic • Reinforcement with the Workforce Team of the priority to be attached to audit requests for information • A revised SOP had been approved in March 2021 with a clear reporting process through Executive Team and Remuneration Committee to ensure compliance. • Agencies/Suppliers of Interims had all been informed that invoices would not be paid if process had not been followed. • The Team had now built a process that should not be impacted in the event of a further pandemic • The Team had learnt from the issues over the last 12 months and had implemented the actions to address the recommendations. • Monitoring and compliance with the process was a joint responsibility between Finance and Workforce and there was an acknowledgement that the two teams needed to work in an integrated fashion • Given the ongoing pandemic it was anticipated that Interims would still be required, but the importance of following process/framework was emphasised • All recommendations arising from the Audit had since been implemented and also reported to the Remuneration and Terms of Service Committee and Executive Team. • The Regulation 28 referenced by an Independent Member received which referenced recruitment processes and the taking up of references cut across a number of issues highlighted in the Audit report. The Health Board is now reinforcing the Agency Verification requirements with spot audits of compliance built into	

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the revised process. She also confirmed that there had been no issues of harm or probity in relation to any of the appointments reviewed as part of this Audit **AC21.31.7** The Chair stated that he appreciated the context, however the report was extremely disappointing given that the issues had been identified more than twelve months earlier. He also added that it was totally unacceptable that Auditors had difficulty in obtaining information from the Workforce Team. **AC21.31.8** The Head of Internal Audit then questioned the rationale for future reporting of Interims being taken to Remuneration and Terms of Service (R&TS) Committee and that this potentially placed the Chair in a position of conflict given that he was a Member of R&TS. The Executive Director of Workforce confirmed that the reports had been submitted to R&TS at the request of the Chairman and that the Vice Chair of R&TS had asked her to consider reporting routes for Interim and Acting reports. Members noted that a revised proposal was being drafted which would see elements of reporting to R&TS, Finance and Performance and Strategy, Partnerships and Population Health Committees. **Security Compliance and Violence and Aggression** **AC21.31.9** Consideration of these reports was taken together in view of the synergy between them. The Executive Director of Workforce highlighted that whilst the reports made challenging reading, the findings should not come as a surprise and that the reports did highlight areas for investment. In terms of the management actions there was clarity of what needed to be done and the Team were confident about taking the actions forward but this would require a paradigm shift in the way in which the Health Board approached Security and Prevention of Violence and aggression. **AC21.31.10** Questions were raised about the size of the Team and whether it was sufficient for an organisation of this size. The Executive Director responded to say that the funded establishment for management of security and violence and aggression was 0.8wte, so no it was not sufficient. Since transferring to Workforce & OD, and during the pandemic, the Team had been augmented on a temporary basis and that the security service specification was been revised to have a more holistic approach to managing the risks associated with violence and aggression. Work was also being undertaken around culture and dovetailing into this was a review of how pathways of care were managed. This would however require investment to bring the Health Board to the level required. She cited an example of another Health Board used for benchmarking which was half the size of BCUHB and yet the security service had a budgeted establishment of 48wte and a service funded to iro £1.3m.	

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AC21.31.11 It was acknowledged that addressing the issues would involve a two-three year programme of work. The Chief Executive gave examples from her time in Australia. Finding the right people, coupled with training would be key. **AC21.31.12** Reference was made to an incident in Ysbyty Gwynedd which had been reported in the press but had not been recorded in Datix which was concerning. A number of further points were raised as follows:- • Whether records were kept of the number of incidents that had resulted in police action – the Executive Director confirmed that records were held in cases where the organisation had supported staff to proceed to prosecution and that these were reported to the Quality, Safety and Experience Committee. • It was acknowledged that full records of all incidents did not exist and that there was a considerable amount of work to be undertaken to ensure appropriate and timely reporting of incidents. • The organisation had historically had 0.8 whole time equivalent (WTE) managing violence and aggression. • Whilst security had been augmented there was a need to develop leadership and training to ensure a clear system of support across the whole organisation. • Pockets of good practice did exist e.g. Mental Health Services and consideration could be given to bringing these elements together • Acknowledgement that security issues were a key risk as documented within the Board Assurance Framework. **Water Management** **AC21.31.13** The Executive Director of Planning and Performance and Director of Estates joined the meeting and provided an update in terms of the progress on each of the four recommendations within the report which were being monitored via the audit tracker. **AC21.31.14** The Chair expressed concerns as to why it had taken an audit to identify the issues. The Director of Estates informed Members of a digitally enabled solution which was being progressed and which would flag issues. Members commented on the themes throughout the reports regarding health and safety querying whether the Board was giving them enough attention and resources based on the risks. **AC21.31.15** The Director referred to the 2019 audit and subsequent development of a Business Case in response to the gap analysis findings. Since then the challenges of managing an ageing estate in a post pandemic world had been magnified. The Executive Director	**JW**

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highlighted the importance of the Estates Strategy in terms of addressing the issues. The Chief Executive agreed to take the challenge of resources versus risk back to the Executive Team for review. **Control of Contractors** **AC21.31.15** The Director of Estates introduced the report and outlined the three recommendations and management responses which had been progressed. These would be reported through the audit tracker. **AC21.31.15** The Head of Internal Audit thanked the Audit Committee and Office of the Board Secretary for their support in ensuring that the audit programme of work was delivered. **RESOLVED:** That 1. the progress report, together with the Head of Internal Audit opinion and annual report for 2020-21 be received; and 2. the Limited Assurance Reports on Interim Staffing; Security Compliance; Violence and Aggression; Water Management – Statutory Compliance; and Control of Contractors be received; 3. the concerns of the Committee in respect of the Interim Staffing report be escalated to the Board via the Chair's assurance report; and 4. the Chief Executive review the position with regard to appropriate resourcing of associated health and safety risks.	
AC21.32 Clinical Audit Plan **AC21.32.1** The Senior Associate Medical Director joined the meeting to present the report. The Corporate Clinical Audit Annual plan for 2021/22 had not changed significantly between years due to the impact of the COVID-19 pandemic. Most audit activity had been paused at national and local levels, and these were now gradually re-starting. There had been no additional Tier 1 requirements from Welsh Government. **AC21.32.2** Clinical Audit was an important tool to provide assurance to the Board about the quality of services and was an important mechanism to drive quality improvement and a vital part of the Health Board's overall quality strategy, which was being developed. **AC21.32.3** Audit measured compliance against evidence-based standards, targets or through benchmarking. Tier 1 audits were those mandated nationally; with Tier 2 audits being those considered necessary at a corporate level because of their risk profile or requirement to improve. **AC21.32.4** Clinical Audit had an annual planning cycle, although many audits were continuous across the year. Quarterly reporting to Quality,	

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Safety and Experience Committee on progress against the plan was in place, with an annual report at year end to the Joint Audit and Quality, Safety and Experience Committee. **AC21.32.5** The clinical audit process would be embedded in the overall BCU strategy for quality and improvement. The ongoing process to develop the Quality Strategy [including the Clinical Effectiveness Strategy] would include the clinical audit strategy also going forward. **AC21.32.6** The draft plan included the breadth of topics included in the Welsh Government's National Clinical Audit & Outcome Review Plan (NCAORP). The tier 2 audits had been chosen to reflect key risks and areas for improvement identified from the risk register, claims, regulatory compliance etc. Therefore, Tier 2 audits reflected the areas where improvement needed a focus and within the Plan had been colour coded into themes. Discussion then ensured with the following points being noted:- • Participation in the audits had improved compared to 18 months ago • Fracture liaison work was to be progressed • The Chief Executive and Executive Medical Director were in discussion regarding the plan to ensure that it was fully aligned with clinical risk as well as the requirements to respond to the Tier 1 Welsh Government requirements. Members were asked to approve the plan noting that discussion at the Quality, Safety and Experience Committee would be around ensuring the Tier 2 elements focused on risk. • With regard to resources to support the audits, this was in place in respect of the corporate work, however a business case was to be submitted for Executive approval to enhance the service. • Acknowledgement that audit activity was business as usual and that it was impossible to say what the audits might find that might require further investment. • There needed to be a systematic approach to managing clinical audit aligned with performance improvement • All Tier 1 audits were progressing with the exception of falls fragility which was to be addressed. • In relation to Tier 3 audits and learning at a local level being communicated to other areas of similar concern, the Team had seen much more engagement over the last year and the embedding of audit findings was demonstrated at clinical effectiveness meetings. • An electronic register was now in place in respect of Tier 3 audits which sent email notifications to clinical teams to ensure follow up. • Investment had also been made in a tracker to assist with the follow up of action plans. • Tier 2 audits were being linked to risk and also to incidents.	

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RESOLVED: That the draft Clinical Audit Plan for 2021/22 be approved noting that the Plan was to be presented to the Quality, Safety and Experience Committee in July at which there would be further discussion on the Tier 2 audits and the learning and communication of learning from Tier 3 audits. ***Post Meeting note: Following the meeting the Senior Associate Medical Director advised that she had been informed that Chronic Obstructive Pulmonary Disease (COPD) in Wrexham had not submitted any data (in relation to mandated audits). Arrangements have been made for a plan to be in place within two weeks to rectify the situation.***	
AC21.33 Risk Management Strategy/Policy **AC21.33.1** The Interim Director of Governance presented the report which provided a summary of key changes that had been made to the updated Risk Management Strategy and Policy. The Health Board`s vision and strategic approach to risk management ensured that all staff including partners, contractors etc. who provided services with and/or on its behalf, placed effective risk management at the heart of what they did. **AC21.33.2** The Health Board was committed to embedding a risk-based, agile, dynamic, enterprise-wide, integrated risk stratification and collaborative approach in effectively reducing and managing risks as it delivered its Annual Operational Plan for 2021/22 in a post-Covid-19 era. This would encourage staff to explore integrated, risk-based prioritisation and stratification tools in delivering more joined-up, patient focused personalised outcomes and effective allocation of resources. The Health Board`s vision statement for risk management had been refreshed to reflect the new direction of travel as it navigated through recovery in a post-Covid-19 era. The Equality Impact Assessment had also been updated as part of the process of updating the Risk Management Strategy and Policy. **AC21.33.3** The Interim Director then outlined the main changes to the Policy and drew attention to the revised risk appetite included within the Policy. The following comments were made:- • Reference to paragraph 8.1 and ensuring consistency throughout the document • Page 5 – risk assessment – use of the term ‘brain storming’ – to be rephrased ‘brain storming sessions’	

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• Page 6 – reference to contractors, staff and Trade Unions – agreed to remove the reference to Trade Unions • Cover report reference to Socio Economic Duty – Interim Director to inform Members following the meeting of the actions taken. **RESOLVED**: That 1. the Health Board`s updated Risk Management Strategy and Policy be Approved for onward submission to the Board, subject to the amendments as listed above; 2. the proposed Risk Appetite for 2021/22 be approved and recommended to the Board; 3. the revised risk appetite for use in exceptional circumstances, recognising the appropriate governance approval route from Gold Command, be approved for onward submission to the Board; and 4.the Interim Director of Governance inform Members of the actions taken in relation to the Socio Economic Duty.	**SEE** **SEE**
AC21.34 Chair's Assurance Report - Risk Management Group **AC21.34.1** The Interim Director of Governance presented the Chair's Assurance Report following the meetings of the Risk Management Group (RMG) which had met on 15.3.21 and 14.4.21. The Group had been quorate on both occasions with good representation. The report summarised the activity of the Group and members noted the following key assurances which had been provided at the meetings:- • Progress with the implementation of the Risk Management Strategy and Policy and supporting documentation; • Progress with the implementation of the Board Assurance Framework; • 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; and • Follow up of outstanding actions incorporated into future improvement plans. **AC21.34.2** The following points were noted in the Audit Committee meeting:- • Agreement to extend the time available for improved check and challenge; • Part 2 of the Risk Management Group was to seek an understanding of the Tier 2 risks across the Health Board; • Agreement that any rescheduling of dates would be highlighted. **RESOLVED**: That the report be received.	

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AC21.35 Corporate Risk Register **AC21.35.1** The Interim Director of Governance presented the report on the Corporate Risk Register (CRR) which demonstrated how the Health Board was robustly mitigating and managing high rated risks to the achievement of its operational objectives. **AC21.35.2** The design of both the Board Assurance Framework (BAF) and CRR emphasised their distinctive roles in underpinning the effective management of both strategic and operational risks respectively. The BAF was now reported separately, appearing as the subsequent agenda item. **AC21.35.3** Each Corporate Risk had been reviewed and updated. The following points were discussed:- • The appendices containing the corporate risks represented the risks as presented to the previous cycle of Committee meetings – with some of the actions having moved on – all actions due in March had been completed; • Concerns expressed with regard to the timeline of reporting with agreement to revisit • Audit Committee Members wished to see the latest information • Query regarding legionella risk – need to explain any increases or decreases to make it meaningful for the Committee – further discussion would take place at the Risk Management Group • Risk 20-08 – new risk for escalation but opened in September 2020 – concern expressed about where this had been until now – Interim Director advised that this was a new risk onto the Tier 1 register • Further examination of some of the controls required – view that some were in fact actions. **RESOLVED**: That 1.the progress on the management of the Corporate Tier 1 Operational Risks be noted; and 2.the Interim Director of Governance follow up on the points outlined above.	**SEE**
AC21.36 Board Assurance Framework **AC21.36.1** The design of both the new Board Assurance Framework (BAF) and Corporate Risk Register (CRR) emphasised their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, as well as underlining their symbiotic	

Agenda Item	Action
relationship as both mechanisms had been designed to inform and feed-off each other. This included the evaluation, monitoring and review of progress, accountability and oversight of the Principal Risks and also the high level operational risks which could affect the achievement of the Health Board's agreed Priorities. These were being monitored by regular review with respective leads and oversight by the Risk Management Group and the Executive Team. Oversight and co-ordination of the BAF had transferred to the Office of the Board Secretary from the Corporate Risk Management Team, with the risk management system and process continuing to be managed by the Corporate Risk Team. Engagement with risk leads continued to progress well and work continued to refine and further develop the BAF to ensure it was a tool to ensure strategic risks were visible to the Board and Committees. **AC21.36.2** The Board had updated its strategic priorities as set out within the 2021-22 Annual Plan. Due to the revised strategic priorities, some principal risks did not lend themselves to direct mapping, and had subsequently been mapped to an 'enabler'. **AC21.36.3** The BAF was a 'live' document which continued to evolve, and has progressed with the engagement and support of the full Board. This served well going forward as the Health Board progressed and refreshed 'Byw'n iach, Aros yn iach/Living Healthier, Staying Well' and all underpinning strategies. With the refresh there would be a need to have greater focus and consideration of strategic risks in the BAF as the Health Board looked to the future in delivering its strategies. A revision of the BAF would then need to take place to link to the strategic objectives as defined in the refreshed strategy with any operational BAF risks being managed as part of the Corporate Risk Register going forward. Consideration was also being given to the potential input/engagement from the Good Governance Institute. **AC21.36.4** It was important that the Risk Management Group became the main driver to review the risks and ensure moderation in terms of scoring and proportionality of the risks, and being able to facilitate deep dives. With this in mind a re-alignment of reporting cycles was underway. Key progress on the BAF risks was reflected within the relevant BAF risk sheets as presented. **AC21.36.5** Specific comments were made as follows:- • Audit Wales commended the direction of travel; • Planned Care risk – consideration to be given to whether clinical audit could assist	**GH** **LB**

Agenda Item	Action
• Consideration was being given to a risk relating to the management of COVID and preparedness for an inquiry and whether this would sit on the BAF or CRR • Safe and Secure Environment – reference to Dignity at Work to be updated to reflect 'Respect and Resolution'. **RESOLVED**: That 1. the progress on the Principal Risks as set out in the Board Assurance Framework (BAF) and the comments referenced above be noted; and 2. the remapping of BAF risks to the revised Annual Plan 2021-22 be noted.	**SG(DS**)
AC21.37 Proposed Integrated Governance Framework **AC21.37.1** The Interim Director of Governance presented the report, together with a series of detailed appendices**.** The Health Board (HB) and Welsh Government had identified governance as an area that required improvement. The Interim Director's review built on previous reviews, interviews with Board members and support from internal teams including the Office of the Board Secretary, the Office of the Chief Executive, the Executive Leadership Team and the Equalities Team. The proposed framework was intended to:- • Ensure that the governance, performance management and risk structures were effective, efficient and robust; • Ensure clear accountability at all levels and that the Health Board created an environment for learning and safety; and • Ensure that governance standards were consistent throughout the organisation. **AC21.37.2** Members supported the revised framework with two small modifications as follows:- • Audit Terms of Reference – paragraph 4.5 – review risks assigned to the Committee – the inclusion of this new paragraph was at odds with paragraph 1.6 of the Audit Committee Handbook and it was therefore agreed to delete it. • Diagram referencing Charity Committee to be amended to read Charitable Funds Committee. **RESOLVED:** That subject to the correction of the two minor points listed above, the suite of documents be approved for presentation to the Board.	**SEE**
AC21.38: Schedule of Financial Claims	

Agenda Item	Action
AC21.38.1 The Acting Associate Director of Quality Assurance joined the meeting and provided an overview of the public section of the report. The Chair noted that the paper outlined the various levels of assurance and committees that had provided scrutiny. The Acting Associate Director made reference to the annual audit of claims conducted by Internal Audit each year which would be included within the next report once the audit had concluded. **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.	
AC21.39: Issues of Significance for Reporting to Board **RESOLVED:** That the Chair prepare his assurance report for the Board.	
AC21.40: Date of Next Meeting: 28/09/21	
AC21.41: Exclusion of Press and Public **RESOLVED:** 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

28.09.21

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

Meeting Date	Body	Standard	Issue/Reason for Breach	Details of papers
4.6.21	Healthcare Professionals Forum	Publication of papers 7 days before meeting	Agenda not published to website until 2 days prior to meeting	Agenda only
7.6.21	Remuneration & Terms of Service Committee	Publication of papers 7 days before meeting	Awaiting conclusion of auditing process	Remuneration report
11.6.21	Charitable Funds Committee	Publication of papers 7 days before meeting	Two items amended post-publication	• Minutes • Strategic Action Plan
17.6.21	Strategy, Partnerships & Population Health Committee	Publication of papers 7 days before meeting	Late papers either in terms of submission date or sign off delay	• Quarter 1 Plan refresh • Planning for 2022-25 – timetable • Civil contingency and business continuity progress report • NHS Wales Decarbonisation Strategic Delivery Plan 2021/30 Summary action log • Workforce Strategy presentation Innovation and University Status Research and Medical School progress • Mid Wales Collaborative update

Kate Dunn

Head of Corporate Affairs

10.6.21	Audit Committee	Publication of papers 7 days before meeting	• Items amended post-publication. • Failure to publish to website on day of publication due to technical issues re uploading and the size of the bundle.	• Health Board Annual Report • AGS • SPPH Annual report (appendix)
24.6.21	Finance & Performance Committee	Publication of papers 7 days before meeting	Late papers	• Annual Plan • QPR • Cefni Lease • Former Lluesty site
6.7.21	Quality, Safety & Experience Committee	Publication of papers 7 days before meeting	Late papers	• Vascular • Clinical Audit • Mental Health
15.7.21	Health Board	Publication of papers 7 days before meeting	Welsh version of 1 paper late	• Section 12(2) Doctors
7.9.21	Quality, Safety & Experience Committee	Publication of papers 7 days before meeting	Whole agenda breached due to majority of papers not being available and signed off on publication day. Three papers were further delayed.	• Whole agenda • Summary action log • IPC • Urology
20.9.21	Stakeholder Reference Group	Publication of papers 7 days before meeting	Agenda not published to website until 6 days prior to meeting	Agenda only

Kate Dunn

Head of Corporate Affairs

Audit Committee Summary Action Log: Public Committee

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Louise Brereton	**AC21.08.2: Discussion on Dental Assurance report** (contents / appropriate committee)	June	Meeting held between Office of the Board Secretary, Dental and Counter Fraud. Report format revised and will be submitted for September meeting	Close
Jackie Hughes / Gill Harris	**AC21.28.2: TTP report / in-patient testing**. Query how this compares with internal reporting. Follow up with the Deputy Chief Executive after the meeting.	September	Followed up with Deputy CEO after meeting.	Close
Jo Whitehead	**AC21.31.15**: **Internal Audit / Water Management**. The challenge of resources versus risk to be taken back to the Executive Team for review.	September	Chief Executive has discussed with the Board Secretary and will include a significant discussion on risk management at the EMT away session in November	
Simon Evans-Evans	**AC21.3:3.3: Risk Management Strategy.** • Reference to paragraph 8.1 and ensuring consistency throughout the document • Page 5 – risk assessment – use of the term 'brain storming' – to be rephrased 'brain storming sessions' • Page 6 – reference to contractors, staff and Trade Unions – agreed to remove the reference to Trade Unions • Cover report reference to Socio Economic Duty – Interim Director to inform Members following the meeting of the actions taken.	September	Actioned.	Close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Simon Evans-Evans	**AC21.35.3: Corporate Risk Register** • Concerns expressed with regard to the timeline of reporting with agreement to revisit • Audit Committee Members wished to see the latest information (the appendices containing the corporate risks represented the risks as presented to the previous cycle of Committee meetings – with some of the actions having moved on – all actions due in March had been completed) • Query regarding legionella risk – need to explain any increases or decreases to make it meaningful for the Committee – further discussion would take place at the Risk Management Group • Further examination of some of the controls required – view that some were in fact actions.	September	Actioned	Close
Gill Harris	**AC21.36.5: Board Assurance Framework.** Planned Care risk – consideration to be given to whether clinical audit could assist	September	Risk refreshed.	close
Louise Brereton	**AC21.36.5: Board Assurance Framework.** Consideration as to a risk relating to the management of COVID and preparedness for an inquiry and whether this would sit on the BAF or CRR	September	Discussed at Office of the Board Secretary team meeting – risk being worked up – likely to be a tier 1 CRR rather than a BAF risk but will need to be worked through.	

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Sue Green / Louise Breraton	**AC21.36.5: Board Assurance Framework.** Safe and Secure Environment – reference to Dignity at Work to be updated to reflect 'Respect and Resolution'.	September	Actioned.	Close
Simon Evans-Evans	**AC21.37.2: Proposed Integrated Governance Framework.** • Audit Terms of Reference – paragraph 4.5 – review risks assigned to the Committee – the inclusion of this new paragraph was at odds with paragraph 1.6 of the Audit Committee Handbook and it was therefore agreed to delete it. • Diagram referencing Charity Committee to be amended to read Charitable Funds Committee	September	Actioned.	Close

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 28/09/21**
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:	Louise Brereton, Board Secretary
Awdur yr Adroddiad Report Author:	Dawn Sharp, Assistant Director – Deputy Board Secretary
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**	✓
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable							**N**

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.

Sefyllfa / Situation:

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

Cefndir / Background:

Standing Orders require 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 10/06/21:

- Minutes of the Private Session of Audit Committee held on 18/03/20
- Financial Conformance Report

- Covid-19 Field Hospitals Consequential Losses
- Schedule of Financial Claims
- Counter Fraud Annual Report and Counter Fraud Workplan
- 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 Orders

Impact Assessment

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

Audit Committee

28th September, 2021

To improve health and provide excellent care

Chair's Assurance Report

Name of Group:	Risk Management Group (RMG)
Meeting dates:	15th June and 16th August, 2021
Name of Chair:	Gill Harris, Deputy Chief Executive Officer / Executive Director of Nursing and Midwifery
Responsible Director:	Simon Evans-Evans, Interim Governance Director
Summary of business discussed:	The Risk Management Group (RMG) met on the 15th June and the 16th August 2021. The Group was quorate on both occasions with good representation. This report summarises the activity of the Risk Management Group (RMG) and members noted: **1. Minutes** The minutes from the meeting on the 15th June 2021 were approved as an accurate record. Please note the next meeting of the Risk Management Group is on the 11th October, where August's minutes will be presented for approval. **2. Meeting Action Tracker** Scrutiny of the Risk Management Action Tracker took place, with a further revised format being introduced for the meeting in October to be consistent with the format used during Committee meetings. **3. Board Assurance Framework (BAF) Risk Reviews** A comprehensive review was undertaken on the BAF risks, noting that meetings are still in place with the lead risk officers. Recommendations from RMG on the risks continue to be presented to the Executive Team for agreement before presentation to the appropriate Board level Committee for approval and oversight. Controls and mitigations were checked and challenged, and assurance was provided that further work was continuing to align all the BAF risks to the revised 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 from August to October 2021. In particular deep dive sessions took place with regards to following risks, with assurance and further updates being provided by the risk lead officers:

	(Please note in between the June and August RMG meetings, the BAF was realigned and renumbered. To avoid confusion the reference numbers have been left out of this submission. They will be included within the next report): • Surge/Winter Plan – RMG supported the archiving of this risk noting outstanding actions have been transferred to the Unscheduled Care risk. Learning and actions will also be captured within the unscheduled care risk recognising that winter planning is now closed, but that this will be an ongoing cycle which will be captured as a future operational risk. Further updates were required including a review of the current and target risk scores with evidence to be provided to support any change in the score and to bring in line with the risk appetite statement. • Sustainable Key Health Services – RMG requested evidence to support the increase in scoring and further updates required as to when the target risk score could be achieved. It was also noted that the target risk score was currently sitting outside the risk appetite statement and further evidence to support this position is required. • Mental Health and Learning Disabilities – RMG noted the intention for further actions to be added to support a reduction in the risk score with further work underway to try and amalgamate some of the Mental Health BAF risks into a more overarching strategic risk. Any outstanding operational risks would then be managed as part of the Corporate Risk Register. • Infection Prevention and Control – RMG were presented with improved controls including new leadership and a revised governance structure for infection prevention, however significant further longer term strategic aims will need to be considered to bring the risk within the risk appetite statement. Further work is underway to strengthen leadership and implementing new technology to capture data across the Health Board and ensure infection prevention is everyone's business. • Security Services - RMG noted the target risk score remains outside of the risk appetite statement and agreed for a deep dive to take place in the October meeting. • Health and Safety – RMG noted the target risk score remains outside of the risk appetite statement and agreed for a deep dive to take place in the October meeting. • Pandemic Exposure – RMG noted the situation with regards to fit testing and staff returning to substantive posts. Further discussions with Health and Safety colleagues was suggested to support the strengthening of the controls.

	• Digital Estates and Assets – RMG challenged the inherent and current risk scores being the same, and requested further work be undertaken to consider this scoring alongside clinical risk scoring. • Impact of Covid-19 – RMG Members noted that controls, mitigations and actions timeframes have been updated to reflect the current position of the pandemic. The risk score remains unchanged in light of the increasing community transmission being balanced against the effect of the vaccination programme. A prevention response plan has been agreed with partners, but contains gaps in capacity across all organisations in response to the community transmission. • Delivery of a Planned Annual Budget – further work is being undertaken to review this risk in line with the updated financial planning considerations, and to also merge the risk with the Annual Operational Plan risk. **4. Review of the Tier 1 Corporate 1 Risk Register** A comprehensive review was undertaken on the CRR risks, noting that meetings are still in place with the lead risk officers. Recommendations from RMG on the risks continue to be presented to the Executive Team for agreement before presentation to the appropriate Board level Committee for approval and oversight. 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 from August to October 2021. In particular deep dive sessions took place with regards to following risks, with assurance and further updates being provided by the risk lead officers: • CRR20-01 – Asbestos Management and Control – assurance was provided regarding completion of actions through the Health and Safety Gap Analysis Action Plan and also the reasonable level of assurance result from a draft Internal Audit report. RMG recommended to ET and ET approved a recommendation to the QSE Committee for a reduction in the current risk score from 20 to 10. *QSE Committee have since approved a reduction in the current risk score from 20 to 15 and requested further evidence to address the identified gaps for the further reduction to be considered.* • CRR20-02 – Contractor Management and Control – assurance was provided on completion of actions including the implementation of updated guidance and securing funding for the new software. RMG recommended to ET and ET approved a recommendation to the QSE

	Committee for a reduction in the current risk score from 20 to 15. *QSE Committee have since approved a reduction in the current risk score.* • CRR20-03 – Legionella Management and Control – assurance was provided on completion of actions including the implementation of the revised Water Safety Policy and mobilisation of the Water Safety Plan. RMG recommended to ET and ET approved a recommendation to the QSE Committee for a reduction in the current risk score from 20 to 16. *QSE Committee have since approved a reduction in the current risk score.* • CRR20-04 – Non-Compliance of Fire Safety Systems – assurance was provided on completion of actions including Fire Audit Returns and the implementation of a programme of work to address gaps in the audit findings. RMG recommended to ET and ET approved a recommendation to the QSE Committee for a reduction in the current risk score from 20 to 16. *QSE Committee have since approved a reduction in the current risk score.* • CRR20-05 – Timely access to Care Homes – further work was requested to identify additional actions to be considered in support of this risk given the increase in the number of Covid-19 cases in Care Homes / Domiciliary workforce. • CRR20-06 – Informatics – RMG members challenged the current risk scoring, requesting further evidence be provided and discussed with clinicians in order to get their input in appropriately quantifying the score, to be reviewed again during the October RMG meeting. • CRR20-07 – Informatics Infrastructure – RMG members discussed this risk alongside the BAF Digital Estate and Asset risk, and agreed to recommend it's closure due to duplication. Any residual elements will be transferred to the BAF risk for future management. • CRR20-08 - Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients – RMG members noted the progress with the insourcing work in ophthalmology and the link with the BAF Planned Care risks. Following this, the RMG Chair requested that the Risk Management Team support the clinical divisions with the escalation of their clinical risks following the approved governance framework and in line with the Risk Management Strategy. **5. New Escalated Risks** Seven new risks were agreed to be escalated to the Board Committees for agreement to be managed at Tier 1, four will be presented in September to each Committee for approval:

	i. CRR21-11 – *(ID3659)* – Cyber Security – has been presented and agreed for oversight at the Digital and Information Governance Committee. Further work to align the target risk score with the Health Board's risk appetite framework was required. ii. CRR21-12 – *(ID1875)* – National Infrastructure and Products – has been presented and agreed for oversight at the Digital and Information Governance Committee. Further work is required on the scoring due to the inherent and current risk score remaining the same and does not appear to be cognisant of the controls in place. iii. CRR21-13 – *(ID1976)* – Nurse Staffing – has been presented and agreed for oversight at the Quality, Safety and Experience Committee. Overdue action dates were requested to be revised before further submission to the Committee. The following risks were approved at the QSE meeting on the 7th September and are awaiting allocation of new reference numbering: iv. Risk *ID4024* - The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours. v. Risk ID3893 – Non-compliance with manual handling training resulting in enforcement action and potential injury to staff and patients. vi. Risk ID2548 – There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients. vii. Risk ID3766 – There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014. **6. COVID High Risk Review** Further to the deep dive on the BAF Covid Risk, confirmation was provided that the COVID-19 High Level risks were continuing to be presented to the Executive Incident Management Team (EIMT), with the Risk Lead Officer in attendance at the Risk Management Group providing updates. The Risk Lead Officer noted an increase in Datix notifications containing reference to Covid as a contributory factor. It was agreed that the Corporate Risk Team would review these risks with the Lead Officer and offer support to divisions raising the risk. **7. Risk Management Improvement Plan** The plan was presented noting the progress around the ongoing piece of work on designing trajectories for monitoring and evaluating implementation of the various actions on the plan as this will provide greater assurance. Evidence of what and where this will be reported will be picked up in the Risk Management

Reporting Framework that is being developed and will support the Risk Management Strategy and Policy.

8. Divisional Risk Reports

A review of the RMG Cycle of Business for Divisional Risk Reporting was undertaken in July to align Area, Corporate and Secondary Care reports with each other to support cross divisional sharing of risks and lessons learnt. Nine Divisional reports were provided on time, noting the level of risk management maturity and compliance with the Risk Management Strategy and Policy within the Division, however not all leads were present to allow the check and challenge process to take place. Two out of the nine confirmed they had updated and implemented their local RM04 – Local Risk Management Procedures, with the remaining seven being supported by the Corporate Risk Team to finalise and implement their local procedures within the next 3 months.

The two reports not presented will be updated and represented by the lead officer in the October meeting.

Further support and meetings will be arranged with the divisions not currently reporting in line with the Risk Management Cycle of Business to ensure timely submissions and attendance at future meetings.

9. Issues of Significance from the Strategic Occupational Health and Safety Group.

A report was presented and included an update on the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) incidents reported April 2020 to March 2021, noting a significant increase compared with the previous period. These were predominantly due to numbers reported as Occupational Diseases following a requirement to report persons at work who has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus.

Two risks were being identified as requiring escalation and those were in relation to:

i. The Inability to deliver a fit testing programme to meet demand;
ii. Manual Handling Training and lack of dedicated facilities.

RMG members discussed the risks and requested further work be undertaken on updating the risks before escalation could be considered.

10. Once for Wales Integrated Risk Management Project

An update on the national Datix Risk Module was provided noting that work to develop the National Risk Module is continuing with

	NHS Wales Risk Lead officers attending monthly meetings to agree on the standardised layout and format of the risk module. This includes the use of agreed terminology and categories of risk. The Health Board will continue to ensure preparedness in light of this revised date and will escalate any concerns regarding changes to categorisations or terminology to the Executive Director of Nursing. **11. Concerns Management and Quality Systems (CMQS)** An update on the national Datix Project was provided noting that the Complaints, Claims and Inquest Module that was intended to go live from April 2021, is now looking to be implemented from October 2021 in a phased roll out with the incident module following on. Local data validation issues have been experienced within BCUHB and the local team is working with the national team to rectify the situation and then local acceptance testing will commence ahead of roll-out. Quality Dashboard System has gone live across the Health Board as planned. Patient, Care and Visit Real Time Feedback system (CIVCA) back office implementation is ongoing and in line with the project plan.
Key assurances provided at these meetings:	• Progress with the implementation of the Risk Management Strategy and Policy. • Progress with the completion and implementation of the actions within the Risk Management improvement plan. • Progress with the continued scrutiny of the Board Assurance Framework. • Progress with the continued scrutiny of the Corporate Tier 1 Operational Risks. • 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.
Key risks including mitigating actions and milestones	1. Compliance with the Risk Management Strategy and Policy. 2. Potential delay in timely implementing the Risk Management Improvement Plan if there is a further wave of Covid-19.
Issues to be referred to another Committee	None of note
Matters requiring escalation to the Board:	None of note
Well-being of Future Generations Act Sustainable Development Principle	The work of the Risk Management Group will help to underpin the delivery of the sustainable development principles by: • Fully embedding Enterprise Risk Management to proactively manage risk to the delivery of the Health Board's planning and risk assessment processes.

	• Working collaboratively across Wales to deliver solutions with partners to improve planning and system delivery.
Planned business for the next meeting:	• Review of Corporate Risks. • Review of Board Assurance Framework. • Review of High Covid-19 Risks. • Review and approve risks for escalation / de-escalation to the Executive Team. • Review of Divisional Risk Reports • Update on Once for Wales Integrated Risk Management Project
Date of next meeting:	11th October 2021.

Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee** **28/09/21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Emergency Scheme of Reservation and Delegation (SORD)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Board Secretary
Awdur yr Adroddiad **Report Author:**	Assistant Director – Deputy Board Secretary
Craffu blaenorol: **Prior Scrutiny:**	Board Secretary
Atodiadau **Appendices:**	• Draft Emergency SORD together with Appendix 1 – Cabinet Terms of Reference and Appendix 2 – Abbreviated Business Case

Argymhelliad / Recommendation:

The Committee is asked to recommend approval of the Emergency SORD to the Board.

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**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.

Sefyllfa / Situation:

Further to discussions at the Audit Committee on 10th June 2021 (Minute AC21.26 refers) the Emergency SORD is now presented for approval.

Cefndir / Background:

Following a review by Internal and External Audit of the initial governance arrangements in response to the first wave of the pandemic is was suggested that an Emergency SORD should be drafted.

The attached draft Emergency SORD would be deployed in the event of the standing up of the Gold Command structure and Cabinet (See Appendix 1 attached for Cabinet Terms of Reference)

When an incident is declared, such that it is necessary to stand up the Gold Command structure and Cabinet (both of which would need to be signed off via Chair's Action), the Chief Executive, in consultation with the Chairman and Executive Director of Finance will then enact the Emergency SORD.

Given emergency investment tends to require accelerated timescales, it is not possible to comply with the full requirements of the Procedure Manual for Managing Capital Projects. In the event of this Emergency SORD being enacted, the Manual is suspended but provides the principles of good practice that should considered within the constraints of the accelerated timescales.

Asesiad / Assessment:

Strategy Implications
There are no associated strategic implications.

Financial Implications
There are no associated resource implications related to this report itself.

Risk Analysis
There are no associated risks

Legal and Compliance
Compliance with Internal and External Audit recommendations.

Impact Assessment
This report is purely administrative; there is no associated impact or specific assessments required.

Emergency Scheme of Reservation and Delegation (SORD)

To be deployed in the event of the standing up of the Gold Command structure and Cabinet (See Appendix 1 attached for Cabinet Terms of Reference)

N.B When an incident is declared, such that it is necessary to stand up the Gold Command structure and Cabinet (both of which would need to be signed off via Chair's Action), the Chief Executive, in consultation with the Chairman and Executive Director of Finance will then enact the Emergency SORD.

Given emergency investment tends to require accelerated timescales it is not possible to comply with the full requirements of the Procedure Manual for Managing Capital Projects. In the event of this Emergency SORD being enacted, the Manual is suspended but provides the principles of good practice that should considered within the constraints of the accelerated timescales.

NON FINANCIAL DECISIONS (i.e. clinical/workforce etc.)		CAPITAL £ DECISIONS	REVENUE £ DECISIONS
Impact beyond BCUHB boundary and/or Outside Policy and/or RED Quality Impact Assessment (NB Urgent approval of Red QIA delegated to Medical Director and Nurse Director to be noted at Gold)	**GOLD**	£250k ≤£500k £500k to 999,999 Cabinet ensuring WG compliance with required retrospective notification to Minister and Ministerial approval over £1m (prospective) Short justification (including high level impact and risk assessment – see proforma attached as Appendix 2) with capital team support Gold meeting approval required (HB Chair's action also needed if over £1m)	☐ £250k to £500k Revenue business justification (to include high level impact and risk assessment – see proforma attached as Appendix 2) with finance business partner support. Approval by → Executive Director of Finance & 2 x Executives (normally Silver and Gold Executive Leads) £500k and over Gold & Executive Director of Finance with formal reporting to Executive Team/Cabinet
Impact across BCUHB within policy and/or AMBER Quality Impact Assessment	**SILVER**	≤£100k Service Group Manager level decision (to include high level impact and risk assessment – see proforma attached as Appendix 2). Rapid email clearance by Head of Capital & Executive Director of Finance	≤ £100k ILG Director or Director of Clinical Services Operations & cc £ Business Partner £100k ≤£250k

		£100k ≤£250k Short justification (including high level impact and risk assessment – see proforma attached as Appendix 2) with capital team support. Approval by → Executive Director of Finance & 2 x Executives (normally Silver and Gold Executive Leads)	Short justification (to include high level impact and risk assessment – see proforma attached as Appendix 2) with finance business partner support. Approval by → Executive Director of Finance & 2 x Executives (normally Silver and Gold Executive Leads)
Impact in Locality within policy and/or GREEN & YELLOW Quality Impact Assessment	**BRONZE**		

APPENDIX 1

Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

Covid-19 Cabinet Meetings

1. INTRODUCTION

1.1. The Board shall re-establish a group and associated governance arrangements, to be known as the **Covid-19 Cabinet.** The detailed terms of reference and operating arrangements in respect of these meetings are set out below.

2. PURPOSE

2.1. The Chief Executive is responsible for the management of the Health Board's response to the Covid-19 pandemic. The purpose of the Covid-19 Cabinet is to be responsible for Board level oversight and assurance of key high-level strategic decisions. On occasion, the Covid-19 Cabinet may be required to take decisions on those matters normally requiring escalation to the full Board.

3. DELEGATED POWERS

3.1. The Covid-19 Cabinet is authorised by the Board to:

3.1.1. Ensure that the Health Board has agreed a clear strategic direction, with associated objectives, in respect of its COVID-19 response;

3.1.2. Ensure the adequacy of key arrangements fundamental to assurance, including the command structure, reporting, decision-making, and risk registers;

3.1.3. Seek assurance that lessons are being learnt and that, if appropriate, learning is being applied throughout the COVID-19 response;

3.1.4. Oversee the effectiveness of joint working with partners and of communications, ensuring the avoidance of reputational harm as appropriate;

3.1.5. Make urgent decisions on behalf of the Board in relation to the operational management of the response to Covid-19 that would normally be reserved to the Board, provided that any decision made by the Covid-19 Cabinet is communicated to the full Board and formally reported at the next meeting of the Board.

4. AUTHORITY

4.1. The Covid-19 Cabinet may investigate or have investigated any activity (clinical and non-clinical) to enable it to discharge its responsibilities. It may request from the Chief Executive, any information it deems necessary to maintain visibility of critical issues and transparency of the full Board.

4.2. The Covid-19 Cabinet may also obtain external legal or other independent professional advice if it considers this necessary, in accordance with the Board's procurement, budgetary and other requirements.

4.3. The Covid-19 Cabinet has the authority to consider and where appropriate, recommend full Board approval of any Covid-19 related policy or strategy within the remit of its terms of reference.

4.4. The Covid-19 Cabinet has the authority to review the Covid-19 Risk Register and advise the full Board on the appropriateness of the scoring and mitigating actions in place.

5. MEMBERSHIP

5.1. **Members**

- Health Board Chairman (who will be Covid-19 Cabinet Chair)
- Health Board Vice-Chair
- Audit Committee Chair
- Independent Member
- Chief Executive (Covid-19 Cabinet Lead Executive)

5.2. **In attendance**

- Deputy Chief Executive
- Executive Director - SRO Covid-19 Response
- Interim Director of Governance
- Board Secretary
- Other Executives, Independent Members, officers and special advisers may join as required by the Chair or Chief Executive, as well as any others from within or outside the organisation whom the Covid-19 Cabinet considers should be invited, taking into account the matters under consideration at each meeting.

5.3. Member Appointments

5.3.1. The membership of the Covid-19 Cabinet shall be determined by the Chair, taking account of the balance of skills and expertise necessary to deliver the Covid-19 Cabinet's remit and subject to any specific requirements or directions made by the Welsh Government. The Chair may if required appoint a Vice-Chair of the Covid-19 Cabinet, who shall be an Independent Member.

5.3.2. Appointed Independent Members shall normally hold office as part of the Covid-19 Cabinet for the duration of the Covid-19 pandemic response. A member may resign or be removed by the Chair.

5.4. Secretariat

The Secretariat will be determined by the Board Secretary.

5.5. Support to Committee Members

The Board Secretary, on behalf of the Covid-19 Cabinet Chair, shall arrange the provision of advice and support to Covid-19 Cabinet members on any aspect related to the conduct of their role.

6. COVID-19 CABINET MEETINGS

6.1. Quorum

At least two Independent Members must join a meeting to ensure the quorum of the Covid-19 Cabinet, one of whom should be the Covid-19 Cabinet Chair or Vice-Chair and the Chief Executive or the Deputy Chief Executive in their absence.

6.2. Frequency of Meetings

Meetings shall be held at least once per month, but may be convened at short notice if requested by the Chief Executive and with the agreement of the Chair.

6.3. Withdrawal of individuals in attendance

The Covid-19 Cabinet may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6.4. Conduct of Meetings

Meetings will be held using video-conferencing and similar technology, to comply with social distancing requirements.

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

7.1. Although the Board has delegated authority to the Covid-19 Cabinet for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2. The Covid-19 Cabinet is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1. The Covid-19 Cabinet Chair shall:

8.1.1. Report formally, regularly and on a timely basis to the full Board on the Covid-19 Cabinet's activities;

8.1.2. Ensure appropriate escalation arrangements are in place to alert the full Board of any urgent/critical matters that may affect the operation and/or reputation of the Health Board;

8.2. The Chief Executive shall:

8.2.1. Convene an informal weekly conference call for Independent Members and senior staff to communicate key decisions and information in relation to the response to the Pandemic, to be led by an Executive Director.

9. REVIEW

9.1. These terms of reference and operating arrangements shall be reviewed by the Covid-19 Cabinet as required by the Chair, and at least annually, with any changes recommended to the Board for approval.

Approved by Audit and Board Chairs' Action November 2020

Endorsed by Cabinet 4.11.20

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

Emergency Capital Business Case

(for items over £5,000)

Project Lead	
Department :	
Hospital/Site :	
Project Sponsor: eg lead clinician, dept head or capital programme lead	
Scheme Title : ie. Name of equipment or description works to be undertaken	

Description of scheme and case of need ie. function of equipment in lay terms or nature of works

Options Analysis

Options Considered	**Option 1-No change**
	Option 2-Other
	Option 3-Preferred

Option 1 (No change)

Finance Option 1 (no change)

CAPITAL COST	No. of items	Unit cost	Total (inc VAT)
Equipment Cost			
Building / Engineering Cost			
IT Cost			
Total Capital Cost			0

Capital Charges	Estimated Life of asset in yrs	

CURRENT REVENUE COSTS per annum	
Maintenance	
Consumables	
Staffing	
Facilities	
Property Rates	
Training	
Other	
Total Cash Revenue Cost	0
	#DIV/0!

Total Revenue Impact	#DIV/0!

Option 2 (Other)

Finance Option 2 (Other)

CAPITAL COST	No. of items	Unit cost	Total (inc VAT)	REVENUE COST include increase/decrease per annum		
Equipment Cost					Set up costs	Ongoing
Building / Engineering Cost				Maintenance		
IT Cost				Consumables		
Total Capital Cost			0	Staffing		
				Facilities		
				Property Rates		
				Training		
				Other		
				Total Cash Revenue Cost	0	0
Capital Charges		Estimated Life of asset in yrs			#DIV/0!	#DIV/0!
				Total Revenue Impact	#DIV/0!	#DIV/0!

Option 3 (preferred option)

Outline the benefits of the preferred option

What are the risks if the preferred option is not implemented?

Provide details of the procurement strategy (eg competitive tender, single tender waiver, etc)

Outline the key programme dates

Finance Option 3 (Preferred Option)

CAPITAL COST	No. of items	Unit cost	Total (inc VAT)
Equipment Cost			
Building / Engineering Cost			
IT Cost			
Total Capital Cost			0

REVENUE COST include increase/(decrease) per annum		
	Set up costs	Ongoing
Maintenance		
Consumables		
Staffing		
Facilities		
Property Rates		
Training		
Other		
Total Cash Revenue Cost	0	0
	#DIV/0!	#DIV/0!
Total Revenue Impact	#DIV/0!	#DIV/0!

FUNDING SOURCE

Discretionary Capital:	
Other Capital: (e.g. All-Wales, SaFF, SIFT, etc.)	
Charitable Fund no.	Agreed with fund manager (name)
Voluntary Organisation (League of Friends etc.) (name) :	

Is preferred option a new development, upgrade or a replacement for an existing capital asset?

REPLACEMENT / UPGRADE / NEW DEVELOPMENT (delete as appropriate)

CHECKLIST

Review the following list to ensure that all support issues have been considered.

- All associated building/engineering/facililties issues and costs	YES / NO/ NA
- All associated IT issues and costs - eg: installation, business continuity, security, support, training,	YES / NO/ NA
- End Users have signed off design?	YES / NO
- Infection Prevention issues considered?	YES / NO/ NA
- Medical Engineering have been contacted regarding G111compatibilty, decommissioning, PPQ completion, acceptance testing, etc.?	YES / NO/ NA
- Medical Physics have been contacted regarding radiation protection?	YES / NO/ NA

Prepared name/title by :		Date	
Date:			

Countersigned by Lead Director

Name		Date	

Revenue consequences of preferred option approved by Management Accountant			
Name		Date	

Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee 28th September 2021**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Internal Audit Progress Report - 1st June to 31st August 2021**
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 has been considered and approved by the Board Secretary.
Atodiadau **Appendices:**	• Appendix 1: Progress Report

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive the progress report; and
- Approve the revised arrangements for the distribution of discussion and draft internal audit reports outlined at paragraph 14.

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 (Appendix A) is produced in accordance with the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management and the Board.

Cefndir / Background:

The progress report summarises eleven assurance reviews finalised since the last Committee meeting in June 2021, with the recorded assurance as follows:

- Substantial assurance (green) – one;
- Reasonable assurance (yellow) – five;
- Limited assurance (amber) – none; and
- Assurance not applicable (grey) – two.

The report also details:

- Reviews issued at draft reporting stage and work in progress.

Asesiad / Assessment & Analysis

Strategy Implications

The Internal Audit plan for 2021/22 was approved by the Audit Committee in March 2021.

Financial Implications

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

Risk Analysis

The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan.

Legal and Compliance

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

Impact Assessment

The Internal Audit report provides third line 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.

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

1st June 2021 to 31st August 2021

NWSSP Audit and Assurance Services

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

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

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

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 2021/22 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.

Reports Issued

2. Several 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
Welsh Risk Pool Claims Management Standard (20/21) Review completed May 2021 with Executive approval June 2021 *We identified no issues relating to this review.*	Substantial	-	-	-	We reviewed the extent to which practice complied with documented requirements for a sample of reimbursed claims and found that the controls in place were robust. During the period 1st April 2020 to 4th February 2021 the Health Board submitted and were reimbursed for forty-three claims following approval by the Welsh Risk Pool Advisory Board. Of these we selected a sample of claims for review with a total monetary value of approximately £2,509,610.
Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices (20/21) Review completed April 2021 with Executive approval June 2021 *The review identified the procedure relating to medical device alerts and field*	Reasonable	1	1	-	The review of medical device alerts and field safety notices identified that the process embedded in the Health Board was not underpinned by an operational procedure articulating roles, responsibilities, and process to be followed upon receipt of and obtaining a response from operational areas on actions taken. The review has also identified: • There was no reporting on the status of each alert/notice to operational group/Committee whether implemented or otherwise; • No points of contact established for notices; • Manufacturers of the various devices in use

Title	Assurance Level	High	Medium	Low	Key Messages
safety notices required review to ensure a robust control mechanism was implemented akin to other safety alerts.					across the Health Board can raise and email a notice via any member of staff on their contact list and may go unregistered. We found some evidence of discussions at relevant operational management team meetings to ensure lessons are learnt and shared across the organisation, however this was inconsistent for Patient Safety Alerts and Patient Safety Notices.
HASCAS & Ockenden external reports: Recommendation progress and reporting (20/21) Review completed May 2021 with Executive approval July 2021 *A number of agreed actions have been implemented however one is yet to be implemented in full.*	Reasonable	-	-	-	We undertook a review to ascertain whether there was adequate evidence provided to support the narrative in the closure of the recommendations mentioned above. A review of evidence to support the progress/closure for recommendations 2a, 2b, 3,10,14 of Ockenden and recommendation 11 of HASCAS, as stated in the in the Improvement Group Monthly Highlight Report and Quality, Safety & Experience Committee, was undertaken. Recommendation R3 Policy Review (Ockenden) & R11 Evidence Based Practice (HASCAS) whilst partially implemented requires additional focus and support to progress.
Performance measure reporting to the Board: Accuracy of information (20/21) Review completed May 2021 with Executive approval June 2021 *The review*	Reasonable	-	2	-	This review focused solely on the reporting of Urology Referral to Treatment data. We did not review the accuracy of source data nor did we investigate the validity of RTT clock adjustments. We reviewed copies of the December 2020, January 2021 and February 2021 Quality and Performance Reports and found the following issues: One instance (February 2021) of discrepancy between the key target performance table data and relevant narrative (38,433 vs. 38,533).

Title	Assurance Level	High	Medium	Low	Key Messages
identified some variances in the reporting of data between some months and the need to implement the RTT pathway SOP.					Aggregate figures reported in February did not include Cardiology RTT data, which was included in the reported aggregates in the December and January reports. No explanation for this change in reporting methodology was provided in the Quality and Performance Report. Whilst national guidance is available to support the management and administration of Referral to Treatment, the Health Board did not, at the time of review, have local policy and guidance documentation in place. We confirmed that a RTT 26 Week Pathways Standard Operating Procedure has been developed and at draft stage.
Capital Systems (20/21) Review completed May 2021 with Executive approval June 2021 *The review identified some issues of compliance with the Health Board's procedure.*	Reasonable	-	6	-	The Procedure Manual for Managing Capital Projects allows the Project Director to tailor requirements "in order to ensure the correct level of procedural governance without being over bureaucratic". To aid the process, a Stage Deliverables Checklist is provided to define the requirements. The completion of the Stage Deliverable Checklist prior to the stage commencing helps confirm the expected control against which compliance can be assessed. Of the three projects reviewed as part of this audit, a deliverables checklist was only employed on one Project. Stage Deliverables Checklist should be completed for all projects in advance of stage progression.
Health & Safety – Reviewing progress on the Gap analysis action plan (20/21) Review completed May 2021 with Executive approval June	Not applicable	1	-	-	The overall objective was to review the status of the gap analysis undertaken in 2019 and ascertain whether the milestones for set actions have been achieved. We reviewed the agreed action plan underpinning the gap analysis and worked with both Corporate Health and Safety and Estates Operational Services teams to ascertain what progress had been made. We reviewed the Gap Analysis twelve-month

Title	Assurance Level	High	Medium	Low	Key Messages
2021 *The review identified that progress against the gap analysis, except for Stress Management, did not accurately reflect the correct position. Whilst noting the impact C-19 has had on the Health Board, we would draw attention to Working at Height Regulations 2005; Corporate Manslaughter and Homicide Act 2007; and Personal Protective Equipment for swift review.*					action plan and identified four areas to review within work streams 1, 3, 5 and 7. The areas reviewed were: • 1d Working at Height Regulations 2005. • 3d Stress Management. • 5b Corporate Manslaughter and Homicide Act 2007. • 7c Personal Protective Equipment (PPE). Whilst reviewing the Gap analysis action plan, we identified that all actions had various completion dates along with a Red-Amber-Green (RAG) rating. We identified that a green rating of compliance was automatically applied to the action once the completion date is reached. By the 1st October 2020, a green rating was attributed to all tasks within the action plan, however, the four areas we reviewed were found to be at different stages of progress. Of the four areas reviewed, only one area (stress management) had completed all identified gap analysis actions.
Security Invoice Review (21/22) Review completed July 2021 with Executive approval August 2021 *The review identified breach of the 'No Po No Pay' process and overall receipting of services was not timely for the Health Board to maximise prompt*	Not applicable	-	-	-	This review was requested by the Executive Director of Finance and focused solely on information obtained from ORACLE e-Financials and GRAMMS systems [Estates] focusing on: • Review of orders raised from the GRAMMS and E-Financials system. • Compliance with the "No Purchase Order, No Pay" policy. • A review of data to identify any anomalies that may not have been identified as part of the expected controls, including duplicate invoice numbers. We reviewed two hundred and one (201) invoices paid to the supplier across both GRAMMS and E-Financials totalling

Title	Assurance Level	High	Medium	Low	Key Messages
payment discount.					£2,735,773.58. In accordance with the request from the Executive Director of Finance, we did not review compliance against the contract and therefore the findings should be viewed in this context: • Invoices were not supported by timesheets and were unable to corroborate that all services invoiced and paid could be supported. • Areas of expenditure identified as outliers for further management review. • Possible duplicate payment of £720 (including VAT). • Prompt payment credit from the Oxygen system was only applied to 52 invoices, generating a total discount of £6,059.81. • Breach of the 'No PO No Pay' process where orders have been raised after receipt of the invoices.
Statutory Compliance – Asbestos Management (21/22) Review completed July 2021 with Executive approval August 2021 *The review identified an issue with evidencing contractors are being provided with necessary information prior to starting work.*	Reasonable	1	1	-	The overall objective of this audit was to review compliance with the Control of Asbestos Regulations 2006 and associated Health Board policy. Key matters arising concerned: • We are unable to determine if contractors are being provided with the necessary information and instruction. • Asbestos Awareness Training compliance for estates staff was low (43%), however we are advised that this has since increased to 84% (as of August)

Work in Progress Summary

3. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
HASCAS & Ockenden external reports: Recommendation progress and reporting	Draft briefing paper issued, awaiting Executive approval.	26th July 2021
Upholding Professional Standards in Wales	Draft report issued, awaiting management response.	24th August 2021

Fieldwork

4. The following reviews are currently in progress:

- Temporary Hospitals: Follow-up of KPMG recommendations – The review is near to completion. The decommissioning element is being reviewed separately.
- Follow up of previous Healthcare Inspectorate Wales reports – This review is near completion and was delayed due to our confirmation of reporting arrangements and identification of a sample; we have focused on the 2020/21 financial reporting period to identify the sample.
- Procurement and Tendering – The review is near to completion, with evidence received to support our testing.
- Secondary Care Division: Ysbyty Glan Clwyd – The review is in progress; meetings have been held with senior hospital staff and key documentation is being reviewed.
- Establishment Control: Leaver Management – The review is in progress, there was a delay in receiving the data for us to select our sample, however this has now been received and we are able to proceed with testing.
- Womens Services Division - The review is in progress; information has been received to support our testing.
- Learning Lessons – The brief has been agreed and evidence to demonstrate learning for a sample of serious incidents, complaints and concerns has been requested.
- Business Continuity Plans – The brief has been agreed and we are reviewing a sample of business continuity plans from across the Health Board.
- Planned Care: Waiting List Management – The brief has been agreed and we are requesting meetings and data to support our testing.

- On-Call arrangements – The brief has been agreed, meetings and data to support our testing has been requested.

Follow Up

5. 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.

6. No follow up work has been undertaking in this reporting period.

Contingency/Organisational Support/Advice

7. 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.

8. During the period, the following review/advice/guidance/support has been provided:

   - Attendance at the Health Board Symphony/National WEDS Project Board.
   - Supported the NHS Wales Finance Academy Finance Business Continuity Project.
   - Provided a paper to the Board Secretary and Interim Director of Governance comparing the reporting of risk management arrangements and Board assurance framework at the Health Board with its peers in NHS Wales.
   - Attendance at the Single Tender Waiver Improvement Reduction Programme Meeting.

Delivering the Plan

9. The additional support provided to the Health Board with focused reviews is channelled through contingency.

10. As new risks are identified in year, the Board Secretary and internal audit consider the planned reviews against the emerging high-level risks.

11. The continued impact of COVID-19 (C-19) on the Health Board has been one that necessitates on-going discussion with Board Secretary, Deputy Board Secretary and Director of Finance with subsequent dialogue with the Executive Team.

12. The following tables detail the planned performance indicators (Table 3) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 4) with the assurance provided.

13. Table 3 is reporting a positive status across two indicators, however the management response to draft reports has decreased from 76% to 50%. It should be noted that this is based on two reports where management responses have been due and is likely to level out as more draft reports are issued.

14. To improve management response times, we have agreed with the Board Secretary to amend reporting arrangements going forward. Currently a discussion draft is issued to management, who provide confirmation of factual accuracy and a management response within ten days. This is then issued to the Executive to approve within a further ten days. Going forward, discussion drafts will be issued to management to confirm factual accuracy, with a response required within five days; management and Executive leads will then be required to provide approval and a management response within a further fifteen working days.

15. We have experienced delays in receiving information/evidence to support our reviews which has had 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 3 – 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 Lead at time of agreeing the audit brief	Red	50%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 4 – Core Plan 2021-22

Planned output	Outline timing	Status	Assurance
Risk Management	Q4		
Governance structure	Q4		
Targeted Intervention	Q3		
Transformation of services	Q3/Q4		
Impact Assessments	Q3		
Standards of Business Conduct: Declarations	Q2	Brief agreed, fieldwork to start in October 2021.	

Planned output	Outline timing	Status	Assurance
Integrated Service Boards (ISB)	Q2/Q3	Brief agreed.	
Budgetary Control & Financial Reporting, including COVID-19 financial governance	Q3/Q4		
Procurement & Tendering	Q1	Review in progress.	
Value Based Healthcare	Q3		
Learning Lessons	Q1/Q2	Review in progress.	
HASCAS & Ockenden external reports – Recommendation progress and reporting	Q1/Q4	Draft briefing paper issued.	Reasonable
Clinical Audit	Q2/Q3	Planning meeting held with Medical Director; brief being drafted.	
Planned care – Waiting list management	Q1	Review in progress	
Network and Information Systems Regulations 2018 (NIS Regulations)	Q3/Q4		
Digital Strategy	Q3		
Cluster working/Health and Social Care Localities governance and accountability	Q2/Q3	Brief agreed.	
Unscheduled Care	Q3		
Business Continuity Plans	Q2/Q3	Review in progress.	
Secondary Care Division – Ysbyty Glan Clwyd	Q2	Review in progress.	
Women's Services Division – Sustainability of services	Q1/Q2	Review in progress.	
Recruitment – Employment of medical locum doctors	Q3		
Roster management	Q4		
Establishment control – Leaver management	Q1/Q2	Review in progress.	
Upholding Professional Standards in Wales	Q1	Draft report issued.	Reasonable
On-Call arrangements	Q2	Review in progress.	
Statutory Compliance: Asbestos Management	Q1	Final report issued.	Reasonable
Waste Management	Q3		
Preparedness for Climate Change/ Decarbonisation	Q4		
Capital Funded Systems	TBC		

Planned output	Outline timing	Status	Assurance
Integrated Audit and Assurance Plans	TBC		
Carry over: Temporary Hospitals – Follow-up of KPMG recommendations	Q1/Q4	Review in progress.	
Carry over: Follow up of previous Healthcare Inspectorate Wales reports	Q1	Review in progress.	
Contingency: Security Invoice Review	Q1	Final report issued.	Assurance Not Applicable

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Cyfarfod a dyddiad: Meeting and date:	**28th September 2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	• Audit Wales programme update • Assessment of the Health Board's plans for the £297 million Welsh Government strategic financial allocation • Rollout of the COVID-19 vaccination programme in Wales • Management response to the Review of Welsh Health Specialised Services Governance Arrangements • Wellbeing of Future Generations Report – verbal update on the approach with recommendations
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary, on behalf of the executive team
Awdur yr Adroddiad Report Author:	Andrew Doughton, Simon Monkhouse and Dave Thomas
Craffu blaenorol: Prior Scrutiny:	All final Audit Wales 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 and discuss the audit reports.
- Note the WHSSC management response
- Note the verbal update on the approach for the Wellbeing of Future Generations report

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	✓	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

The documents include the regular audit update alongside reports finalised since the last audit committee.

Cefndir / Background:

The documents include statutory work undertaken on the Health Board financial accounts and the result of that work.
The update provides an overview of progress of the external audit programme
The performance audit reviews provide assurance and opinion on the effectiveness of arrangements in key areas as are described within the reports.

Asesiad / Assessment & Analysis
Goblygiadau Strategol / Strategy Implications
Opsiynau a ystyriwyd / Options considered
Goblygiadau Ariannol / Financial Implications The documents include statutory audit work undertaken on the Health Board 2020-21 financial accounts and the result of that work.
Dadansoddiad Risk / Risk Analysis
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Asesiad Effaith / Impact Assessment .

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: September 2021

Document reference: 2021A2020-21

This document has been prepared for the internal use of Betsi Cadwaladr University Health Board as part of work performed/to be performed in accordance with statutory functions.

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Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2021-22 Financial Statements.	Audit Planning work is set to take place between January and April 2022, with the audit of the financial statements taking place in May 2022.
Opinion on Financial Statements	It is anticipated that the opinion will be issued during the first half of June 2022.
Audit of the 2020-21 Funds Held on Trust Accounts	The audit will take place during December 2021 and January 2022. Our audit report will be issued in January 2022.

Performance audit update

3 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.

4 In relation to the Welsh Health Specialist Services Commissioning Committee (WHSSC) review, the committee received the report in June. The management responses provided by WHSSC and Welsh Government are included in the agenda of the September Audit Committee.

Exhibit 2 – Work completed

Area of work	Audit Committee
Rollout of the Covid-19 vaccination programme in Wales	September 2021
Use of strategic support funding from Welsh Government	September 2021

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
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.	Report issued, currently in clearance – December Audit Committee

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
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.	Drafting report – December Audit Committee
Ophthalmology services in Betsi Cadwaladr Health Board Executive Lead Gill Harris	We have recommenced the review of eye care services, which we paused at the onset of the pandemic. This is considering both acute ophthalmology and community optometry service modernisation and action taken to reduce risk of harm resulting from delays in access to services.	Drafting report – December Audit Committee
Structured Assessment Executive Lead Jo Whitehead	This work is being undertaken in two phases. • Phase 1 reviewed the effectiveness of operational planning arrangements. • Phase 2 examines how well NHS bodies are embedding sound arrangements for corporate governance and financial management.	Final report issued Drafting report – December Audit Committee
Orthopaedic services – follow up	This review is examining the progress made in response to our 2015 recommendations. The report	Drafting report - December Audit Committee

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Chief Operating Officer	will take stock of the significant elective backlog challenges. Therefore, reporting has been moved to later in 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).
Structured Assessment Executive Lead Jo Whitehead	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.	Final report issued Drafting report – December Audit Committee

Exhibit 4 – Planned work not yet started

Topic	Focus of the work	Current status
Follow-up outpatients Executive Lead To be confirmed	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. This work will also examine progress against any outstanding recommendations from our previous review of Follow up outpatients.	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.

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. This includes the material from our COVID-19 Learning Week held in March 2021.

7 Details of future events are available on the GPX website.

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. The Auditor General has also published his Annual Report and Accounts for 2020- 21.

Exhibit 5 – Recent NHS-related or relevant studies and all-Wales summary reports

Title	Publication date
Rollout of the Covid-19 vaccination programme in Wales	June 2021
Cwm Taf Morgannwg Joint Review follow up	May 2021
Procuring and Supplying PPE for the COVID-19 Pandemic	April 2021
Test, Trace, Protect in Wales: An Overview of Progress to Date	March 2021
Doing it Differently, Doing it Right?	January 2021
Welsh Community Care Information System	October 2020
National Fraud Initiative 2018-20	October 2020

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Ms Jo Whitehead
Chief Executive
Betsi Cadwaladr University Health Board
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Reference: PA331/DT/hcj

Date issued: 19th August 2021

Dear Jo

Assessment of the Health Board's plans for the £297 million Welsh Government strategic financial allocation

I am writing to provide feedback on our high-level review of the Health Board's plans to utilise the additional strategic financial allocation from the Welsh Government announced in November 2020. This work was carried out in June and July 2021.

We have considered the first 6 months additional allocation in 2020-21 to determine whether it was spent as intended. Our work has also focused on the Health Board's plans for the additional strategic funding in 2021-22 and the extent of oversight and assurance on the spend.

Any other additional Welsh Government allocation, such as the Health Board's share of the additional £100 million recently announced is outside the scope of this review. Our findings are set out on the following pages.

We took the opportunity to share a draft of this letter with Sue Hill to provide comments on accuracy in advance of us formally issuing it.

The first six months of additional allocation was spent in the required areas. The Health Board is currently preparing an analysis of usage of the allocation and outcomes achieved for the Welsh Government.

The broad conditions for the use of the additional £82 million annual allocations are set out in the statement of the Minister for Health and Social Services at plenary on 3 November 2020. Each annual allocation is to:

- cover the budget deficit of up to £40 million
- support improvement to unscheduled care and build a sustainable planned care programme (£30 million)
- support performance improvement and implementation of the mental health strategy (£12 million).

The Health Board is currently preparing a report for the Welsh Government highlighting the schemes that the allocation was used to fund, and the outcomes achieved for 2020-21.

Additional strategic funding of £51 million was allocated to the Health Board for the 2020-21 financial year, of which £40 million was provided to cover the budget deficit. This £40 million allocation was spent on covering the budget deficit as set out in the November 2020 Ministerial statement and it was sufficient to cover the forecast deficit. This enabled the Health Board to report a year-end surplus of £0.5 million for 2020-21 on its revenue spend.

Planned and actual usage of the remaining £10.3 million for Planned Care and Unscheduled Care and £0.7 million for Mental Health was reported to the Finance and Performance Committee. In December 2020 the Committee was presented with a high-level summary of plans for utilising the funding, and in June 2021 it received a breakdown of the areas where the £11 million has been spent.

The Health Board's Annual Plan clearly apportions the 2021-22 strategic support allocation over a number of schemes in line with the broad conditions set by the Welsh Government

The Health Board's financial plans for 2021-22 are set out in its Annual Plan, which was approved by the Board at its meeting in July 2021. The annual plan includes the strategic support funding available in the current year. The £40 million element of the allocation is being utilised for the purpose intended and is anticipated to be sufficient to cover the deficit for the 2021-22 financial year. This is subject to financial risks including the remaining financial impact of Covid-19 and the risk of non-delivery of planned savings. In June 2021 the Health Board was reporting a balanced forecast position for 2021-22.

The Annual Plan provides sufficient details of the schemes to be funded by the strategic support allocation. The Health Board is investing £30 million to improve performance across North Wales in both planned and unscheduled care. The Annual Plan shows this funding spread over 18 areas of investment, along with the expected impact and return from these investments.

As part of the £12 million to support improvement and implementation of the Together for mental health strategy, the Health Board has allocated £6.7 million to improve Mental Health and Learning Disability services (including Child and Adolescent Mental Health Services) and to progress delivery of the strategy. The proposal for the allocation of strategic support for mental health is broken down over 14 schemes in the Annual Plan.

The remainder of the £12 million includes an allocation of £5.3 million to provide additional capacity to drive forward engagement with the Health Board's population, staff and stakeholders, to continue to improve governance and to transform clinical and operational services.

The Health Board intends to use business cases to help best utilise the additional funding, although progression of these has been slow in some areas

The strategic support funding for 2020-21 is allocated over many schemes. A paper to the Executive Team in May 2021 recognised a lack of clarity within the Health Board about decision making governance on low value non-recurrent spending. In response, the Health Board is adopting a leaner approach to decision making for smaller investment decisions, including some schemes funded by the strategic support monies.

Each scheme will be supported by either a business case or a Project Initiation Document. We understand that the status of the schemes remains a mixed picture: some set up and approved, others are in development or yet to be developed. Given that the funding announcement was in November 2020, the Health Board should have ideally prepared cases earlier and be looking to build up a multi-year approach. There is a risk that the Health Board, in seeking to spend the allocation by the end of the financial year, may not achieve the optimum value for money or impact from the spend. This is particularly a risk if progress is slow or additional 'contingency' cases are used to ensure that the money is spent.

The Health Board is putting in place appropriate arrangements to monitor and oversee the use of strategic support funding. In due course, the health board will need to assess the impact of the funding on service improvement.

Information on the intended use of the schemes is contained in the annual plan which has been provided to the Board in July 2021. Currently, a Revenue Business Case Tracker is used to monitor the progress of schemes funded through the £30 million additional allocation (for supporting improvement to unscheduled care and building a sustainable planned care programme). This tracker is updated monthly and is presented regularly to the Executive Management Team and current Finance and Performance Committee. The £12 million strategic support provided for the mental health transformation agenda is not currently included in the tracker but spend against this allocation is monitored by the finance team and there are plans to incorporate this into a single integrated business case tracker in future. The recent report to the Health Boards Strategy, Partnerships and Population Health Committee provides detail on progress and some early outcomes.

The Health Board has reviewed and approved changes to its governance at its Board meeting in July 2021. The revised committee and delivery structure will be introduced during the autumn, and it creates three cross-functional Executive Delivery Groups for delivery of strategy. The Executive Delivery Groups are an extension of the Executive Leadership Team and each one has responsibility for providing assurance on delivery and impact. The groups will drive the transformation agenda. In particular, the Transformation and Finance Executive Delivery Group will plan and oversee the use of additional strategic support funding. The Board's new Performance, Finance and Information Governance Committee will have oversight of this Executive Delivery Group and through this, the use of the additional Welsh Government funding.

These proposed revisions to the governance arrangements should be sufficient to provide visibility of all strategic support funding schemes. In due course, the Performance, Finance and Information Governance Committee will need assurance on progress on the use of the funding during the year and the extent that the funding is enabling transformation, improvement and placing the organisation on a more sustainable footing.

Emerging conclusions and next steps

From the initial high-level work that we have undertaken, we are assured that the Health Board has set out broadly clear plans for how it will spend the strategic financial support funding it is receiving from the Welsh Government.

There are some emerging concerns around the pace of business case development to support the use of the strategic funding in some areas and this should be an area of immediate focus. Plans appropriately consider the resources that will be needed to deliver them, but workforce capacity, any associated estate investment, and procurement timeframe constraints are likely to present ongoing risks.

There are evolving arrangements in place for on-going monitoring of plans but also a need to ensure that monitoring arrangements cover the whole range of strategic funding and develop a clear focus on whether the funding is achieving its intended benefits.

We have not issued formal recommendations as part of this work, but we will continue to monitor progress through routine engagement with the Health Board, and as part of future audit work. We will use this to inform our annual audit planning and our routine engagement with the Welsh Government as part of escalation and intervention discussions.

In the short term, it would be helpful to get your reaction to our initial high-level findings, and an update on any actions that are in hand to take forward the issues we have raised around business case preparation, ensuring resources are in place to deliver the Health Board's emerging plans, and arrangements for monitoring the use of the totality of strategic funding and the benefits and outcomes that are being achieved from it.

Finally, we would like to extend our thanks to the Health Board staff for their involvement and cooperation in this work.

Yours sincerely

David Thomas
Audit Director

Copied to:

Sue Hill, Executive Director of Finance
Olivia Shorrocks, Welsh Government
Kath Williams, Healthcare Inspectorate Wales.

Archwilio Cymru
Audit Wales

Rollout of the COVID-19 vaccination programme in Wales

Report of the Auditor General for Wales

June 2021

This report has been prepared for presentation to the Senedd under the Government of Wales Act 1998.

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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4 Key messages

Context

1 The COVID-19 pandemic has affected everyone. The vaccination programme is a key strategic tool to fight the virus and help reopen the economy and wider society.

2 The purchase and supply of the vaccines is the responsibility of the UK Government. The vaccination programme in Wales is the responsibility of the Welsh Government and NHS Wales.

3 This report considers the rollout of the vaccination programme in Wales. In it, we discuss the shape of the programme, how it is performing, the factors that have affected rollout to date, and future challenges and opportunities. **Appendix 1** describes our audit approach and methods.

4 There are many vaccines in development globally, and the UK government has signed contracts for vaccine supply with eight major pharmaceutical providers (**Appendix 2**). At the time of our fieldwork, three vaccines were approved by the Medicines and Healthcare products Regulatory Agency (MHRA): Pfizer-BioNTech, Oxford-AstraZeneca and Moderna. All three vaccines require two doses to maximise effectiveness.

Key findings

5 Overall, the programme has delivered at significant pace, with local, national and UK partners working together to vaccinate a considerable proportion of the population who are at greatest risk. At the time of reporting, vaccination rates in Wales were the highest of the four UK nations, and some of the highest in the world. The milestones in the Welsh Government's vaccination strategy have provided a strong impetus to drive the programme. To date, the Welsh Government's milestones have been met.

6 The Welsh Government has adopted UK prioritisation guidance from the Joint Committee on Vaccination and Immunisation (JCVI). A national group in Wales provides additional guidance where further clarity on prioritisation is required. The guidance has generally been followed, but the process of identifying people within some of the nine priority groups (**Appendix 3**) has been complex.

7 The organisations involved in the rollout have worked well to set up a range of vaccination models which make best use of the vaccines available, while also providing opportunities to deliver vaccines close to the communities they serve.

8 Overall vaccine uptake to date is high, but there is lower uptake for some ethnic groups and in the most deprived communities. There are also increasing concerns about non-attendance at booked appointments, although health boards to date have been able to minimise vaccine waste.

9 The dependency on the international supply chain is the most significant factor affecting the rollout. Limited stock is held in Wales, primarily to allow for second doses and short-term supply to sites. This means that shortfalls in supply can seriously impact the pace of rollout. However, increasing awareness of future supply levels is allowing health boards to manage the calling of individuals effectively.

10 In the short-term, the workforce supporting the vaccination programme has been meeting the demands placed on it and many staff have been working 'above and beyond'. The current programme is unlikely to complete all second doses until September 2021, and an autumn booster programme is being discussed. This will offer little respite for key vaccination staff in an environment where workforce resilience is vital.

11 Early observations from military partners identified some sites were more efficient than others. Some vaccination sites may become unavailable in coming months as partner organisations look to reopen venues over the summer.

12 As Wales maintains its focus on delivering against existing milestones, there is a need now for the Welsh Government and NHS Wales to develop a longer-term plan for vaccine rollout. This needs to include sustainable workforce models which can respond to supply, whilst also responding to demands as other services are restarted.

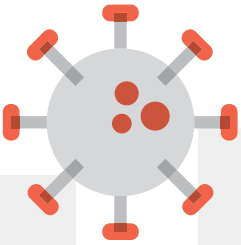
13 Consideration also needs to be given to the longer-term estate requirements to support autumn boosters, with a focus on ensuring that vaccination models are cost effective. Strategies to minimise waste need to be maintained and increased action taken to encourage uptake as the programme moves to the remaining population.

14 More broadly, there is much to be learnt from the positive way in which the vaccine programme has been rolled out to date. The Welsh Government and NHS Wales should be looking to apply that learning to wider immunisation strategies and the delivery of other programmes.

> Wales has made great strides with its COVID-19 vaccination programme. Key milestones for priority groups have been met and the programme is continuing at pace with a significant proportion of the Welsh population now vaccinated. This is a phenomenal achievement and testament to the hard work and commitment of all the individuals and organisations that have been involved in the vaccine rollout to date.
>
> However, the job is far from over. A longer-term plan is needed that moves beyond the existing milestones and considers key issues such as resilience of the vaccine workforce, evolving knowledge of vaccine safety, the need for booster doses, and maintaining good uptake rates - especially in those groups that have shown some hesitancy in coming forward for their vaccinations.

Adrian Crompton
Auditor General for Wales

Key facts



3.3 million

Vaccinations given in Wales

0.4%

Percentage of all vaccines considered unsuitable for use

91.5%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a first dose

£29.4 million

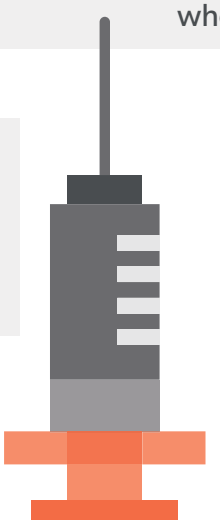
Costs for 2020-21 (excludes redeployed staff and the cost of vaccines)

84.4%

Percentage of the 2.52 million eligible adults who have received a first dose

66.1%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a second dose



Vaccinations being delivered in:

54 mass vaccination centres

346 general practice locations

30 hospital locations

11 pharmacies

18 mobile team units

As of the end of May 2021

Source: Public Health Wales and the Welsh Government

Main report

How the programme is set up

15 Public sector partners across the UK have worked together since the beginning of the pandemic to explore the potential for a COVID-19 vaccination. The programme in Wales was first established in June 2020 to enable an appropriate infrastructure to be put in place before any vaccinations came online.

16 The programme is based around the principle of local autonomy for vaccine deployment through health boards. Supply policy and guidance is nationally coordinated:

a the UK government's Department for Business, Energy & Industrial Strategy (BEIS) led on UK-wide arrangements for research, purchase, and coordination of the national vaccine supply[1] working with the UK Vaccine Taskforce. Responsibility for the Vaccine Taskforce is now shared between BEIS and the UK Department of Health and Social Care. Welsh Government officials engage with the Vaccine Taskforce to streamline vaccine supply and anticipate upcoming issues.

b the Welsh Government is leading on vaccine deployment in Wales. It developed the national Vaccination Strategy for Wales[2] and formed a national programme structure (including Stakeholder and Deployment Boards, and an operational delivery group). The Vaccine Clinical Advisory and Prioritising Group (VCAP) considers clinical developments in vaccination against COVID-19 infection. The group advises the programme and partners on the implementation of the national vaccination programme, interpreting the priorities as outlined by the JCVI for the Welsh context. Collectively, these national groups provide policy and guidance, support financial resourcing, and have facilitated the Primary Care COVID-19 Immunisation Scheme[3] for commissioning primary care.

1 The UK Government Vaccine Taskforce (VTF): 2020 achievements and future strategy report provides an overview of UK level progress

2 The Vaccination Strategy for Wales was first published in January 2021 and formally updated in February, March and June 2021.

3 The Primary Care COVID-19 Immunisation Scheme sets out requirements and reimbursement for Primary Care providers that have signed up to the scheme.

c health boards are responsible for local vaccination plans, set up of mass-vaccination sites through collaborative working with local partners, and aspects of training and staffing. They are also responsible for securing vaccination centres in primary care and outreach/mobile services, with the Welsh Immunisation System (WIS) working to identify those in the priority groups using information on GP and hospital-based IT systems.

d Public Health Wales provides expert advice, surveillance data, vaccine effectiveness and safety monitoring, and public and patient information and reporting. It also assists in the development of training policy, patient group directions (PGDs) and tools.

e other partners are responsible for logistics:

- NHS Wales Shared Services Partnership and the Welsh Blood Service are responsible for supporting the pharmaceutical co-ordination team for consumable and storage logistics.
- Digital Health and Care Wales has led the design, test and rollout of the WIS that enables identification and coordination of priority groups and related appointment booking, vaccination recording and clinical quality assurance such as vaccine batch control. The system also provides performance data.

17 The Vaccination Strategy for Wales provides a high-level framework setting out the expectations for prioritisation and delivery of the COVID-19 vaccine. The Welsh Government has adopted the Joint Committee on Vaccination and Immunisation: advice on priority groups (**Appendix 3**). The national strategy focusses on developing the infrastructure for vaccine deployment, and communication about progress.

18 The first version of the strategy provided a clear milestone for the first four priority groups. In February 2021, the updated strategy provided target dates for the remaining milestones (**Exhibit 1**), with the aim of achieving 75% uptake for priority groups 5-9. This approach has continued to focus all partners on the time-critical aims of the vaccination programme as it continues to roll out.

Exhibit 1: Current key milestones for the vaccination programme

Milestone 1	**By mid-February 2021**: Priority groups 1 – 4 Subject to supply, the aim is to offer first dose vaccination to all care home residents and staff; frontline health and social care staff; those 70 years of age and over; and clinically extremely vulnerable individuals.
Milestone 2	**By mid-April 2021:** Priority groups 5 – 9 Subject to supply, the Welsh Government's aim is to offer first dose vaccination to all remaining priority groups.
Milestone 3	**By July 2021:** Offer first dose vaccination to the rest of the eligible adult population according to the JCVI guidance.

Source: Welsh Government

19 Programme oversight and monitoring take place at national and local levels receiving significant and regular officer level scrutiny as well as ministerial oversight. Public Health Wales and the Welsh Government publish regular updates[4]. Public Health Wales also undertakes enhanced surveillance, including analysis on vaccination uptake by deprivation, age, ethnic background and gender.

20 Vaccination delivery models vary by health board, predominantly based on geography and population density. Mass vaccination sites are being used in areas of higher population density, but in rural and hard to reach areas some health boards have adopted smaller local site models which enable vaccines to be delivered closer to the communities that they serve. Some health boards also depend more on primary care than others. Irrespective of geography, health boards are using outreach models to vaccinate in care homes and have set up temporary and mobile hubs (such as the Swansea Bay UHB Immbulance service).

21 Workforce planning is largely a delegated responsibility for health boards. A national workforce group has created policy and guidance providing high-level productivity modelling and has developed role descriptors for recruitment.

4 Public Health Wales vaccination updates are available on their interactive dashboard. Welsh Government updates are published each week.

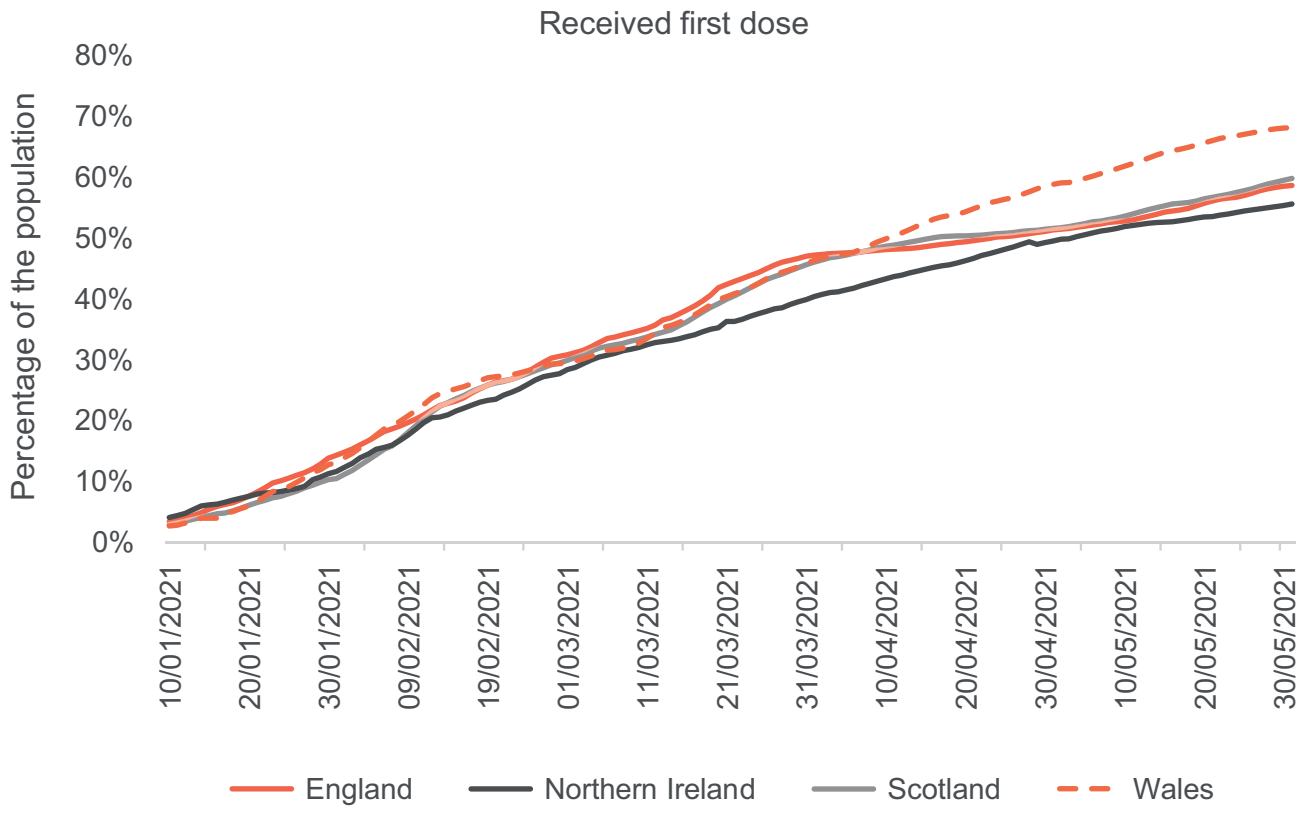
22 To date, vaccine procurement costs have been met by the UK Government in full. The Welsh Government funds the transport, storage, and additional local deployment costs in Wales. It provisionally estimated these costs at £34.9 million for 2020-21, including an estimated cost of £7.8 million for personal protective equipment (PPE). At the end of March, the actual costs for 2020-21 were reported as £29.4 million, as a result of costs associated with PPE largely being funded through existing PPE budget allocation. . Of the £29.4 million, £10.8 million has been spent on additional staffing, £9.54 million on the Primary Care COVID-19 Immunisation Scheme and £0.2 million on capital costs. Some staff are redeployed from within their organisations at no additional cost, although this has potential workforce implications for the part of the business where they originally worked.

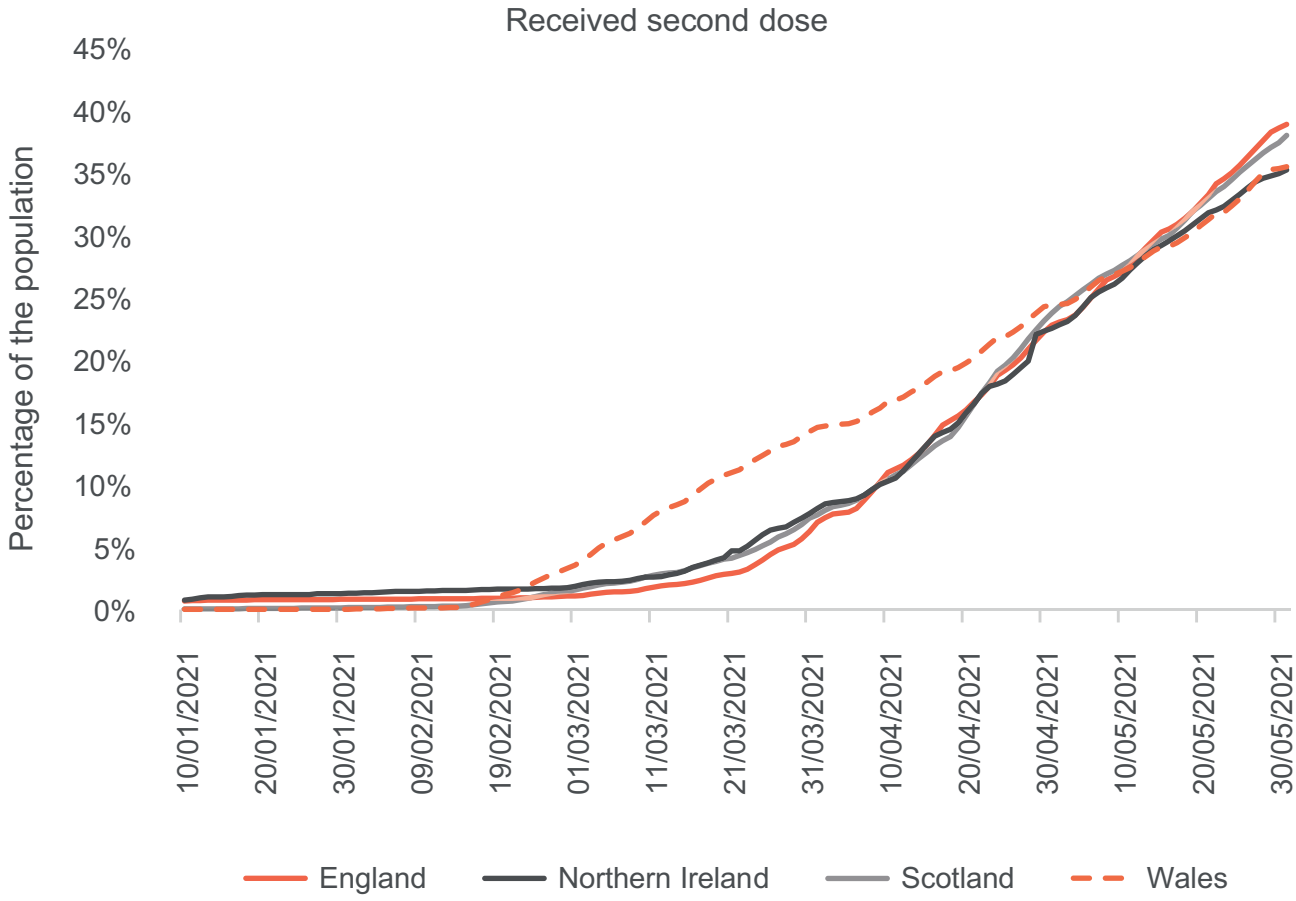
23 Other non-pay costs include transportation, site venue hire, personal protective equipment and syringe packs, security, and communications material. We understand that some vaccination sites are provided to the programme at no additional revenue cost. This is likely to change if local authority or other partners require the return of their facilities and health boards need to relocate to alternative accommodation which may come at a cost. The forecast costs of the programme for the first three months of 2021-22 (April to June 2021) are £31.5 million.

How is the programme performing?

24 Overall, as of 31 May 2021, the percentage of the adult population to have received the vaccine in Wales is higher than in the other UK nations (**Exhibit 2**). Wales made particularly good progress delivering second doses in March, although England and Scotland have now accelerated the delivery of second doses.

Exhibit 2: Percentage of the adult population to have received first and second doses of COVID-19 vaccination by country, as at 31 May 2021

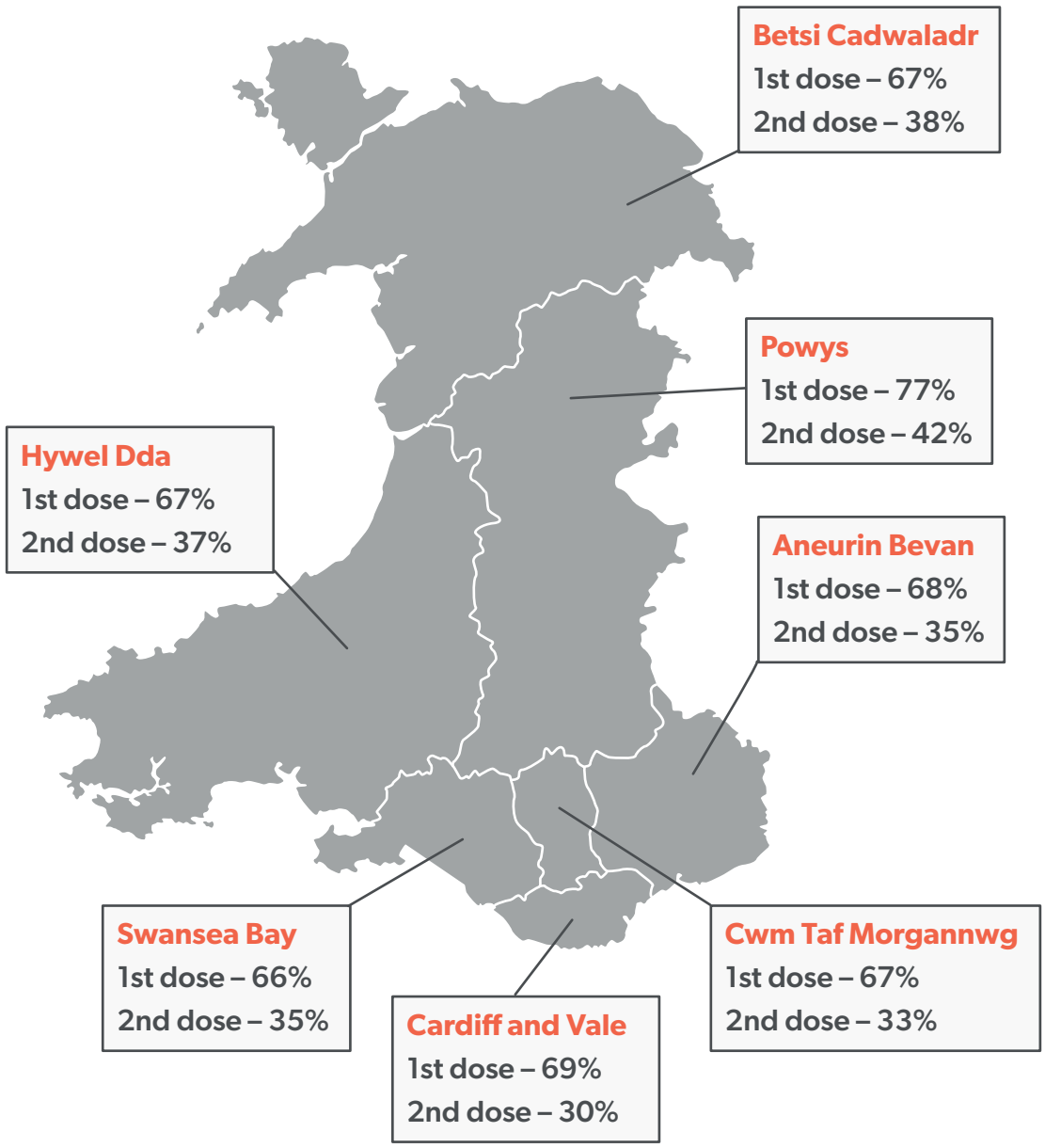




Source: UK Coronavirus Dashboard

25 There is some variation in the progress across health boards, most notably for Powys Teaching Health Board which is making the greatest progress (**Exhibit 3**). This is due to a combination of factors in Powys including a greater proportion of an older population and a higher level of supply per population as a result of batch sizes.

Exhibit 3: Vaccine doses given by health board as a percentage of the adult population as at 31 May 2021



Source: COVID-19 Vaccination Enhanced Surveillance Report, Public Health Wales

26 On 12 February 2021, the Minister for Health and Social Services announced that Milestone 1 of the vaccination strategy had been met. The Minister also announced on 4 April, that Milestone 2 had been met. Both milestones focus on the offering of an appointment for a vaccine. It is not possible to know if everyone eligible within the priority groups 1-9 were identified in the booking process. However, Welsh Government and health board officials took steps to help verify the position, such as contacting care homes to ensure all staff and residents had been offered a vaccination. At 31 May, around 95.5% of those in Milestone 1, and 87.9% of those in Milestone 2 had received their first dose.

27 While the programme has moved ahead to focus on Milestone 3, the Welsh Government and health boards are operating a ‘no one left behind’ policy. This means that anyone eligible in previous groups who has not yet had a vaccine for any reason can inform the relevant health board and make an appointment.

28 Public Health Wales surveillance reports show that influenza vaccine uptake is typically around 70% for those aged 65 and older. So far, the overall COVID-19 vaccine uptake for priority groups 1-9 is 91.5% which reflects positively in comparison. Reasons for not achieving 100% uptake include for example, people that are too unwell to receive the vaccine and the minority, to date, that have chosen not to have the vaccine. At the time of reporting, 66.1% of the priority groups 1-9 had received their second dose, and good progress was being made with vaccine rollout to younger age groups.

29 **Exhibit 4** shows some variation on uptake of first doses against the prioritisation groups by health board, particularly for priority group 6. We have observed extensive national-level discussion to respond to the challenges of identifying relevant population datasets. This included identifying all those aged 16-64 years clinically at risk where definitions of clinical conditions have needed to be clarified, and information about individuals is contained on different systems. There have also been challenges identifying unpaid carers who have previously not been recorded on any system. This indicates some of the difficulty in using a complex vaccination prioritisation model in the environment where no single centrally maintained population dataset exists for this purpose.

Exhibit 4: Percentage of first doses given by priority (P) group, at 30 May 2021

Priority Group		Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
P1.	Residents of care homes	97.5	98.6	98.0	96.4	98.2	96.8	98.8
P2.	80 years +	96.3	96.0	94.3	95.9	96.1	97.2	96.2
P3.	75-79 years	97.0	96.5	95.9	97.1	96.6	97.2	97.3
P4.	16-69 years clinically extremely vulnerable	94.2	93.8	93.2	94.7	93.9	95.7	94.4
P4.	70 – 74 years	96.6	95.6	95.4	96.5	95.7	96.2	96.6
P5.	65-69 years	94.9	94.5	93.5	95.4	94.3	95.0	95.5
P6.	16-64 years clinically at risk	88.6	86.5	88.1	88.2	86.7	90.4	87.8
P7.	60-64 years	93.6	91.6	91.5	93.7	92.2	91.6	93.3
P8.	55-59 years	91.6	89.4	89.3	91.9	90.0	89.4	91.1
P9.	50-54 years	89.7	87.7	86.5	90.1	87.5	88.1	89.0

Note: P2, P3 and P4 also includes data for those in the respective age groups who are also residents of care homes. Frontline health and care staff, as well as unpaid carers are not explicitly identified at health board level but instead included within the relevant age groups.

Source: Weekly COVID-19 coverage report, Public Health Wales

30 Equality considerations are a growing concern. Public Health Wales data shows clear variation in uptake among different ethnic groups with uptake lower particularly within the Black community (**Exhibit 5**).

Exhibit 5: Percentage uptake of first dose of COVID-19 vaccine by age and ethnic group as at 5 May 2021

Ethnic group	White	Black	Asian	Mixed	Other
80+ years	97.2	80.7	87.3	93.1	82.5
70-79 years	96.6	79.9	87.3	88.0	83.4
60-69 years	94.4	76.8	86.6	84.5	78.9
50-59 years	91.3	71.9	84.3	79.4	71.7

Source: Monthly enhanced surveillance report, including analysis on equality of coverage, Public Health Wales

31 As part of their analysis, Public Health Wales also found lower uptake in deprived communities. Although the differences are not as great as for ethnic groups, uptake between the least and most deprived areas for some age groups varies by up to 5.3%. Analysis of COVID-19 positive cases over the last 12 months has indicated that case prevalence and severity have been higher in Black, Asian and Minority Ethnic groups as well as in some of Wales' most deprived areas, with Merthyr Tydfil experiencing the highest number of cases per head of population. In March 2021, the Welsh Government published its Vaccination Equity Strategy for Wales. The Vaccine Equity Committee met for the first time in April 2021 and is preparing a vaccine equity plan.

32 Vaccine wastage (known as vaccines unsuitable for use) to date is around 0.4% of all vaccines supplied. As of 31 May, this equated to around 14,400 doses. Wastage is more prevalent for Pfizer-BioNTech with 0.8% of doses unsuitable for use. Only 0.2% of Oxford-AstraZeneca doses have been deemed unsuitable, with 0.04% reported for Moderna. In comparison, NHS Scotland has estimated that around 1.8% of COVID-19 vaccines are wasted[5]. The other UK nations do not publicly report vaccine wastage.

5 Scotland's COVID-19 Vaccine Deployment Plan – Update March 2021

33 Reasons for vaccines being unsuitable for use include doses that fail quality assurance on initial inspection, doses that fail quality assurance following preparation and vials/doses which expire during the vaccination session. Specific requirements for storage, transportation, and shelf-life of Pfizer-BioNTech once thawed have presented challenges.

34 Arrangements to minimise wastage include:

a systematic recording of temperatures during the different stages of transportation to ensure storage requirements are met from source to site storage, and then on to vaccine centres.

b using reserve lists so that people can attend at short notice at the end of the day to use any vaccine left because of people not attending booked appointments. Approaches to reserve lists vary across health boards with some making reserve lists open to all priority groups while others are targeted to specific priority groups.

c allocation of the Pfizer-BioNTech vaccine mainly to mass vaccination sites. Pfizer-BioNTech shelf-life once defrosted is shorter than the Oxford-AstraZeneca, so the allocation to mass vaccination sites helps to ensure that it is used rather than reaching the end of its shelf-life.

What have been the factors affecting rollout to date?

35 Vaccine supply is the most significant factor affecting the pace of the rollout. UK-wide supply, while agreed through formal contractual obligations, is constrained by commercial pharmaceutical supply and international demand. In general, the Welsh Government and NHS Wales are informed of the expected notional supply around one month ahead. But this can change at short notice both upward and downwards, so reliable projections are difficult beyond two weeks and are in a range, with best, realistic, and worse case scenarios from BEIS.

36 Supply challenges to date include:

a the temporary withholding of a batch of Pfizer-BioNTech vaccines, equating to 25,000 vials, because of quality control issues in January. The MHRA quality control process ensures that vaccines are safe to administer.

b a reduction in February resulting from the refurbishment of both Oxford-AstraZeneca and Pfizer-BioNTech facilities in Europe to accommodate increased production levels.

c a reduction in April owing to the reprioritisation of Indian-produced Oxford-AstraZeneca vaccine resulting in an expected four-week delay.

37 Workforce models have evolved since the beginning of the vaccination programme, with a need to remain flexible to expand or reduce services at relatively short notice in response to supply. All health boards initially used registered health staff immunisers. This was then supplemented through GP practices, which has enabled vaccination activity to be scaled up and offered close to home. Changes to UK legislation has also enabled non-registered staff to be trained to vaccinate under supervision, and over time other partners, such as the military and more recently fire and rescue service personnel, have assisted in the rollout. Plans are also in place to use community pharmacies, with the first pharmacy offering of the COVID-19 vaccine launched in April 2021 in Cardiff.

38 Support staff, clinical staff who have either previously left or retired, and volunteers are also helping at vaccination sites in a variety of roles. The Welsh Government and health boards recognise the goodwill of retired staff who have agreed to come back and assist, as well as volunteers, but we heard mixed views on how easy and beneficial making use of these groups has been in practice. We heard of cumbersome processes to bring back retired or returning staff, some volunteers were only offering to help for short periods, and there were differing views about the need to undertake mandatory training.

39 Prioritisation in line with the Welsh Government policy and guidance has been an essential element of the programme to date. Almost all (99%) of the population at most risk from COVID-19 are in priority groups 1-9. All health boards have adopted prioritisation principles set out within the national vaccination strategy. However, there have been concerns about how the prioritisation approach has varied across Wales and the risk that some (including NHS staff) may have received their vaccine ahead of their allotted priority group. This has arisen because of the desire not to waste unused vaccine and the differing approaches to manage reserve lists. Welsh Government officials have written to health boards in an attempt to standardise the approach for reserve lists. There have also been challenges defining ‘frontline’ for health and social care staff, which may have also resulted in some staff receiving the vaccine earlier than intended.

40 We found that communications relating to prioritisation for the COVID-19 vaccination at a UK, Welsh Government and health board level have been generally consistent, reducing the risk of mixed messaging. In addition, work undertaken by Community Health Councils has found that the public have generally been happy with the communication that they have received from health boards. However, there appeared to be greater concern at earlier stages of the programme from people:

a wanting to know where and when they will be vaccinated;

b not understanding why, for example, a couple could not go to the same vaccination centre on the same day; and

c feeling that some with lower priority had been vaccinated before them.

41 As the programme has gathered pace, many of those initial concerns have eased. A longer lasting issue related to the format of invite letters. These letters are produced automatically by the Welsh Immunisation System for individuals invited to attend a mass vaccination centre, and for the first three months of the programme there was little that could be done to tailor them. We heard of concerns around:

a identical letters being used for first dose and second doses. An example was given to us where an individual was called back for a second dose at the initial recommended four-week period[6], but they thought they had received a first dose letter again in error and ignored it.

b the format of the letters, with interchangeable use of English and Welsh language over several pages, affecting the clarity of the letter and how to raise a concern or rearrange the booking.

42 The format of invite letters has since been addressed in relation to the use of English and Welsh language although the need to make clearer that the invitation is for second doses remains.

6 Initial guidance from the JCVI recommended that the second dose of the COVID-19 vaccine should be administered at four weeks after the first dose. This was subsequently changed to up to 12 weeks in January 2021.

What are the future challenges and opportunities?

43 The vaccine programme in Wales has progressed extremely well but there is still some way to go. Around 4.5 million doses are needed to protect 90% of the adult population in Wales with two doses. At the current rate, and with 3.3 million doses completed as at 31 May, this could mean that second doses for the remaining adult population are not completed until September. Alongside this, there is increasing discussion of an autumn booster programme. It is likely that there will be little respite between finishing vaccinating the remaining adult population and planning a possible next phase of the programme. This all points to a need to develop a longer-term plan for vaccine rollout that looks further ahead and moves beyond the here and now.

44 Vaccine supply is likely to remain a significant challenge. While new vaccines are also becoming available, the more that are in use, the greater the challenge to coordinate their deployment. Storage, transportation, preparation, shelf-life, and training requirements differ depending on the vaccine. Changes to JCVI guidance may also present challenges. For example, the recent guidance to offer under 40s an alternative to the Oxford-AstraZeneca vaccine[7] could result in slower rollout if alternative vaccines are not available. As more vaccines come on stream in Wales, complexity will increase further as may waste and operational efficiency. The Welsh Government are aware of this risk and are working to mitigate it.

45 The current workforce model is meeting the needs of the vaccination programme. However, as other services are restarted and as the wider economy reopens, a sustainable and still flexible workforce solution will be needed for the medium to longer term. Key issues include:

a some health board staff supporting the vaccination programme have been redeployed from their normal role. As other services are restarted, there will be competing workforce pressures as staff are called back to their core roles.

b we have heard that the workforce is fatigued, with many having worked above and beyond at many stages of the pandemic. This will not be sustainable in the longer term. We also heard that as the economy reopens and COVID restrictions are eased, the supply of volunteers is reducing.

c consideration is being given to the potential to combine a COVID-19 booster programme with the routine flu immunisation programme, or whether there is a clinical need to keep them separate. Either way, there are implications for the development of the workforce to meet demand.

7 JCVI statement on Use of the AstraZeneca COVID-19 vaccine: 7 May 2021

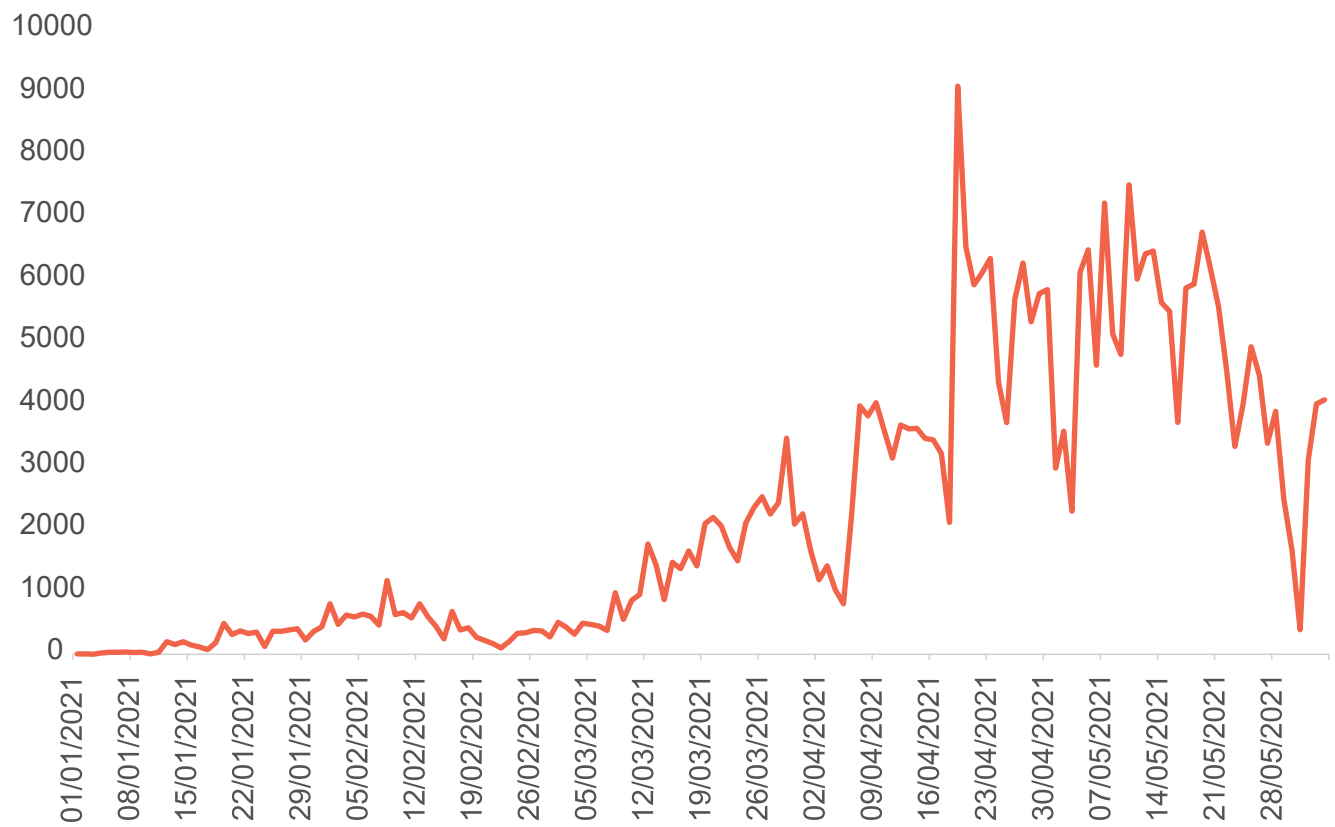
46 Sites used as mass vaccination centres have largely been made available to health boards through the goodwill of partners. Many of these venues were closed due to COVID-19 restrictions. With restrictions easing, organisations will now be looking at the potential to reopen these venues before the anticipated end of the current programme as a way of remaining commercially viable, for example, Venue Cymru in Llandudno. Health boards are likely to need to consider alternative cost-effective options for vaccination centres at relatively short notice to deliver the remainder of the current programme. They will also need to look at how to accommodate the longer-term COVID-19 vaccination programme alongside the wider immunisation programme.

47 There will always be differences in vaccination models to respond to local population needs and geography. Nevertheless, some models will be delivering greater efficiency than others. Early observations from the military partners involved in the vaccination programme identified vaccination sites were not always making the most efficient use of qualified staff and that rates of vaccination per hour per staff varied between 2.6 and 10.2. This variation in vaccination rates merits further investigation by operational officials, but the local variations will be, in part, due to supply and vaccine type. Health boards and the Welsh Government need to maintain a focus on ensuring that service models provide value for money. This will also help inform the shape of future models and programme design.

48 As the programme moves forward, there is a growing concern that the younger population are less likely to accept the offer of a vaccination. Health boards are continually assessing and adapting vaccination models to ensure they are accessible to all and working in partnership with other agencies to understand the reasons for vaccine hesitancy and to put actions in place. This has included some positive actions being taken to engage community leaders in particular ethnic communities, and members of the travelling community. Health boards and partners need to maintain this focus to build trusted relationships and improve the confidence in the vaccine programme. This is likely to be resource intensive if the Welsh Government and NHS wants to maintain its overall positive uptake rate for the remainder of the population and to ensure uptake of second doses is as high as is being achieved for first doses.

49 Having dropped at the end of March and early April, the number of individuals who do not attend for their appointment has since increased again (**Exhibit 6**). It is understood that non-attendance is greater for first dose vaccines, than second dose vaccines. Non-attendance impacts the pace of the programme and represents a cost-inefficiency as staff can end up underutilised. Arrangements to call those on reserve lists in at short notice are helping to fill empty slots, but as the percentage of the population yet to have a vaccine reduces, filling these slots will become more challenging. Non-attendance rates do vary by health board with Aneurin Bevan, Cardiff and Vale, and Swansea Bay University Health Boards experiencing some of the highest levels.

Exhibit 6: Numbers of people invited for vaccination but did not attend by day up to the end of May 2021



Source: Welsh Government

Note: the data used is intended for internal management information purposes and has therefore not been validated

50 Some of the reasons for non-attendance have included delays in invite letters being received, and problems getting through to contact numbers to rearrange appointments, as well as people not turning up because of vaccine safety concerns. Difficulties in getting time off work to attend appointment slots and clashes with holidays as society opens are increasingly likely to result in further non-attendance over the coming months. There is opportunity to reflect on the current approach for booking, with consideration to web-based systems to support self-booking of appointments. This will help provide flexibility and minimise the resource intensive process when people have to re-book or staff must find people to fit in the slots. The programme is actively working on establishing this with Digital Health and Care Wales.

51 Following a recent 'Programme Assessment Review' in March, the Welsh Government has considered future challenges and how it strengthens national programme management arrangements. To date, there has been limited additional central capacity to drive the programme at a national level, and reliance has been placed on a relatively small number of officials both within the Welsh Government and across the NHS to lead the rollout programme. Programme management arrangements during the early part of the vaccine rollout were rather unwieldy, with early oversubscribed Stakeholder Boards due to intense interest. In excess of 60 people from different professional backgrounds attended. Changes have been made to tighten up these arrangements and we understand that more changes are planned to further streamline programme management and governance.

52 Whilst the challenges outlined here need to be carefully considered as the vaccine rollout moves to its next stage, it should be recognised that the programme has moved at a scale and pace not previously seen in Wales. There is much to celebrate in that and there are many positive lessons to learn for the delivery of other programmes and the wider immunisation agenda.

Appendices

1 Audit approach and methods

2 UK COVID-19 vaccines purchased and status as at 1 June 2021

3 Welsh Government's vaccine prioritisation (based on the JCVI recommendation)

1 Audit approach and methods

Our primary focus was on the national vaccination programme and the deployment of vaccines in Wales. We drew on the vaccination deployment of three health boards to obtain an understanding of rural and urban settings. We considered the set-up of the national programme, performance of the programme, and the factors or issues that have affected rollout.

Our work excluded vaccination arrangements administered by the UK government. The National Audit Office has examined the UK government's preparations for potential COVID-19 vaccines[8]. We reviewed that report to help inform our wider understanding of procurement, contracting and vaccine costs, which are administered UK-wide.

Audit methods

We used a range of methods:

- **document review**: we reviewed national strategy, guidance, Welsh Government announcements and update reports, health board vaccination plans, local and national performance reporting. We also reviewed national vaccination stakeholder and deployment board papers and minutes.
- **observations**: we attended several national vaccination stakeholder board and deployment board meetings as observers.
- **semi-structured interviews**: we interviewed Welsh Government officials involved in the vaccination programme, selected members of the national vaccination deployment board, and senior managers from three health boards involved in the set-up of vaccination sites and the deployment of vaccines.
- **data analysis**: we reviewed available data on first and second dose vaccination progress in Wales and the other UK nations. We considered vaccine wastage and deployment costs, in relation to pay costs, non-pay costs and the extent of costs associated with vaccination in primary care settings.

It is not possible for us to present data for the same period throughout this report. Data in this report are taken from differing sources and are published at differing intervals. Detailed information on vaccine availability, stock, and utilisation by manufacturer is not publicly available for reasons of commercial confidentiality.

We completed our fieldwork between February and April 2021.

8 Investigation into preparations for potential COVID-19 vaccines, National Audit Office, December 2020

2 UK COVID-19 vaccines purchased and status as at 1 June 2021

Vaccine	No of doses	Status
Oxford-AstraZeneca	100 million	Approved 30 December 2020 and in deployment across Wales from January 2021
Janssen	20 million	Approved 28 May 2021
Pfizer-BioNTech	100 million	Approved 2 December 2020 and in deployment across Wales from January 2021
Moderna	17 million	Approved 8 January 2021 and in deployment from April 2021 in Aneurin Bevan and Hywel Dda University Health Boards
GlaxoSmithKline/ Sanofi Pasteur	60 million	Phase 3 trials
Novavax	60 million	Encouraging phase 3 safety and efficacy data
Valneva	100 million	Phase 3 trials
CureVac	50 million (initial order)	Phase 3 trials
Total	**507 million**	

Source: Recent GOV.UK announcement, updated based on information from the London School of Hygiene and Tropical Medicine and recent GOV.UK announcement

3 Welsh Government's vaccine prioritisation (based on the JCVI recommendation)

Vaccine prioritisation groups	
1	People living in a care home for older adults and their staff carers
2	All those 80 years of age and older and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and people who are extremely clinically vulnerable (also known as the "shielding" group) – people in this group will previously have received a letter from the Chief Medical Officer advising them to shield
5	All those 65 years of age and over
6	All individuals aged 16 years to 64 years with underlying health conditions*, which put them at higher risk of serious disease and mortality
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

Source: Welsh Government

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WHSSC COMMITTEE GOVERNANCE ARRANGEMENTS – MANAGEMENT RESPONSE

1.0 SITUATION

The purpose of this report is to present the management response to the Audit Wales report WHSSC Committee Governance Arrangements.

2.0 BACKGROUND

In 2015, the Good Governance Institute (GGI) and Healthcare Inspectorate Wales (HIW) undertook two separate governance reviews for WHSSC which highlighted issues with WHSSC's governance arrangements. The GGI highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. HIW) conducted a review of clinical governance and found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality and also improve clinical engagement.

Since then, considering the increasing service and financial pressures, and the potentially changing landscape of national collaborative commissioning and NHS Executive as set out in Welsh Government's "A Healthier Wales", the Auditor General for Wales felt it was timely to undertake a review WHSSC's governance arrangements.

The Audit Wales review into Committee Governance arrangements at WHSSC was undertaken between March and June 2020, however as a result of the COVID-19 pandemic, aspects of the review were paused, and re-commenced in July. A survey was issued to all Health Boards and the fieldwork was concluded in October 2020.

The scope of the work included interviews with officers and independent members at WHSSC, observations from attending Joint Committee and sub-committee meetings, feedback from questionnaires issued to Health Board Chief Executive and Chairs and a review of corporate documents.

The findings were published in May 2021 in the Audit Wales Committee Governance Arrangements at WHSSC report.

The report outlined 4 recommendations for WHSSC and the 3 recommendations for Welsh Government.

3.0 MANAGEMENT RESPONSE

3.1 WHSSC Management Response

The report outlined 4 recommendations for WHSSC and the draft management response has been circulated to Health Board CEO's, Welsh Government and Audit Wales for comment and feedback.

The feedback received has been reviewed and the updated WHSSC management response is presented at ***Appendix 1*** for information and assurance.

Progress against the actions outlined within the management response will be monitored through the Integrated Governance Committee (IGC) on a quarterly basis, and a full progress report will be presented to the Joint Committee 18 January 2022, once the actions related to the Integrated Commissioning Plan (ICP) process and engagement events have been completed.

3.2 Welsh Government Management Response

The report outlined 3 recommendations for Welsh Government (WG) and the management response is outlined in the letter from Dr Andrew Goodall, Director General Health & Social Services/ NHS Wales Chief Executive to Mr Adrian Crompton, Auditor General for Wales which is presented at ***Appendix 2*** for information and assurance.

Progress against the WG management response will be monitored through discussions between the Chair, the WHSSC Managing Director and the Director General Health & Social Services/ NHS Wales Chief executive.

4.0 GOVERNANCE & RISK

Audit Wales undertake an annual programme of independent external audits on NHS services, and NHS bodies are required to present a formal management response to recommendations through a public report.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report and the proposed WHSSC management response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- **Note** the Welsh Government response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- **Note** the proposed arrangements for monitoring progress against the actions outlined in the management responses.

6.0 APPENDICES / ANNEXES

Appendix 1 - WHSSC Management Response to the Audit Wales Report Committee Governance Arrangements at WHSSC
Appendix 2 – Letter from Welsh Government to Audit Wales – Welsh Government's Management Response

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Implementation of the agreed ICP
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	The Management responses outline activities to strengthen and develop WHSSC's impact on quality, safety and patient experience.
Resources Implications	Some improvement actions may require the application of additional resources.
Risk and Assurance	Risk management is a key element of developing WHSSC's services and risk assessments will be undertaken as required.
Evidence Base	-
Equality and Diversity	There are no equality and diversity implications.
Population Health	There are no immediate population health implications.
Legal Implications	There are no direct legal implications.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

Response to the Recommendations from the Audit Wales Report Welsh Health Specialised Services Committee Governance Arrangements

In May 2021, Audit Wales published the "Welsh Health Specialised Services Committee Governance Arrangements"[1] which found that the governance, management and planning arrangements at WHSSC have improved, however the impact of COVID-19 will require a clear strategy to recover key services and that the Welsh Government's long-term model for health and social care 'A Healthier Wales', and the references made to WHSSC should be re-visited.

Audit Wales made a number of recommendations for both WHSSC and Welsh Government and the management response to the WHSSC recommendations are outlined below:

Recommendation	Response/ Action	By when	By whom
Quality governance and management			
R1 Increase the focus on quality at the Joint Committee. This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.	We accept the recommendation and intend to take the following actions. We will include in our routine reports to Joint Committee (JC) on quality, performance and finance a section highlighting key areas of concern to promote effective focus and discussion. We will develop a revised suite of routine reports for JC that will include elements of the activity reporting, that we introduced during the pandemic, and will take into account the quality and outcome reporting that is currently being developed by Welsh Government (WG).	Sept 2021 Mar 2022	WHSSC Executive leads WHSSC Executive leads

[1] Welsh Health Specialised Services Committee Governance Arrangements (audit.wales)

Recommendation	Response/ Action	By when	By whom
	We will encourage members of the JC to engage in consideration and discussion of key areas of concern that are highlighted. We will include routinely at JC an invitation for an oral report to be delivered by, or on behalf of, the Chair of the WHSSC Quality & Patient Safety Committee (Q&PSC) based on the written report from the Chair of Q&PSC.	Sept 2021 Sept 2021	Chair of WHSSC Chair of WHSSC
Programme Management			
R2 Implement clear programme management arrangements for the introduction of new commissioned services. This should include clear and explicit milestones which are set from concept through to completion (i.e. early in the development through to post implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the Joint Committee.	We accept the recommendation and intend to take the following actions. **a) Building Programme Management competency/capacity** A number of new staff have recently joined WHSSC in senior positions in the planning team who bring with them strong programme and project management skills. There are 'lunch and learn' sessions planned to share this approach, and the use of common templates is embedding, it is anticipated that this approach will grow programme management competency and capacity within the organisation. The approach is already starting to embed in the way the planning team operates, with programme management approaches already	To commence Sept 2021	WHSSC Director of Planning

Recommendation	Response/ Action	By when	By whom
	applied to the two strategic pieces committed to through the 2021 ICP (namely paediatrics and mental health) and to the management of the CIAG prioritisation process. Common templates apply to highlight and exception reporting, risk logs and timelines/milestones. **b) Programme management on WHSSC commissioned services.** Programme arrangements have previously been used for strategic service reviews and the development of the PET (positron Emission Therapy) business case. We will further develop this approach as outlined above, i.e. through a common approach to programme management across the organisation and to and the use of common templates. These will become the basis of reporting through programme structures and as necessary to joint committee. **c) HB Commissioned Services** – when services are not the sole responsibility of WHSSC, and where the senior responsible officer is outside of WHSSC, we will contribute to the programme arrangements, offering clarity about the role of WHSSC and		

Recommendation	Response/ Action	By when	By whom
	the scope of the responsibilities it has within the programme. We will seek to deliver against any key milestones set, and report progress, risk and exception accordingly.		
Recovery Planning			
R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on: a. the backlog of waits for specialised services, how these will be managed whilst reducing patient harm. b. potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening. c. the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.	We accept the recommendation and recognise the post COVID-19 recovery challenges. We intend to take the following actions. **a) Managing backlog of waits whilst reducing harm** i. Introduction of real-time monitoring and reporting of waiting times to Management Group and Joint Committee ii. Review of recovery plans with Welsh provider Health Boards, iii. Regular Reset and Recovery meetings with services to monitor performance against plans. Significant variance from plans will be managed through the WHSSC escalation process iv. Introduction of the WHSSC Commissioner Assurance Framework (CAF), v. Workshop with Joint Committee members on how to deliver 'equity' in specialised services. Report shared with HBs and WG.	Sep 2021 Jul 2021 From Apr 2021 In place In place Completed May 2021	WHSSC Executive leads WHSSC Executive leads

Recommendation	Response/ Action	By when	By whom
	b) Potential impact and cost of managing hidden demand. i. Introduction of demand monitoring compared to historical levels for high volume specialties, findings to be reported to the WG Planned Care Board and HBs to inform non-WHSSC commissioned pathway development. ii. Appointment of an Associate Medical Director for Public Health to work with Health Board Directors of Public Health to assess impact. **c)Financial consequences of services that were commissioned and under-delivered as a result of COVID-19** i. This information is already captured through our contract monitoring process and compared against the national block contract framework implemented to maintain income stability through COVID-19. This will inform future planned baselines and contract negotiation, where the negotiation is within our control. WHSSC is working with contracted providers across Wales and England to establish their specialised recovery trajectories	In Place Q3/Q4 2021/22 In Place	WHSSC Executive leads

Recommendation	Response/ Action	By when	By whom
	and where appropriate will secure recovery funding from WG to direct to providers for recovery performance if above established contracted baseline levels. **d) Reporting Analysis** We will review and analyse the business intelligence gathered from the actions outlined in points a,b and c above and use the real-time and historical data to inform our decision making on managing existing, and developing new specialised commissioned services. We will report our analysis and outcomes to the Joint Committee, Welsh Government and the Management Group as appropriate.	Sept 2021	
Specialised Services Strategy			
R4 The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021. This should: a. embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post pandemic recovery. b. be informed by a review of the extent of the wider services already commissioned by WHSSC, by	We accept the recommendation and work had begun on developing a new Commissioning strategy, however the COVID-19 pandemic delayed progress. To move forward the new specialised services strategy will be informed by the WG policy for reset and recovery. We intend to take the following actions. **a. Embrace New Innovations** i. We will continue to utilise our well-established horizon scanning	Q4 2021/22 In place Jul 2021	WHSSC Managing Director

Recommendation	Response/ Action	By when	By whom
developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services: • which do not demonstrate clinical efficacy or patient outcome (stop); • which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer); • where alternative interventions provide better outcome for the investment (change); • currently commissioned, which should continue (continue).	process to identify new therapeutic and technological innovations, drive value and benchmark services against other commissioning models to support , short, medium, and long-term approach for post pandemic recovery ii. We will continue to develop our relationship with NICE, AWMSG and HTW in relation to the evaluation of new drugs and interventions, iii. We will engage with developments for digital and Artificial intelligence (AI), iv. We will continue our regular dialogue and knowledge sharing with the four nations' specialised services commissioners, v. We will continue to build upon our existing relationships with the Royal Colleges, vi. We will continue to develop our work on value-based commissioning, vii. We will develop a communication and engagement plan to support and inform the strategy. viii. As previously agreed with Joint Committee a stakeholder engagement exercise will be undertaken to gain insight on long term ambitions and to inform how	Q3 2021/22 In place Dec 2021 Dec 2021	

Recommendation	Response/ Action	By when	By whom
	we shape and design our services for the future. This will inform the Specialised Services Strategy and the supporting the 3 year integrated commissioning plan. **b. Approach to Review of Services will be considered in strategy engagement** i. The draft strategy will consider our approach to the review of the existing portfolio of commissioned services and undertake a value based services assessment to assess if existing services are still categorised as specialised, ii. We will continue to undertake our annual prioritisation panel with HB's to assess new specialised services that could be commissioned, iii. We will continue to undertake a process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services, iv. WHSSC will investigate opportunities for strengthening its information function through internal re-organisation and investment. This will include the development of an outcome	Sept 2021	

Recommendation	Response/ Action	By when	By whom
	manager post to support both the WHSSC strategic approach to outcome measurement as well as a feasibility analysis of currently available tools. We will pursue our planned investment to utilise the SAIL database with a view to assessing the population impact of services in a number of pilot areas. As previously agreed with the Joint Committee a stakeholder engagement exercise will be undertaken to gain insight from our stakeholders on long term ambitions and to inform how we shape and design our services for the future. This will inform transferring commissioned services into and out of the WHSSC portfolio to meet stakeholder and patient demand.		

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
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2 June 2021

Dear Adrian

Welsh Health Specialised Services Committee (WHSSC) Governance Arrangements: Report of the Auditor General for Wales, May 2021

Thank you for the above Audit Wales report, published on 12 May.

I welcome your conclusion that governance arrangements and decision making at WHSSC have improved since previous reviews. The WHSSC team has worked hard to make these changes and I will expect them to make further progress by addressing your recommendations in relation to an increased focus on quality, programme management, COVID-19 recovery and the specialised services strategy. My officials will be following up on these areas at their regular meetings with WHSSC.

In terms of your recommendations to the Welsh Government, I set out my initial response below, although these may well be subject to any views from the new Minister in light of her priorities.

Recommendation 5: Independent Member recruitment – accepted and action in train

I am aware there have been challenges in securing nominations from health boards to undertake the independent member role at WHSSC. My officials have been looking at options in relation to recruitment, remuneration and retention of independent members and I am currently considering their advice before the matter is raised with the Minister. There are a number of options, some of which could be achieved relatively simply and others which would require changes to the legislation. I will write to you again when we have a clear way forward.

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Recommendation 6: Sub-regional and regional programme management (linked to recommendation 2 directed to WHSSC) – accepted

As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened. The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.

Recommendation 7: Future governance and accountability arrangements for specialised services – accepted in principle

A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner and provider standpoint. However, I recognise the inherent risk of conflict of interest in this arrangement and note the reference made in your report to the Good Governance Institute's report of 2015 which suggested a more national model may be appropriate.

In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would be become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update you should there be any change to the direction of travel I indicated in 2019.

Yours sincerely

Dr Andrew Goodall CBE

cc: Chair of the Senedd Public Accounts Committee.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Schedule of Closed Claims Over £50,000 - Quarter 1 2021/22
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Nursing and Midwifery/Deputy CEO Acting Associate Director of Quality Assurance
Awdur yr Adroddiad Report Author:	Claims Managers
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality Assurance
Atodiadau Appendices:	Schedule of closed claims and financial value for quarter three of 2020/21 (over £50,000)

Argymhelliad / Recommendation:

The Committee is asked to receive this report for assurance.

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

Sefyllfa / Situation:

The attached report sets out total payment information for any claims against the Health Board with a spend of over £50,000 closed during Quarter 1 (April-June) of the 2021/22 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 reimbursement procedures that bring the scrutiny of learning early in the lifecycle of a case. These changes become effective from 1 October 2019. The WRP procedures require 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 Learning Advisory Panel and 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 been completed and the process given **Substantial Assurance** with no recommendations made.

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)	Notes
ZG-CLA18-3520	Clinical Negligence	BCUHB East	Gynae Surgery (Secondary)	27/04/2015	£60,046.00	
CLA17-2796	Clinical Negligence	BCUHB East	Gynae Surgery (Secondary)	19/09/2014	£57,650.10	
CLA17-3127C	Personal Injury	BCUHB Central	General Surgery (Secondary)	01/01/2017	£78,426.47	
ZG-E11-347	Clinical Negligence	BCUHB East	Obstetrics (Secondary)	02/11/2004	£796,831.09	
C13-1080	Clinical Negligence	BCUHB Central	Obstetrics (Secondary)	11/03/2011	£104,656.20	
CLA2538	Clinical Negligence	BCUHB Central	Urology (Secondary)	19/12/2014	£142,499.01	This case was previously reoprted to audit committee, however the cases was reopened and closed again due to an additional CRU payment that was required and had not been notified to us previously .
					£1,240,108.87	

Cyfarfod a dyddiad: Meeting and date:	Audit Committee 28th September 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Performance and Accountability Framework – Impact and Effectiveness
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad Report Author:	Kamala Williams, Interim Director of Performance
Craffu blaenorol: Prior Scrutiny:	N/A
Atodiadau Appendices:	Appendix 1 – Performance and Accountability Framework (PAF) impact and effectiveness report. Appendix 2 – Board Approved PAF, November 2020

Argymhelliad / Recommendation:

Members of the Audit Committee to note the report provided, Appendix 1

Please tick as appropriate

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

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqlA) and a socio-economic (SED) impact assessment as an appendix.	**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

In November 2020, the Board approved and agreed immediate implementation of the Performance and Accountability Framework (PAF) see Appendix 2.

Cefndir / Background:

Audit Committee discussed the PAF in December 2020 and requested a report on the impact and effectiveness of the PAF at the September 2021 meeting of the Committee; the report is included as Appendix 1.

Asesiad / Assessment & Analysis

Strategy Implications
Robust performance and accountability arrangements are key to delivery of the Health Board's strategic priorities as articulated in the 2021/22 Annual Plan.

Options considered
N/A

Financial Implications
N/A

Risk Analysis
Robust performance and accountability arrangements are key to ensure the timely identification and management of any risks associated with non-delivery of Annual Plan.

Legal and Compliance
N/A

Impact Assessment
An impact assessment has not been completed.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Report on the impact and effectiveness of the Performance and Accountability Framework (PAF) – September 2021

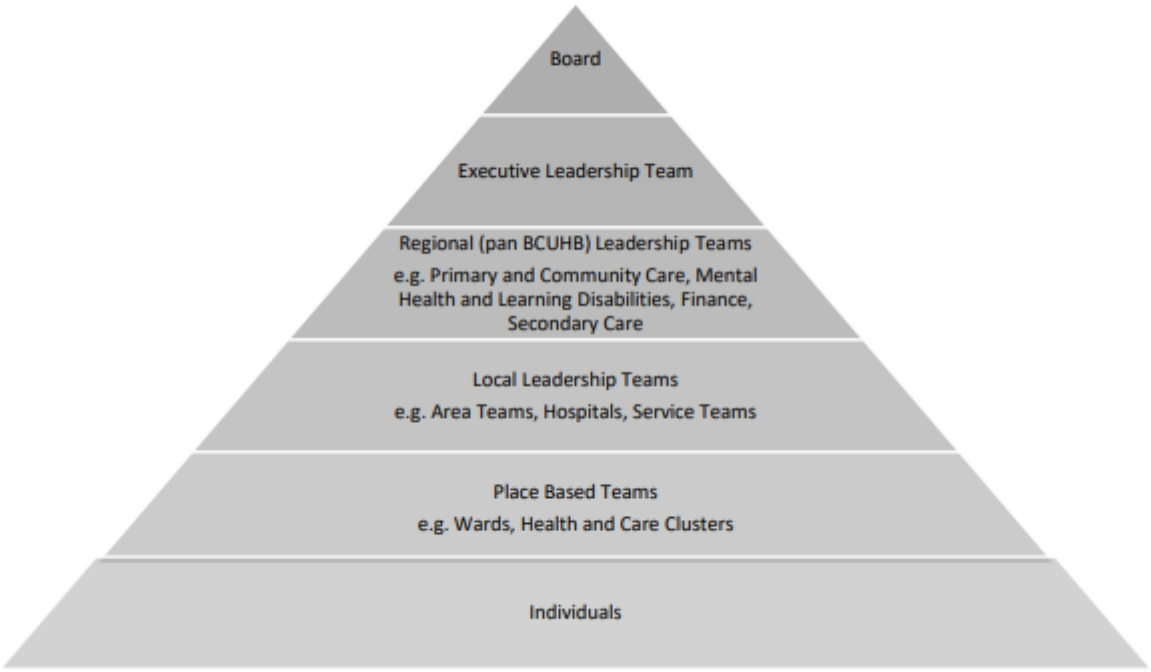
Situation

Audit Committee has requested a review of the impact and effectiveness of the Performance and Accountability Framework (PAF), as approved and activated on the 11th November 2020.

Background

The PAF sets out the hierarchy of performance reviews spanning six organisational levels from the individual to the Board see Figure 1 below.

Figure 1- Summary of Performance and Assurance Management Cascade



Assessment

The PAF comprises the following key components:

- Accountability and performance management structures
- Clearly defined reporting arrangements and expectations

- Agreed and well understood routes for escalation of concerns

Assessment of each component is as follows:

1. **Are PAF accountability structures in place?**
   The accountability structure in the PAF replicates the cascade arrangements set out in figure 1 above and as per the table below.

1	Place based teams are **accountable to** local leadership teams.
2	Local leadership teams are **accountable to** Regional leadership teams.
3	Regional leadership teams are **accountable to** Executive Directors.
4	Executive Directors are **accountable to** the Board **via** the Chief Executive and the Board Assurance Committees.
5	The Board is **accountable to** Welsh Government.

   The five Health Board Divisions – Secondary Care (SC), North Wales Managed Clinical Services (NWMCS), Women's Services, Mental Health and Learning Disabilities (MHLD) and Primary and Community Care (PCC) are able to describe their accountability structures at local and placed based level. There are differences within some of the larger divisions i.e. SC and PCC at the local level, which can present a challenge when considering performance and accountability at a regional level. For example, whilst accountability for delivering actions in the Annual Plan may be at a divisional level there can be local variation in performance at Acute Hospital Site or Area Level.

   The PAF does not specify arrangements for managing cross-divisional performance and accountability, although the PAF notes that there is an opportunity for the Performance Oversight Group (POG) to pick up specific issues as a thematic review. Whilst there are examples of cross-divisional performance and accountability structures, for example Joint Leadership Team meetings these are not consistent and are generally informal. Further work is required to ensure clear lines of reporting and governance, this is particularly important given the increased focus on end-to-end pathway working to support service transformation.

   A number of Divisions are currently reviewing their governance and accountability arrangements as part of the strengthening governance work currently lead by the Interim Director of Governance. This work also provides an opportunity to address cross-divisional issues.

2. **Is the performance management structure in operation?**

   The Executive Performance Oversight Group: There are agreed Terms of

Reference for the POG and there have been three meetings of the POG to date. At the most recent meeting of the POG on the 15th September, members resolved to review the ToR of the POG to ensure the Group focusses on strategic performance priorities not already covered by other groups/meetings.

Executive Divisional Accountability Meetings: Take place on a quarterly basis with dates set at the beginning of the year. Meetings provide an opportunity for Executives to challenge senior managers regarding the non-achievement of performance targets; to seek additional assurance and for senior managers to highlight particular areas of concern/risk and discuss any support required. At each meeting actions are agreed, recorded, and monitored via an action log.

Accountability and Assurance Agreements: The Framework stipulates that senior managers at Executive and Regional levels sign an Accountability and Assurance Agreement. These agreements, between the Chief Executive and individual Senior Managers set out the scope of the individual's responsibility for performance against which they will be held to account, this should include specific budget and staffing levels to achieve the deliverables agreed.

Agreements, relating to delivery of Annual Plan schemes, were introduced in late December 2020/21 with variable success. Issues included timing of the agreements relative to the start of the financial year; the approach to planning which was quarterly rather than annual and the dynamic nature of planning resulting in changes to actions/action leads over time.

Further work is required to ensure that responsibilities for performance relating to the Annual Plan form part of the Performance Appraisal Review and Development (PADR) process. Discussions are taking place between the Interim Director of Performance and Workforce and Organisational Development colleagues to progress.

3. **Are reporting arrangements and expectations clearly described and in place?**
   At Board and Committee level reporting arrangements and expectations are clearly described and in place.

   There are 2 regular performance reports that go to Board and Committees:

   The Operational Plan Monitoring Report (OPMR): This report is currently received by the Finance and Performance (F&P) and Strategic Partnerships and Population Health (SPPH) Committees and Health Board on a quarterly basis. The report sets out performance against the programme level actions in the Annual Plan. Each Programme has a lead Executive Director with programme level actions assigned to a named individual.

The OPMR utilise a RAG rating system to assess performance. Where information is available members of the performance team triangulate to verify the reported position.

The Quality and Performance Report (QAP): F&P and the Quality, Safety and Experience (QSE) Committees receive reports tailored to their areas of focus. The Health Board receives an aggregated report. At present, the reports predominantly feature a sub set of the Welsh Government National Delivery Measures. Performance is reported by exception or for strategic Health Board priorities.

Work to replace the QAP with an Integrated Quality and Performance report, which will include assurance level and data quality indicators, greater statistical analysis and local indictors, is underway. These changes require a significant programme of work. Phase 1 will be the introduction of an improved QAP report and is due to conclude at the end of Q3 2020/21.

4. Are arrangements for escalation of performance issues in place?

The PAF makes provision, convened by the F&P and QSE Committees or Chief Executive. These meetings are with specific Accountable Managers and their teams facing significant and sustained performance issues. To date no Extraordinary Performance Review Meetings have taken place.

The Executive Divisional Accountability meetings provide Divisions with an opportunity to highlight areas for escalation to the Executive Team. There is limited evidence i.e. very few issues, escalated through other groups. Whilst this may be appropriate, there are a number of areas where under achievement has been prolonged and it is suggested that further work is undertaken at the local and regional level to ensure there are clear thresholds and processes in place for escalation.

The coversheet that accompanies the QAP report and OPMR recommends that the Committee scrutinise the reports and advise any areas to be escalated for consideration by the Board. Committee members can request additional assurance/information relating to actions not delivered on time or targets that not achieved. Generally, this information is included in the next Committee report or dealt with as a separate action.

Recommendations

Audit Committee is asked to note the assessment of the impact and effectiveness of the PAF and the further work that is underway or planned, to strengthen the performance and accountability arrangements within the Health Board.

Version & Reference Number 1.09 - Final

Performance and Accountability Framework

Author & Title	Simon Evans-Evans Interim Director of Governance				
Responsible Dept / director:	Workforce and Organisational Development Sue Green				
Approved by:	Executive Leadership Team				
Date approved:	11/11/2020				
Date activated (live):	11/11/2020				
Documents to be read alongside this document:					
Date of next review:	31/03/2021				
Date EqIA completed:	n/a				
First operational:					
Previously reviewed:					
Changes made yes/no:					

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document

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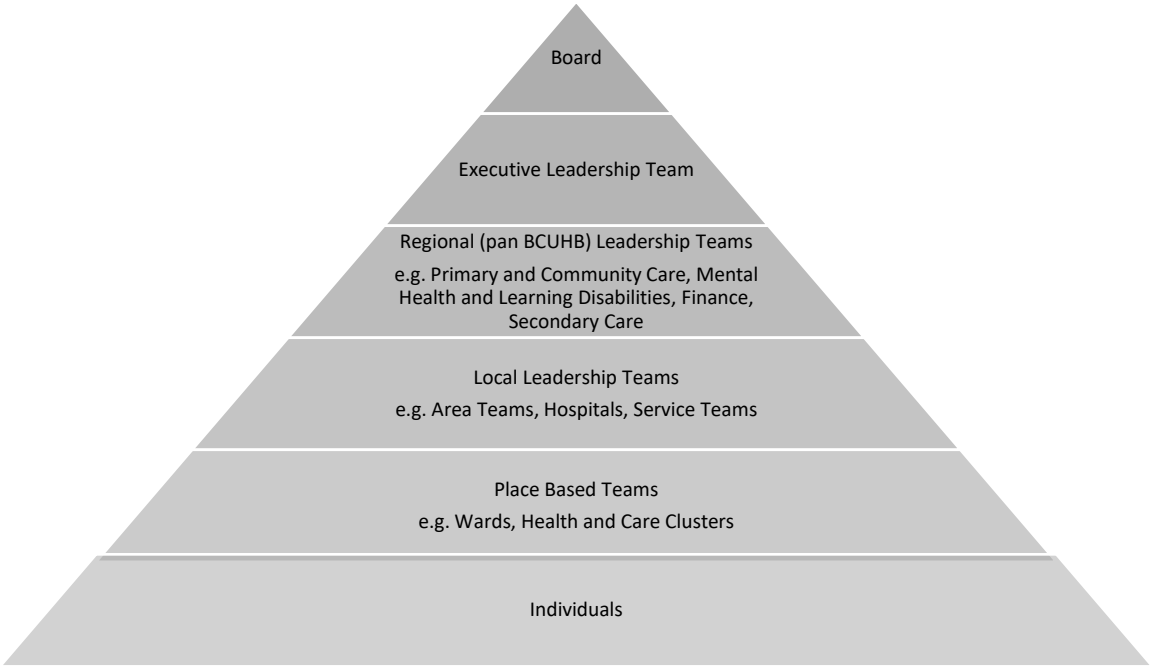
1. The Performance and Accountability Framework

1.1. What is the Performance and Accountability Framework?

The Performance and Accountability Framework sets out the means by which the Health Board can easily identify areas of excellence for wider sharing and celebration and areas where additional support may be required. It is the framework by which the Board, Executive Leadership Team, hospitals, community & primary care area leadership and specialty teams, and corporate functions are held to account for their performance.



Summary Performance and Assurance Management Cascade

This framework is designed to hold teams to account for delivery of team targets; it is aligned to the Personal and Developmental Review (PADR) process.

Team and individual objectives are aligned to the Performance and Accountability cascade outlined above:

- The Welsh Government has laid out the national Strategy for A Healthier Wales;
- The Board develops strategies that deliver for “A Healthier North Wales”:
- The Executive Leadership Team develop detailed plans to implement the strategy, clearly laying out the responsibilities of teams for delivery.
- Team plans then inform individual performance targets

1.2. What do we mean by Performance?

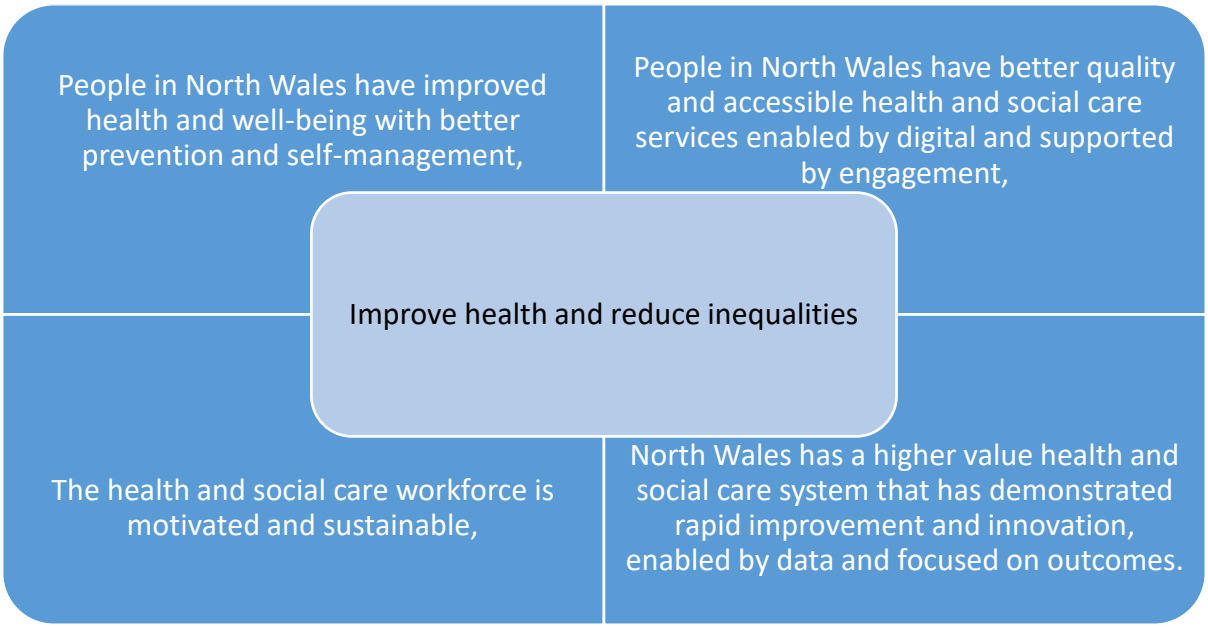
The health board seeks to provide the highest quality services to our patients; performance is a multi-faceted term and covers both **what** teams are delivering and **how** they deliver.

1.2.1. How do we measure what teams are delivering?

1.2.1.1. Outcomes for Patients

From a National perspective, our performance is viewed through four domains reflected in the NHS Wales Delivery Framework 2020-2021 (as amended from time to time):

- People in North Wales have improved health and well-being with better prevention and self-management;
- People in North Wales have better quality and accessible health and social care services enabled by digital and supported by engagement;
- The health and social care workforce is motivated and sustainable;
- North Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.



1.2.1.2. Learning and response to Covid-19

Our performance, corporately and as teams is also measured against the impact of Covid-19 on the communities we serve to avoid:

- Harm from Covid itself;
- Harm from overwhelmed NHS and social care system;
- Harm from reduction in non-Covid activity;
- Harm from wider societal actions/lockdown.

1.2.1.3. Delivery of our strategy for North Wales

Teams will have targets set to contribute to the delivery of BCUHB strategies and strategic priorities and plans.

1.2.1.4. Sustainability of Health Care in North Wales

While living within their financial allocation must be a fundamental priority for managers, the Performance and Accountability Framework is explicit in its intent that performance be managed across the four domains set out above

1.2.2. How do we measure how teams are delivering?

Performance meetings and reports will also focus on how teams deliver; this will include:

- How teams work together and support each other to deliver performance for our patients;
- How teams work with other teams to deliver joint performance targets for our patients;
- How teams work with other teams to support them deliver performance for our patients;
- Areas of excellence and learning;
- How teams develop improvement plans to address areas of non-delivery, including the quality of those plans and identification of any support required; and
- How effectively teams are proactively using the integrated governance framework to identify and manage risk, escalate issues and share learning.

The emphasis in the Performance and Accountability Framework is on recognising areas of excellence and on improving performance at all levels in the Health Board.

1.3. What do we mean by Accountability?

Accountability is about ensuring that those making decisions and delivering services are answerable for them, although the range and strength of different accountability relationships varies from function to function. Effective accountability is concerned with not only reporting on actions completed, but also ensuring that stakeholders are able to understand and respond as the entity plans and carries out its activities in a transparent manner.

2. Accountability for Performance

2.1. Accountability structure

The accountability structure replicates the cascade laid out in section 1.1 and is set out below:

1	Place based teams are **accountable to** local leadership teams.
2	Local leadership teams are **accountable to** Regional leadership teams.
3	Regional leadership teams are **accountable to** Executive Directors.
4	Executive Directors are **accountable to** the Board **via** the Chief Executive and the Board Assurance Committees.
5	The Board is **accountable to** Welsh Government.

2.2. Accountable Managers

Executive Directors, regional, local and place based leaders are considered Accountable Managers for their areas of responsibility. They are therefore fully responsible and accountable for the managing their teams and for services they lead and deliver.

Accountable Managers are required to have formal performance management arrangements in place with the individual services they are responsible for, to ensure delivery against performance expectations and targets.

2.3. What are managers accountable for?

It is the responsibility of Accountable Managers to identify proactively issues of underperformance and to act upon them promptly and to the greatest extent possible to avoid the necessity for escalation within the organisation.

- Accountable Managers and teams have responsibility and accountability for all aspects of service delivery;
- Accountable Managers and teams have responsibility and accountability for the performance of services and the outcomes for patients within their allocated budget;
- Accountable Managers and teams have responsibility and accountability in relation to the identification and management of risk;
- Accountable Managers and teams have responsibility and accountability in investigating and disseminating learning from incidents;

- Accountable Managers have responsibility and accountability to report on their team's performance, areas of excellence, development of Impact Improvement Plans or the nature of support or interventions to achieve targets.

Accountable Managers will each be provided with a budget to deliver the services set out in the Health Board's Annual Plans and in their service level Operational Plans. They are accountable for their performance in delivering against these plans, within budget and for any specified performance improvements.

Once *realistic and achievable measures for performance and performance improvement have been set and agreed*, these will form the basis for performance monitoring and management.

It is acknowledged that in a minority of cases, achieving performance against plan may not be fully within the operational control of an individual Accountable Manager. Where this is the case, Line Managers are required to clearly identify and quantify these issues and share accountability for both the Impact Improvement Plans and actions required to address these challenges. Once these issues have been identified and quantified, they will be specifically reflected within the relevant Accountability and Assurance Agreements. These shared accountabilities will be the exception rather than the rule and will not dilute the accountability of Accountable Managers for delivering on their overall budget and plan.

2.4. What is an Accountability and Assurance Agreement?

Senior managers at Executive and Regional levels are required to sign an Accountability and Assurance Agreement. These agreements, between the Chief Executive and individual Senior Managers set out the scope of what they are responsible for and against which they will be held to account including the specific budget and staffing levels to achieve the deliverables agreed and such agreement shall not be unreasonably withheld.

The Accountability and Assurance Agreement is written confirmation that Senior Managers;

- Accept responsibility and accountability for producing and delivering their operational, impact improvement, quality, governance and financial plans.
- Accept the regime of supports, interventions and sanctions set out under the Performance and Accountability Framework.

3. What is the Performance Management Structure?

The management of performance is primarily through performance conversations within teams, holding themselves to account for delivery and developing Impact

Improvement Plans as necessary, reporting and holding to account for delivery will be in line with the cascade outlined in section 1.1.

3.1. What is the Performance Oversight Group [POG]?

The Performance Oversight Group (POG) is the key performance and accountability oversight and scrutiny process for the Health Board to support the Chief Executive in fulfilling their accountability responsibilities.

It is the responsibility of the Performance Oversight Group as a part of the overall accountability process, to scrutinise the performance in all areas of the Health Board, to assess performance, understand key risks, investigation and learning from incidents and Health Board specific targets and priorities. The POG will also identify areas of excellence and best practice for sharing and dissemination.

The POG meets on a monthly basis to review performance across the Health Board.

The standing membership of the Group is the;

- Deputy Chief Executive and Executive Director of Nursing (Chair)
- Executive Medical Director
- Executive Director of Workforce and Organisational Development
- Executive Director of Planning and Performance
- Executive Director of Primary Care and Community Services
- Executive Director of Finance
- Executive Director of Therapies and Health Sciences
- Executive Director of Public Health
- Executive Director of Mental Health and Learning Disabilities
- Interim Chief Operating Officer

POG will routinely meet with each regional team individually every 3 months to hold them to account for their performance, risk and learning from incidents.

POG will decide whether to hold additional monthly or bi-monthly escalation meetings with the team where a regional or local team has one or more areas of performance at escalation level 2 or above. POG will decide whether the meeting will cover all areas of performance, risk and learning (full POG) or only those in escalation (part POG).

In addition, POG may hold thematic reviews of performance where there are similar concerns across a number of teams, or the actions of one team are adversely affecting another.

Individual Accountable Managers will be required to attend routine POG meetings and additional meetings when required for performance issues or escalation.

3.2. What other performance oversight processes will be in place?

3.2.1. Monthly Performance Review Meetings

The relevant Executive Director will hold individual Performance Review Meetings (PRM) monthly supported by two other relevant Executive Directors or their deputies and the Performance Team. The PRM will cover:

- Patient safety, quality and compliance (including key learning from incidents and events)
- Service performance against patient outcome targets
- Service performance against BCUHB strategic, tactical and operational targets
- Financial and workforce performance
- Governance (including top risks)
- Celebrating success
- Impact Improvement Plans
- Contribution to BCU corporate priorities
- Other agenda items as agreed

3.2.2. Annual Performance Review Meetings

As part of the normal POG cycle of business formal Performance Review Meetings (PRM) will be held annually, the purpose of these meetings will be to:

- Review organisational performance for the previous year against the annual Accountability and Assurance Agreements;
- Plan for the set-up of the coming year in advance of the annual Accountability and Assurance Agreements being signed.

3.2.3. Exceptional Performance Review meetings

Both the Finance and Performance Committee and the Quality, Safety and Experience Committee may request or the Chief Executive may decide to convene Extraordinary Performance Review Meetings with specific Accountable Managers and their teams where significant performance issues are identified.

3.2.4. Service level performance management processes

It is a core responsibility of each Accountable Manager to manage the delivery of services for which they have responsibility.

Each level of management is accountable for the service they manage, for which they are required to:

- Keep performance under constant review;
- Have in place a monthly performance management process that will include formal performance meetings with their teams aligned with the accountability structure;

- At these meetings agree, monitor and report on actions to address underperformance;
- Take timely corrective actions to address any underperformance emerging and develop Impact Improvement Plans;
- Assess the effectiveness of team working.

Key points
- Accountable Managers are responsible and accountable for the performance of the teams and services they manage before during and after escalation.
- Senior Managers are required to sign an Assurance and Accountability Agreement.
- Accountable Managers are expected to have in place, a monthly performance management process that will include formal performance meetings with their next line of managers aligned with the accountability structure.
- Monthly Performance Review Meetings will be led by an Executive Director, supported by relevant Executive Directors or their deputies and the Performance Team
- POG is responsible for monitoring and scrutinising performance and will hold performance review meetings on a risk based approach

4. Describing performance expectations and reporting

4.1. Describing performance expectations

4.1.1. National

NHS Wales Delivery Framework 2020-2021 is in effect the annual contract, setting out the type and volume of services, between the Health Board and the Welsh Government, against which the Health Board's performance is measured.

Headline indicators for the health service performance are captured in the framework, which represents performance through four domains. The four domains are set out in section 1.2.

4.1.2. Corporate

The Board's Annual Plan sets out the strategic direction of the Health Board as well as the framework for managing risks and learning from incidents.

4.1.3. Operational Plans

Detailed operational plans at service levels are developed to give effect to the priorities set out in the Annual Plans.

4.2. Reporting on performance

4.2.1. Monthly Performance Information:

Monthly performance information is provided to Accountable Managers and the POG for oversight of performance and use in internal performance meetings.

4.2.2. Monthly Performance Profile

A monthly Performance Profile is produced setting out monthly performance against the National and Corporate targets. The Profile forms the basis of the POG performance oversight process.

4.2.3. Monthly Performance Report

Relevant performance reports will be compiled and presented to the Quality, Safety and Experience Committee, the Finance and Performance Committee and the Board and published on the Health Board's web site.

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Key points

- The Operational Plans set out the performance priorities and targets for the year.
- Performance information is produced on a monthly basis.

5. The Performance Escalation process

5.1. Escalation

Under the Performance and Accountability Framework, there is provision for the formal escalation of teams that are not achieving performance expectations.

Escalation reflects an increased level of concern in relation to performance that requires more intense focus, action and scrutiny in order to bring about improvement.

Underperformance also includes performance that:

- Harms patients or service users;
- Does not meet the required standards or targets for that service;
- Departs from what is considered normal practice;
- Derives from ineffective team or joint working.

5.2. The levels of escalation

Performance management and the operation of the Performance and Accountability Framework is expected to be a process managed primarily at the level of the relevant Accountable Manager.

Level 0 Accountable Manager	**Steady state** Performance is being achieved against plan.	Performance subject to routine performance monitoring by the

		relevant Accountable Manager
Level 1 Accountable Manager	**A variance emerges.** A variance from plan is identified and intervention and support in response to early signs of difficulty is managed at an Accountable Manager level	A decision to escalate an area of underperformance in individual services under their remit is made by the Accountable Manager
Level 2 Executive Director	**The problem persists**. It becomes harder to fix and potentially spreads or affects other areas / teams of the Health Board. Intervention and support are required.	A decision to escalate an area of underperformance by the relevant Executive Director.
Level 3 POG	**The problem becomes critical or where prolonged underperformance puts quality, safety and financial sustainability at risk**. The performance issue persists and the Accountable Manager has been unable to reverse underperformance. Significant intervention is required.	A decision to escalate an area of underperformance is made by the POG. External supports, interventions or sanctions may be required.
Level 4 Board	**Significant governance or organisational risks are identified that affect the functioning or reputation of the Health Board** The actions determined by POG do not achieve the necessary impact Board action may be required	A decision to escalate the significant governance or organisational risks is made by the Chief Executive

The levels of escalation **do not** necessarily indicate the seriousness of a particular performance issue but rather the need for the organisational response to be led at a more senior level. This may reflect either the capacity or capability of other levels to manage the improvements required. For example, performance issues at LEVEL 1 may be as serious as performance issues at LEVEL 4; however, there is confidence that the relevant Accountable Manager is managing these issues appropriately.

5.3. Escalation where remedial actions do not work

Where remedial action is not possible or is not achieving the required correction, it must be discussed with the next level of management for the purpose of further advice, support or intervention as necessary. Managers in the first instance will be responsible for initiating corrective actions.

The Performance and Accountability Framework envisages that performance issues may be escalated to a more senior level of management where;

- There are concerns that the appropriate level of management are not taking the appropriate actions to address underperformance;
- There is a lack of engagement by teams or managers with the performance improvement process;
- The actions required to address underperformance lie outside of the control of Accountable Managers.

When an area of performance has been escalated, primary responsibility for managing performance remains with relevant Accountable Manager unless this authority has been removed.

Key points

- Corrective actions should be taken as soon as underperformance is identified.
- Where remedial actions do not work, an Impact Improvement Plan will need to be put in place.
- The Performance and Accountability Framework envisages that performance issues may be escalated by a more senior level of management where specific conditions are met.

5.4. Is escalation primarily the responsibility of the Executive Director or POG?

No. Performance is expected to be managed on a day-to-day basis by Accountable Managers. Managing performance requires managers to review performance data and meet formally with their teams on at least a monthly basis to review performance and decide upon actions to address variances in performance.

Levels 1 and 2 escalations should be the first line of the performance escalation process and lie within the responsibility of the Accountable Managers.

5.5. When is escalation by the Executive Director triggered?

The Executive Director triggers Level 3 Escalation when there is:

- A serious concern related to service delivery, quality and safety of care and/or organisational effectiveness or financial performance arises.
- When other levels of management responsible for performance levels have failed to reverse underperformance.

5.6. When is escalation to Board triggered?

Level 4 Escalation to or by the Chief Executive is expected to be a very rare occurrence. It will be triggered where significant governance or organisational risks are identified that are expected to severely affect the functioning or reputation of the health service.

5.7. What are the 'thresholds' for escalation?

Thresholds for performance escalation will be agreed by the POG. These thresholds **do not** indicate an automatic escalation of services. They merely act as a trigger for review of specific areas of performance. A decision in relation to escalation is based on the outcome of this review of performance at the appropriate level.

For example, two services may have the same performance levels, one is not escalated because there is confidence that the actions being undertaken to address underperformance are adequate, while another service may be escalated as the actions being taken are inadequate, or are not achieving the required improvement in performance.

These thresholds combine a specified variance from target at a point-in-time as well as a specified timeframe over which underperformance has been noted. This means that in most cases an in month variance may not be a cause for concern, whereas the variance continuing over three months may be. Details are set out in Appendix 2.

5.8. Is Board level escalation invoked regularly?

No, it should be the exception that the Chief Executive invokes the formal escalation process to Board level.

In some cases, issues may be escalated to Board because the resolution of the performance issues lies outside of the control of an individual Accountable Manager or because an organisation does not have the capability / expertise available locally to fully solve the issues.

5.9. What happens when performance is escalated by the POG?

The POG will seek assurance that services are delivering against performance priorities and targets. The POG will explore whether appropriate and timely remedial actions are being taken to address areas of underperformance.

The POG will:

- Identify areas of underperformance,

- Require a formal diagnostic to be undertaken to assess whether a service is underperforming or whether there are factors outside the control of the service or team that are affecting performance levels.
- Require additional remedial actions to be put in place or an Impact Improvement Plan to be developed.
- Commission an external performance or governance review
- Provide assurance to the Board on performance outcomes and performance management processes.
- Recommend specific courses of action to the Board as appropriate.

5.10. Does escalation mean individual managers are no longer responsible or accountable?

No. In instances where underperformance has been escalated this;

- **Does not** mean the transfer of responsibility or accountability to a higher level of management;
- **Does not** remove or dilute the full accountability and responsibility of the Accountable Manager or their team nor does it alter their responsibility or accountability;
- **Does** provide for a graduated response to underperformance that may take the form of support, intervention or sanction;
- **In exceptionally rare circumstances, escalation to level 3 or 4 may mean that responsibility / reporting lines for a particular service will be changed to ensure effective and speedy action is initiated in response to the problem.**

5.11. Is all underperformance treated in the same way?

No. It is expected that there will be a differentiated response taken to performance by ensuring that individual services that contribute to underperformance are clearly identified and that high performing services will not automatically be the subject of escalation actions. Poor performance will be addressed through the agreement and implementation of explicit, time bound actions and more rigorous performance management of the specific services where the underperformance lies.

The Board is committed to providing support to managers and services who are struggling to achieve improvements. This support and any form of escalation must however always enhance rather than remove or blur individual or team accountability and avoid diffusing responsibility or passing it upwards.

Consequences or sanctions will be considered if reasonable improvement is not achieved and further detail is set out in Sections 6.4 to 6.6 below.

5.12. What is an Impact Improvement Plan?

Where significant and sustained underperformance has been identified and where remedial actions have not been successful, the POG may request the

development of an Impact Improvement Plan. The Plan will be required at a minimum to contain the following elements.

- A full analysis and diagnostic identifying the reasons for poor performance.
- Detailed actions for improving performance. These actions should be specific and measureable.
- The planned improvement trajectory, with targets set out by month and showing how long it will take to achieve the national target or the desired level of improvement as determined by POG. This information together with the agreed improvement actions will be used to assess the success of the Plan.
- Actions will have clear, named owners who will be accountable for delivering on the actions.
- The plan may also describe how the Board's Performance and Accountability Framework will be invoked where actions are not delivered and performance does not improve in line with the Plan.

5.13. When is an issue deescalated?

Escalation **is not** intended to be an end in itself. Performance issues should be in escalation for as short a period as possible. Services are not escalated or deescalated based on a single month's performance and the period of escalation will vary from issue to issue.

It is expected that performance areas will be deescalated as soon as the actions taken to address them are shown to be achieving the desired result. Therefore, escalation is only sustained until:

- There is a return to the required performance level or,
- There is a credible Impact Improvement Plan in place and,
- The trajectory of improvement is being sustained over an agreed period.

Key points

- Performance is expected to be managed on a day to day basis by managers
- There are 4 levels of escalation. It is expected that the majority of performance issues will be managed at Level 1.
- Thresholds for performance escalation will be agreed by POG with decisions on the appropriate level of escalation made through Accountable Managers, Executive Directors and/or POG.
- Where underperformance has been escalated, this does not mean the transfer of responsibility or accountability to a higher level of management.
- Poor performance will require explicit, time bound actions and more rigorous performance management of the specific services where the underperformance lies.
- Where a service or service issue has been escalated, Accountable Managers are expected to ensure that managers reporting to them are

notified that the issue is the subject of escalation and that the appropriate remedial actions are being taken and monitored.
- Where remedial actions have not been successful, the POG may request the development of an Impact Improvement Plan.

6. The consequences of escalation

6.1. What happens if performance does not improve?

Accountable Managers are required to ensure that a graduated and appropriate regime of;

- Support,
- Intervention and
- Sanction, is in place for managers and services where performance does not improve.

6.2. What support is available?

Where remedial actions are not working sufficiently to address underperformance, Accountable Managers may need to put in place additional support for teams reporting to them. Similarly, Accountable Managers may also seek support from their line manager, support may include:

- Assistance to form the Impact Improvement Plan including diagnosis, actions, milestones and timelines
- Specialist resources to work with them and their teams.
- Mentoring and advisory support

In cases where additional supports are provided, the Accountable Manager or manager will be required to reaffirm their agreement to and ability to meet the commitments set out in their Accountability and Assurance Agreement or operational plan.

The Accountable Manager to whom support is being provided will be expected to meet with their line manager on a regular basis in line with what is considered appropriate in terms of timescales agreed as part of any improvement plan.

6.3. What do you mean by interventions?

If following on-going monitoring and support, performance does not improve, or where plans are not being delivered, the relevant Accountable Manager, Executive Director, or Chief Executive may put specific interventions in place. These interventions may include:

- Enhanced monitoring through formal review meetings with the relevant line manager.
- Additional controls being put in place.
- Setting out the explicit performance requirements, arrangements for monitoring and consequences where performance does not improve.

- Commissioning of an external improvement initiative, performance or governance diagnostic review.
- Performance meetings with the Executive Director, or Chief Executive culminating in a set of performance expectations and requirements. These may be additional improvement actions and expectations, supports, interventions or sanctions.

6.4. What type of sanctions can be applied?

While the focus of the Escalation process will be on supporting managers to improve performance, the Performance and Accountability Framework also provides for sanctions to be applied in the case of continued underperformance where despite remedial plans, supports and interventions being in place, performance does not improve. Sanctions can be applied at both the team level and the individual level.

6.5. What type of organisational level sanctions can be applied?

6.5.1. Service Level

In the first instance, sanctions may be applied to services, that is individual area teams, hospitals, or corporate functions where performance does not improve after appropriate supports and interventions are taken. These sanctions could include the following.

- A formal Performance Notice will be issued to the relevant service from the appropriate Accountable Manager. Performance notices will specify the reason for the notice, the performance improvement expectation, timeframe, accountability arrangements and consequences where there is insufficient improvement.
- An Impact Improvement Plan will be required.
- A decision to issue any Performance Notice must be ratified by the POG.

Performance Notices signal a significant level of concern in relation to the delivery of performance improvement. As such, they should be issued sparingly. All normal performance management processes should be exhausted first.

6.5.2. Publication of Performance Notices

Performance Notices issued will be reported on to the Board in public session

6.6. What type of individual level sanctions can be applied?

6.6.1. Performance / Capability Process

Where there has been no improvement in performance within the specified timeframe and where organisational support and interventions do not result in improved performance, this is likely to become a matter of personal performance for named managers or team members.

In these cases, the All Wales Pay Progression Policy and / or the All Wales Capability Policy may be invoked (for the latest versions please see the BCUHB intranet pages).

Key points

- A graduated and appropriate system of supports, interventions and sanctions are in place for managers and services where performance does not improve.
- Where remedial actions are not working sufficiently to address underperformance, Accountable Managers may need to put in place additional supports for managers.
- If following on-going monitoring and support, performance does not improve, or where plans are not being delivered, specific interventions may be put in place.
- While the focus of the escalation process will be on supporting managers to improve performance the Performance and Accountability Framework also provides for sanctions to be applied in the case of continued underperformance.
- In the first instance, sanctions may be applied to services, where performance does not improve.
- The issuing of Performance Notices is an important part of the escalation process. Performance Notices can normally only issued once they have been ratified by the POG
- Where there has been no improvement in performance this is likely to become a matter of personal performance for named individuals.

7. The consequences of excellence

In the same way that poor performance is recognised, excellence should also be recognised for teams and individuals. At each regular meeting, where appropriate, the POG will identify an area of outstanding excellence to be reported to the Board, the Chair of the Board and the Chief Executive will jointly send a letter of commendation to the relevant team.

Areas of outstanding excellence will be aligned to our values:

7.1. Put Patients first:

- Outstanding levels of patient care;
- Delivered Transformation programmes that enable re-investment in patient care.

7.2. Work together:

- Outstanding team or partnership working improving outcomes for patients.

7.3. Value and respect each other:

7.4. Learn and innovate:

- Improvements in care leading to significant improved outcomes for patients.

7.5. Communicate openly and honestly:

Consideration will be given to creating a formal Reward and Recognition programme.

Appendix 1: NHS Delivery Measures

Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management	
People will take responsibility, not only for their own health and well-being, but also for their family and for people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and well-being throughout their whole lives. It will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.	• Percentage of babies who are exclusively breastfed at 10 days old • Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1 • Percentage of children who received 2 doses of the MMR vaccine by age 5 • Percentage of adult smokers who make a quit attempt via smoking cessation services • Percentage of those smokers who are CO-validated as quit at 4 weeks • European age standardised rate of alcohol attributed hospital admissions for individuals • resident in Wales (episode based) • Percentage of people who have been referred to health board services who have • completed treatment for alcohol misuse • •Uptake of influenza vaccination among: 65 year olds and over; under 65s in risk groups; • pregnant women and; health care workers • •Uptake of screening for bowel, breast and cervical cancer • Percentage of health board residents in receipt of secondary mental health services who • have a valid care and treatment plan (for those age under 18 years and 18 years and over) • Percentage of people in Wales at a GP practice (age 65 years and over) who are estimated to have dementia that are diagnosed

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	
There will be an equitable system, which achieves equal health outcomes for everyone in Wales. It will improve the physical and mental well-being of all throughout their lives, from birth to a dignified end. Services will be seamless and delivered as close to home as possible. Hospital services will be designed to reduce the time spent in hospital, and to speed up recovery. The shift in resources to the community will mean that when hospital based care is needed, it can be accessed more quickly.	• Qualitative report detailing evidence of advancing equality and good relations in the day to day activities of NHS organisations • Qualitative report detailing the achievements made towards the implementation of the all Wales standard for accessible communication and information for people with sensory loss • Qualitative report detailing the progress against the 6 actions contained in the Learning Disability – Improving Lives Welsh Government Programme • Qualitative report detailing progress against the 5 standards that enable health and wellbeing of homeless and vulnerable groups to be identified and targeted • Number of patients with Hepatitis C who have successfully completed their course of treatment in the reporting year • Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS • Percentage of children regularly accessing NHS primary dental care within 24 months • Percentage of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being answered • Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes • Number of ambulance patient handovers over 1 hour • Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge • Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge • Percentage of survival within 30 days of emergency admission for a hip fracture • Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time • Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours of the patient's clock start time • Percentage compliance against the therapy target of an average of 16.1 minutes of speech and language therapist input per stroke patient • Percentage of stroke patients who receive a 6 month follow-up assessment • Percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of decision to treat

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable.	
New models of care will involve a broad multi-disciplinary team approach where well-trained people work effectively together to meet the needs and preferences of individuals. Joint workforce planning will be in place with an emphasis on staff expanding generalist skills and working across professional boundaries. Strategic partnership will support this with education providers and learning academies focused on professional capability and leadership	• Average rating given by the public (age 16+) for the overall satisfaction with health services in Wales • Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care provided by their GP/family doctor • Qualitative report providing evidence of implementing actions to deliver the Welsh language objectives as defined in the More Than Just Words Action Plan • Overall staff engagement score • Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training) • Percentage of staff who have had a performance appraisal who agree it helps them improve how they do their job • Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation • Qualitative report providing evidence of learning and development in line with the Good Work – Dementia Learning and Development Framework • Percentage of sickness absence rate of staff • Percentage of staff who would be happy with the standard of care provided by their organisation if a friend or relative needed treatment • Evidence of how NHS organisations are responding to service user experience to improve services • Percentage of complaints that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the complaint was first received by the organisation

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	
Delivering higher value in health and social care will focus on outcomes that matter to the individual and making our services safe, effective, people centred, timely, efficient and equitable. This will bring the individual to the fore and consider the relative value of different care and treatment options, in line with Prudent Health. Research, innovation and improvement activity will be brought together across regions – working with RPBs, universities, industries and other partners. Alignment of funding streams and integrated performance management and accountability across the whole system will be in place to accelerate transformation through a combination of national support, incentives, regulation, benchmarking and transparency.	• Number of patients recruited in Health and Care Research Wales clinical research portfolio studies • Number of patients recruited in Health and Care Research Wales commercially sponsored studies • Crude hospital mortality rate (74 years of age or less) • Percentage of deaths scrutinised by a medical examiner • Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within 1 hour of positive screening • Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within 1 hour of positive screening • Percentage of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours • All new medicines recommended by AWMSG and NICE, including interim recommendations from cancer medicines, must be made available where clinically appropriate, no later than 2 months from the publication of the NICE Final Appraisal Determination and the AWMSG appraisal recommendation • Total antibacterial items per 1,000 STAR-PUs (specific therapeutic age related prescribing unit) • Number of patients age 65 years or over prescribed an antipsychotic • Number of women of child bearing age prescribed valproate as a percentage of all women of child bearing age • Opioid average daily quantities per 1,000 patients • Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product including biosimilar (for a selected basket of biosimilar medicines) • Percentage of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months • Percentage of critical care bed days lost to delayed transfer of care (ICNARC definition) • Number of procedures postponed either on day or the day before for specified nonclinical reasons • Agency spend as a percentage of the total pay bill • Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme

Appendix 2 – Performance Oversight, Escalation and Thresholds

Level 3 Escalation

Level 3 escalation is subject to oversight and intervention by the Executive Director

The Performance Oversight Group will review performance if:

- Performance is reported to be more than 5% away from target / expected activity (YTD) over a period of 3 consecutive cycles or more and /or
- Performance that is outside the parameter set out above will result in a review of the performance results. A decision to escalate to Level 3 will be based on this review of performance.

Level 4 Escalation

Level 4 escalation is subject to intervention by the Board.

Level 4 escalation will be considered if there is a significant governance or organisational risk.

The Chief Executive with POG will base consideration whether to recommend Level 4 escalation, on an assessment.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 28/09/21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Annual Declarations of Interests/Gifts and Hospitality for 2020/21
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Karl Woodward, Head of Counter Fraud in relation to a review of Gifts and Hospitality Declarations
Atodiadau Appendices:	Appendix 1: Board Members' Declarations Appendix 2: Gifts and Declarations

Argymhelliad / Recommendation:

That the Audit Committee receives the report.

Please tick 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 annual update is provided in order to comply with Standing Orders 8.1 – 8.7.

Cefndir / Background:

All Board Members must declare at least annually any personal or business interests which may affect, or be perceived to affect the conduct of their role. This includes any interests held by family members or bodies with which they are connected. Local Health Board (LHB) Officers (senior staff and staff of any grade deemed to be in a position of influence where conflicts of interest may arise) are also required to submit a declaration at least annually, even if a nil return. All Board Members and staff must also declare any gifts or hospitality as per the OBS02 Standards of Business Policy.

An electronic system was introduced in 2016 to record declarations of interests, gifts and hospitality and rolled out across the Health Board. The electronic forms contain the Internal Audit recommended counter-fraud statement. In the case of Board Members, submitted declarations of interests are required to be published and documented within the Annual Report in line with the commitment to openness and transparent governance. Board Members' submitted declarations of interests for the 2020/21 period are documented in Appendix 1 and are included within the Annual

Report. During meetings, Board Members are also obliged to declare any ad-hoc potential conflicts of interest as and when they arise, and this is recorded in the relevant Board/Committee minutes.

In terms of the wider organisation, staff at Band 8C and above (or equivalent pay where staff are not on A4C pay grades) are required to complete a mandatory declaration of interests form (even if this is a nil return) on an annual basis. In addition, and in line with recommendations from previous audits, staff at Band 7 and above who are in a position to influence the purchasing of goods and services as well as fostering relationships with external organisations are required to submit declarations. In certain circumstances, this principle could also apply to any staff regardless of pay band, should their role make it appropriate for them to be deemed to have LHB Officer status as referred to above.

Governance Leads are assigned for Directorates and declarations of interests are routed through these leads for approval/escalation. Following on from the recommendations in a previous audit, all gifts and hospitality declarations are now also routed to the Office of the Board Secretary.

A copy of the electronic gifts and hospitality register for the period 1 April 2020 to 31 March 2021 is attached at Appendix 2. Declarations made with a value of £25 or below have not been included as the policy sets the threshold at any gift with an estimated value over £25. All declarations have also been reviewed by the Head of Counter Fraud.

Members will be aware that following the introduction of the electronic system there has been a continuous drive to increase the compliance figures for declarations of interests. It is pleasing to note an improvement of last year's figures which were up by 18% on the previous year (58% compared with 40%). However further action is being taken to ensure that compliance levels are improved further during the current year.

Asesiad / Assessment & Analysis

Strategy Implications
This report is purely administrative. There are no associated strategy implications.

Financial Implications
Scrutiny of this annual return (undertaken by Counter Fraud, Office of the Board Secretary and the Audit Committee) supports the mitigation of governance/financial risks associated with conflicts of interest and enables the Audit Committee to review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

Risk Analysis
This report is purely administrative. There are no associated risks.

Legal and Compliance
Compliance with Standing Order 8.1 - 8.7

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

30. Related Party Transactions (Continued)

All Board Members are required to submit an annual Declaration of Interests covering the following seven areas:

- Interest in a company which may compete for an NHS contract to supply goods and services to Betsi Cadwaladr University Local Health Board
- Any self-beneficial interest in a private care home, hostel or independent health care provider
- Any relevant outside employment, including self employment, whilst employed by the Health Board
- Interest in the Pharmaceutical Industry or Allied Commercial Sector
- Personal links to, or relationships with, individuals in local or national government / AMs / MPs
- Councillorships, Directorships or any other relevant position
- Any other matters to declare (including issues relating to personal relationships and maintaining clear professional boundaries)

Declarations are also required where an individual Board member does not have any interests to declare.

The following tables details all interests declared by Board Members during the 2020-21 financial year including any material transactions with related parties.

Name	Details of positions held during the financial year (or part thereof)	Dates positions held	Declarations made
Directors / Executive Directors			
S Dean	Interim Chief Executive	01.04.20 - 31.08.20	Seconded civil servant employed by Welsh Government.
Prof A Guha	Interim Executive Medical Director	21.09.20 - 31.03.21	Chair or the Wirral Asian Association, that promotes the culture and heritage of people of Asian heritage. The Charity also works for the community at large. Sits on a number of key committees at Health Technology Assessment Wales, All Wales Medical Strategy Group and Health Education and Improvement Wales.
L Singleton	Acting Associate Board Member Director of Mental Health & Learning Disabilities	01.04.20 - 01.06.20	Husband is the owner of Gwynedd Forklifts and GFL Access.
D Sharp	Acting Board Secretary	01.04.20 - 10.01.21	Partner is employed by Mold Town Council as Town Clerk and Financial Officer.
A Thomas	Executive Director of Therapies and Health Sciences	01.04.20 - 31.03.21	Spouse is employed by Boots UK as an Accuracy Checking Technician. Son is employed by the Health Board.
Independent Members			
M Polin OBE QPM	Chair	01.04.20 - 31.03.21	Spouse is employed by the Health Board as a Health Visitor.
L J Reid	Independent Member and Vice Chair	01.04.20 - 31.03.21	Committee Chair for the Primary Care Appeals Service of NHS Resolution. Employed by regulatory body, Care Quality Commission as a Special Advisor. Justice of the Peace for HMCTS, North Wales Central. Director of Anakrisis Ltd which provides specialist training and advisory services to NHS England Married to a GP in Denbighshire.
Prof N Callow	Independent Member	01.04.20 - 31.03.21	Pro Vice-Chancellor Learning and Teaching and Head of College of Human Sciences, Bangor University
Cllr C Carlisle	Independent Member	01.04.20 - 31.03.21	County Councillor, Conwy County Borough Council. Cabinet Member for Children, Families and Safeguarding, Conwy County Borough Council. Member of the Child Adoption Panel, Conwy County Borough Council.
J Cunliffe	Independent Member	01.04.20 - 31.03.21	Director of Abernet Ltd. Member of the Joint Audit Committee, North Wales Police and Crime Commissioner.
J F Hughes	Independent Member	01.04.20 - 31.03.21	One daughter is employed by the Designed to Smile service in the Health Board. One daughter is employed by District Nursing teams in the Health Board. One daughter is employed by WRVS based in Ysbyty Gwynedd.
Cllr R Medwyn Hughes	Independent Member	01.04.20 - 31.03.21	Director of Meditel Limited. Local Authority member, Gwynedd County Council. Member of the Care Scrutiny Committee and the Audit and Governance Committee at Gwynedd County Council. Bangor City Councillor.
H E Jones	Independent Member	01.04.20 - 31.03.21	Member of Gwynedd Pension Board. Justice of the Peace for North West Wales bench. Member of Adra (Tai) Cyfyngedig/Housing
L Meadows	Independent Member	01.04.20 - 31.03.21	Trustee of Wirral Hospice St John's, in a voluntary capacity.
L Tomos CBE	Independent Member	22.10.20 - 31.03.21	Trustee and Board Member, Books Council of Wales
H Wilkinson	Independent Member	01.04.20 - 23.11.20	Chief Executive, Denbighshire Voluntary Services Council. Wales Committee Member of the National Lottery Community Fund.
Associate Board Members			
M Edwards	Associate Board Member	01.04.20 - 31.03.21	Corporate Director and Statutory Director of Social Services at Gwynedd Council. Lead Director for ADSS Cymru on the Welsh Language. Member of the Welsh Language Partnership Board. Chair of the Regional Integrated Commissioning Board. Member of the Regional Partnership Board.
G Evans	Associate Board Member	01.04.20 - 31.03.21	Member of the Welsh Therapy Advisory Committee (WTAC). Member of the National Joint Professional Advisory Committee. Spouse is employed by the Health Board.
Ff Williams	Associate Board Member	01.04.20 - 31.03.21	Chief Executive of Adra (Tai) Cyfyngedig/Housing Association.

No other Health Board members who served during the 2020-21 financial year disclosed any related party interests.

ID	GiftOrHospitality	JobTitle	DonorType	OfferType	OfferDescription	Value	EmployeeAction	SubmissionDate
10463	Gift	Health Play Specialist / Ty Enfys	A company	Other	EASTER EGGS X 50 DONATED TO AWYR LAS. 10 GIVEN TO THE CHILDRENS WARD	50	Accepted	19/04/2020 15:17
10465	Gift	Health Play Specialist / Ty Enfys	A company	Other	TOILETRIES FOR BABIES WIPES TALC . ALCOHOL AND CHOCS FOR STAFF	60	Accepted	19/04/2020 15:22
10466	Gift	Health Play Specialist / Ty Enfys	A company	Other	EASTER EGGS AND BOOKS	50	Accepted	19/04/2020 15:25
10467	Gift	Ward Manager	A company	Electrical goods Food/drink Voucher	Microwave x 2, Kettle x 2, Coffee Machine x 2. Various food and drink items, handwash and £100 voucher for staff use to replenish tea/coffee etc. Donation was requested by ASDA staff to be given directly to all staff on the paediatric ward.	730	Accepted	28/05/2020 14:59
10471	Gift	Fundraising Support Manager	An individual	Food/drink	Members of the public donated wine, beer and alcopops to YGC during COVID-19 on various dates. These were stored in the General Manager's office until they were collected by representative of the Awyr Las Support Team on 20/08/20. An itemised list has been added to the Harlequin database. They will be taken to YG where they will be stored in a locked container. Dates below for offer / acceptance are approximate.	367.98	Accepted	20/08/2020 17:40
10472	Gift	Consultant Clinical Psychologist	An individual	Art or Ornament	Patient bought decorative items/gifts for the office to brighten the space. Spoke to Deputy Board Secretary about how important it is for the patient to see the items in the building.	100	Accepted	10/09/2020 13:41
10473	Gift	Senior Pharmacist	An individual	Cash	£30 cash received in a thank you card to cancer centre pharmacy staff. Patient was thanking staff for all their help and expertise during their admission on Enfys ward. They enclosed a gift of £30 for a treat now or towards Christmas party. We thought it was just a thank you care and did not know a cash gift was inside until opened.	30	Accepted	11/09/2020 8:18
10475	Gift	Assistant Director For Pharmacy (central)	A company	Discounted good/services	CONNECTED AUTOMATED temperature monitoring for medicine/ vaccine fridges (CAM+) – TEMPORARY COVID-19 FACILITY FOR PHARMACY, LLANDUDNO This is not a personal gift but to BCUHB. Approved by DOF and procurement.	5000	Accepted	02/11/2020 17:22
10477	Hospitality	Associate Specialist	A company	Accommodation . Conference/meeting delegate place . Travel Costs	Attendance at a weekend educational meeting relevant to dermatology was proposed. I had accepted & was set to travel to Barcelona for the meeting but there was a fault in the aircraft so I did not actually go. The pharmaceutical company paid £65 for the transfer from my home to Manchester airport.	65	Accepted	10/11/2020 18:46
10479	Gift	Consultant Physician/cote	An individual	Cheque	Donations in memory of a patient - several individuals, totalling £1530, paid into Awyr Las Parkinsons fund as requested by the donators on 21/1/2020.	1530	Accepted	20/11/2020 16:45
10480	Gift	Consultant Physician/cote	An individual	Bequest	£10000 left to the Awyr Las Parkinsons Fund in the will of the above patient, to be used for the benefit of local Parkinsons patients, and sent to us by the will executor.	10000	Accepted	20/11/2020 16:51

10481	Gift	PA To The Site Director Of Nursing - East	A company	Food/drink	Cheese and Biscuit hampers x 4 received from company Remedium RE: Recruitment for the A&E department. donation made to the Wrexham Foodbank on the 01.12.2020	80	Declined	27/11/2020 15:25
10483	Gift	Physiotherapist	An individual	Cash	Thankyou card in addressed envelop accepted by colleagues in my absence. On opening the card found to have £150:00 cash inside. Informed my line manager for advise as similar amounts shared also with OT & ward staff. Request made for money to be used for Stroke related equipment as was identified by the family on my thanks.	150	Accepted	08/12/2020 16:23
10486	Hospitality	Consultant Clinical Oncologist	A company	Conference/meeting delegate place	San Antonio Breast Cancer Symposium 2020. They sponsored the registration for the online conference	500	Accepted	12/03/2021 18:24
10488	Hospitality	Consultant Physician	A company	Accommodation Conference/meeting delegate place Meal Travel Costs	I was invited speaker at the international Society for Rapid Response Systems annual congress on the 18th and 19th of April 2019. Hotel and flights were paid. I did also teach on a course for healthcare staff from Singapore on the 17th of April and attended a learning event with Philips Healthcare for their staff in Singapore.	3000	Accepted	21/03/2021 8:48

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	General Dental Services Assurance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director Primary and Community care
Awdur yr Adroddiad Report Author:	Tony Benton, Senior Dental Contracts Manager
Craffu blaenorol: Prior Scrutiny:	The report has been seen and approved by Bethan Jones, Area Director Centre
Atodiadau Appendices:	Appendix 1 - North Wales Dental Services: Local Management Procedure For the Reporting of Dental Fraud

Argymhelliad / Recommendation:

The Audit Committee is asked to note that;

- Dental Contracts continue to be monitored for delivery and performance across four key areas of service provision – Quality, Finance, Access & Activity;
- The Covid pandemic has, and continues to impact significantly on service provision by primary care dental providers to the extent that the metrics previously used to monitor activity (UDA) are no longer valid and have effectively been discontinued;
- Welsh Government (WG) have developed and introduced a set of “expectations” for the Health Boards and contractors to work toward and achieve during the recovery phase of the pandemic;
- The “expectations” provide a broad framework for the Health Board to engage with contractors to deliver dental services in accordance with WG and Health Board aims and priorities, however, the expectations are not written into the General Dental Service (GDS) regulations/legislation and accordingly are applied by the HB in a supportive rather than punitive manner
- Contractors who are unable or unwilling to meet the “expectations” will be considered for a contract payment adjustment by the Dental Contracting Team on behalf of BCUHB;
- Contractors retain the right to revert to the UDA system and be monitored and paid in accordance with their performance on that system.

Ticiwch fel bo’n briodol / 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**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

The report does not relate to a 'strategic decision', no Equality Impact (EqIA) and a socio-economic (SED) impact assessment required.

Sefyllfa / Situation:

The purpose of this report is to outline the current position regarding assurance and verification processes relating to the delivery of and payment for primary care dental services.

Cefndir / Background:

Historically, dental services have been commissioned, monitored and reported on across four main areas of service delivery, namely; Quality, Finance, Access and Activity.

The below table provides a broad overview of the main vehicles available and used by the Health Board to monitor and report on each area:

Reporting Area	**Monitoring/Assurance Vehicle**	**Overview Description**
Quality	Quality Assurance Scheme	Annual self-assessment return completed by each contractor and reviewed by the Health Board
	Health Inspectorate Wales (HIW) Practice Inspection	Physical compliance inspection undertaken by HIW on a 5 year rolling programme
	Record Card Reviews	Dental Reference Service (DRS) Review of records to report on: - Standard of record card keeping - Standard or radiographs - Standard of clinical care - Regulatory compliance and claim probity - NHS administration
	BCUHB Quality Assurance Practice Visit	Support and assurance visit by relevant Health Board officers to provide support and guidance as/when appropriate
Finance	GDS Contract	An individual contract agreed and signed by both parties (BCUHB and contractor) for the payment of a specified amount for the delivery of specified services
	Compass	A electronic contract payment and administration system administratively managed by NHS Wales Shared Partnership (NWSSP) on the behalf of health boards to ensure separation of request/input/authorisation

	Statement of Financial Entitlements	Instrument for determination of eligibility for and the setting of payment amounts made to contractors
Access	eDEN (business monitoring tool)	Reports provided on a monthly basis detailing number of patients seen and treatments provided
	Electronic Referral Management System (ERMS)	Real time reports on referral numbers, patterns and clinicians
	Dental Helpline	Reports on numbers and location of patients seeking urgent dental care and unable to access a high street dental practice
Activity	eDEN	Reports provided on a monthly basis detailing quantities of services provided
	NHS Business Services Authority (NHSBSA) Reports	Regular and one-off reports detailing levels of service provision and identifying outliers
	Contractor Declarations	Individual contractor declarations of compliance with specific requirements/expectations

The impact of the Covid pandemic on the above assurance monitoring methods and process has been greatest for those used to monitor Activity.

Units of Dental Activity (UDA) as a metric to monitor performance against a “hard” target was suspended in April 2020 and remains out of use. In its place, Welsh Government (WG) developed and introduced of a series of “expectations” to provide guidance and direction for Health Boards and contractors to work towards and achieve. A new set of metrics have therefore been introduced and implemented in order to provide assurance in this area.

Consequently, this iteration of the Dental Assurance report focuses solely on the current assurance processes in place for the monitoring of Activity levels of primary care dental contractors.

Activity ‘Expectations’

Up until March 2020 the primary measure for activity delivered by GDS contractors was UDA. UDA provided an easily understood method of measuring activity whereby courses of treatment were classified into one of four claim bands and a pre-determined number of UDA awarded for each completed course of treatment in each treatment band.

At the end of a time period (month, quarter or year) the number of UDAs delivered were reconciled against the contracted target and any imbalance between the two generated a corresponding contract payment adjustment.

UDAs were suspended at the outbreak of the Covid pandemic in March 2020 and substituted by a series of “expectations” which have been subsequently reviewed and revised each quarter for the forthcoming period.

Expectations for contractors of 2021/22 have been detailed by WG and are summarised below:

Expectation	Q1	Q2	Q3	Q4
New Patients	At least 2 new patients/week/£165k contract value	Same as Q1	Same as Q1	Same as Q1
Aerosol Generating Procedures (AGPs)	A reasonable number of AGP procedures commensurate with the size of contract and stage of pandemic	Same as Q1	Same as Q1	Same as Q1
Fluoride Varnish	At least 80% of those patients that would clinically benefit from FV (all children and those adults assessed as red or amber for tooth decay)	Same as Q1	Same as Q1	Same as Q1
ACORN completion	100% completion for all patients on an annual basis	Same as Q1	Same as Q1	Same as Q1
eDEN on boarding	Contractor to be on boarded with eDEN	Same as Q1	Same as Q1	Same as Q1
Patient numbers		Patient numbers commensurate with contract size and stage of recovery from pandemic	Same as Q2	Same as Q2
Recall Intervals			No more than 20% of adult patients assessed as green for all aspects of oral health to be recommended	Same as Q3

			for recall routine examine of less than 12 months	
Work Force				Data on staff numbers and types within practices to be collected.
Treatment Outcomes				Monitoring of outcomes by analysis of Acorns produced on an annual basis

It should noted that the expectations are not written into the current GDS regulations/legislation at this point and hence any contractor not wishing to comply with the expectations can opt for their GDS contract to be monitored and managed in accordance with the original UDA system

Asesu a Dadansoddi / Assessment & Analysis

Performance monitoring of all the individual contracts (87 in total) against each of the above metrics is undertaken by the BCUHB Dental Contracting Team on a monthly basis. Data provided by eDEN, NHSBSA and ERMS is used for the review.

The default payment levels set by WG for contractors meeting or approaching all of the above requirements is 90% of contract value.

Contractors meeting all expectations while consistently exceeding two new patients/£165k contract value may be paid 100% of contract value.

Contractors consistently failing to meet or approach any of the expectations should expect to have a conversation with the Contracting Team of the Health Board. The conversation is to be supportive but if satisfactory improvement towards meeting the expectation does not occur then a reduction of payment level to 80% or less is considered.

The most recent monthly monitoring results available at the time of writing this report were for June 2021 (Q1) and are summarised in the below table:

Review Outcome	**Number of contracts**	**“Conversation” Outcome**	**Contract payment level**

Meeting all expectations and exceeding 2 new patients/£165k	43		100%
Meeting or approaching all expectations	35		90%
Meeting most expectations but not providing regular ERMS data	3	Two contractors have practice software issues One contractor has practice protocol issues	90% - to be reviewed end August
Meeting most expectations but have a low level of service provision relative to contract size	4	Two contractors have practice software issues One practice has a practice layout issue One practice has a staff resource issue	90% - to be reviewed end August
Consistently Failing to meet one or more expectations	2	One practice has an ongoing staff resource issue One practice has a AGP provision issue	50% - to be reviewed end August 80% - to be reviewed end August

Contractors who continue not to progress towards meeting expectations following a downward adjustment of contract payments may be:

- referred to the Contract Support and Assurance process to identify and address the underlying causes;
- moved back onto the UDA system for monitoring and payments.

Counter Fraud

The Dental Contracting Team have an established working relationship with Counter Fraud and operate in accordance to a Local Management Procedure included for information at appendix 1. It is worth noting that the Local Counter Fraud procedure focuses a great deal on UDA and claim patterns. Following the establishment of longer term metrics to replace the UDA system the procedure will require review and updating. In the interim, any suspected fraudulent activity by

contractors or patients identified by the Contracting Team will continue to be reported to the Fraud Team as appropriate in accordance with the procedure (as detailed at appendix 1).

Goblygiadau Strategol / Strategy Implications

Improved access and capacity of dental services is a priority, and opportunities are continually reviewed in all aspects of managing and contracting them.

Opsiynau a ystyriwyd / Options considered

No options are considered within this report

Goblygiadau Ariannol / 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.

Dadansoddiad Risk / Risk Analysis

There continue to be risks associated with the monitoring and management of contracted dental services during the recovery period of the Covid pandemic. Performance metrics during this are impacted with updated government guidelines and infection control procedures.
These risks and any potential impact on delivery and/or contract payments will be managed via the processes outlined above along with regular updates and communications with the Chief Dental Officer and relevant Welsh Government officials

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

GDS services are covered by the NHS GDS (Wales) Regulations 2006. Since the outbreak of Covid 19 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*
- *SOP for Dental Services – 26/08/20*
- *SOP for Dental Services (update) - 17/12/20*
- *CDO Letter – Guidance and Expectations – 17/12/20*
- *CDO Letter - Guidance and Expectations – 18/02/21*
- *CDO Letter – Guidance and Expectations – 06/07/21*
- *CDO Letter – Guidance and Expectations – 20/08/21*

Asesiad Effaith / Impact Assessment

No impact assessment has been completed as the paper describes the interim assurance processes in place.

APPENDIX 1

North Wales Dental Services:
Local Management Procedure
For the Reporting of Dental Fraud

Betsi Cadwaladr University Health Board (BCUHB) has in place its policy document Local Anti-Fraud, Bribery and Corruption Policy which is available at:

http://howis.wales.nhs.uk/sitesplus/861/opendoc/334338

BCUHB and its North Wales Dental Services are fully committed to reducing fraud, bribery and corruption in the NHS and will seek the appropriate disciplinary, regulatory, civil and criminal sanctions against fraudsters and where possible will attempt to recover losses to provide improved patient care and front line dental services including orthodontics.

In order to fully support the above statement, the Assistant Director of North Wales Dental Services has agreed to work in partnership with the Local Counter Fraud Service team and assist in providing information which may assist with the Prevention, Detection, Investigation and Prosecution of Dental Fraud against NHS Wales.

In summary, it is recognised that the service's role is to meet its obligation to report suspicions of fraud and it is the proper role of the Counter-Fraud Team alone to investigate and follow up any suspicions.

The Assistant Director of North Wales Dental Services and the Primary Care Contracting Team, will report the following to the BCUHB Local Counter Fraud Service team:

- Evidence of 'ghost' patients and forged claims i.e. claims for treatment provided to patients who did not exist, are deceased, had not seen the dentist at the time claimed etc.

- Evidence of duplicate claims which could involve manipulation of patient data e.g. changes in date of birth, address to allow inappropriate claims to be submitted without being easily identified.

- Evidence of incorrect information knowingly entered into clinical notes e.g. manipulation of dates to change the timing of credits for Units of Dental Activity (UDAs).

- Evidence of more complex treatment being claimed than had been provided which may include incorrect clinical records.

- Evidence of charging both the patient and the NHS for the same treatment.

The above list is not exhaustive and it is agreed through this Local Management Procedure that all evidence of the following types of potential Dental Fraud, or any suspicions of Fraud whatsoever, will also be reported to the Health Board's Local Counter Fraud Service team for proper further investigation and follow-up:

Fraud Type One

Patient did not receive the level of treatment on the FP17W. (Up Coding)

Description

Since April 2006 dentists have been paid a regular monthly amount which is usually one 12th of their contract value. This is paid no matter how much treatment is provided but is subject to a claw back process by the Health Board if the performance is short at the end of the year.

This type of fraud is committed, for example, when the dentist provides a band one treatment, for example: an examination, but claims for a Band 2 treatment such as an extraction. In this case the dentist gets 3 Units of Dental Activity (UDAs) (Band 2 treatment) for work that is worth 1 UDA (Band 1 treatment).

Another example would be when the patient has an extraction, for example (Band 2) and the dentist claims for a crown (Band 3). Here the dentist would claim 12 UDAs instead of 3 UDAs.

It should be remembered that there are treatments other than the examples used above in the respective treatment bands that could potentially be used to commit this type of fraud. Depending upon the circumstance, the NHS Guide to Dental treatment bands should be consulted online.

Offences Committed

Offences to be considered from this type of fraud are:

- Fraud by False Representation contrary to Section 2 of the Fraud Act 2006
- False Accounting contrary to Section 17 of the Theft Act 1968
- Evasion of a Liability by Deception contrary to Section 2 of the Theft Act 1978.

Fraud Indicators

The following are potential indicators that could lead to a referral of this type of fraud:

The dentist shows a high level of activity in last three months of a financial year, particularly for charge-exempt patients. This may occur if towards the end of the financial year the dentist realises that they are falling behind with their UDA activity and may not meet the target agreed within their contract.

Higher than normal numbers of Band 2 and or Band 3 claims submitted usually from January onwards may indicate that the dentist is submitting claims for treatment in higher bands than was actually carried out in order to meet their contracted UDA target.

A typical dentist's activity will show a pattern of; 55% Band 1 claims, 30% Band 2 claims and 10% Band 3 claims. The remaining 5% of claims are for other treatments including; urgent and occasional (emergency) treatment and free denture repairs. These percentages are an average and can vary depending on patient base but excessive percentage claims above these averages may warrant further investigation.

This principle applies when looking at a complete years' worth of data. A dentist, who perhaps did not set out to commit fraud, will show an end of year surge of higher band treatments. The more elusive fraudster will attempt to spread out the up coded claims over the full 12 months. Consideration here should be given to identify those dentists that have consistently excessive levels than usual of higher band treatment throughout the year.

Fraud Type Two

Splitting courses of treatment

Description

This type of irregularity is often the most difficult to prove as fraud. It occurs where a dentist splits treatment into two separate courses when they should have been claimed as one. Under the 2006 contract arrangements a dentist is paid the same money if a patient requires four fillings as they would for a patient who requires just one filling. Prior to April 2006, dentists would have been paid separately for each filling that they carried out.

A dentist that 'splits treatment', carries out all of the treatment the patient requires, for example; four fillings, in one course of treatment, but completes the claim showing separate courses of treatment over two or more dates. This may be considered as fraud.

It should be remembered that in some genuine cases a patient can require a further filling after a short period of time but the frequency of the occurrence should determine the action taken. The usual time period between treatments that give rise to suspicion is two months. However, if a treatment is given to a dental charge payer, then they require further treatment within two months for the same treatment; it is covered by the Dental Charges guarantee procedures and does not attract further payment from the patient.

Offences Committed

Offences to be considered from this type of fraud are:

- Fraud by False Representation contrary to Section 2 of the Fraud Act 2006.

- False Accounting contrary to Section 17(1) (a) of the Theft Act 1968.

Fraud Indicators

The following are potential indicators that could lead to a referral of this type of fraud:

BCUHB should be able to identify these types of referrals from their eReporting exception reports. One particular report identifies the number of days between treatments and can show the frequency of patient visits to the surgery.

Dentist have also been known to alter the date of birth, post code or tamper with the spelling of the surname of patients if they have deliberately committed this type of fraud. This enables them to submit two claims that do not match as being for the same patient and therefore avoids the NHS Dental Services data matching tools.

Also in a dental surgery with more than one dentist it has been known for the second claim to be submitted as if it was provided by a different dentist.

Fraud Type Three

Patient did not visit the dentist

Description

These fraud investigations often arise where the dentist is struggling to fulfil their contractual obligations and targets.

Claims are submitted in respect of patients who have not visited the surgery for a long time and/or who have moved away.

The dentist may have the old dental records stored in archive which makes it simple for them to replicate the treatment previously provided.

It has also been found in some cases the dentist will insert claims for members of their own family or staff and their families.

Because of the indiscriminate way that these patients records may be selected it has been known for a dentist to make claims for a person who is deceased.

The dentist will maximise the payment by showing the patient to be exempt from charges, in order to obtain the full UDA value.

Offences Committed

Offences to be considered from this type of fraud are:

- Fraud by False Representation contrary to Section 2 of the Fraud Act 2006
- False Accounting contrary to Section 17(1) (a) of the Theft Act 1968.

Fraud Indicators

The following are potential indicators that could lead to a referral of this type of fraud:

This type of fraud has in the past been discovered as a result of NHS Dental Services sending out random patient questionnaires to confirm treatments and patient status.

If these questionnaires are returned showing 'not at address' or 'addressee gone away' by the Post Office this may be an indication that the patient did not attend for the treatment claimed. Alternatively, the patient, or ex-patient, may return the questionnaire and explicitly state that they haven't attended the surgery on the given dates.

Fraud Type Four

Patient does not exist

Description

This type of fraud occurs when a dentist creates a patient that doesn't exist with a false name, DOB etc. and claims to have provided treatment to that individual.

To maximise the amount of each claim the dentist will often show them as having Band 3 treatment and as being 'patient charge exempt', in order to maximise the value of the claim i.e. 12 UDA's. With the average UDA value being £25.00 this can be very lucrative to the fraudster with each claim having a value of £300.

If a dentist does make a Band 3 claim using this method they may also have to produce a false laboratory docket to back up the claim and attempt to show that a dental appliance has been produced and fitted.

Since the introduction of the 2006 claims procedure dentists are required to keep details of any laboratory work completed with the patient's dental record.

Offences Committed

Offences to be considered from this type of fraud are:

- Fraud by False Representation contrary to Section 2 of the Fraud Act 2006
- False Accounting contrary to Section 17(1) (a) of the Theft Act 1968.

Fraud Indicators

The following are potential indicators that could lead to a referral of this type of fraud:

This type of fraud is often discovered where large numbers of claims are made without the patients post codes recorded.

It can also be discovered whereby a pattern of claims without a finish date for the treatment is identified, usually shown as 'incomplete'.

Dentists are aware that NHS Dental Services will not check up on any claim marked as incomplete or with an incomplete post code because it is assumed that the patient had moved away during the course of the treatment.

Such patterns of claims can be identified via eReporting exception reports available to the Health Board.

Fraud Type Five

Patient paid for treatment but has been marked as exempt on the FP17W.

Description

This type of fraud occurs where the dentist retains the collected patient charge revenue themselves rather than declaring that they received it and having the amounts deducted from their monthly payments.

Misrepresenting patient charge status on a claim is more difficult as the paper FP17W is usually controlled by reception staff that also collect any patient charge and check the exemption documents.

Misrepresenting patient charge electronically is easier as the dentist or practice manager has the opportunity to alter the status prior to the claim being transmitted.

Offences Committed

Offences to be considered from this type of fraud are:

- Fraud by False Representation contrary to Section 2 of the Fraud Act 2006
- Theft contrary to section 1 to 7 of the Theft Act 1968.
- False Accounting contrary to Section 17(1) (a) of the Theft Act 1968.

Fraud Indicators

The following are potential indicators that could lead to a referral of this type of fraud:

By examining claim data going back over a couple of years, a check of patients with multiple claims can show changes from patient charge exempt to non-exempt. This can often be for good reason, e.g. a person going from charge exempt through being unemployed to a charge payer when re-employed but a suspicious pattern can sometimes emerge which merits further investigation.

Often this type of investigation is referred via NHS Dental Services who have been alerted to the facts after sending out random questionnaires to patients and the replies indicate that the patients have paid for their dental treatment. This information can be used as a basis for the collation of witness statements.

The Health Board can run reports showing the change in patient revenue charges declared by dentists over the last few years and these will appear on eReporting exception reports. Any significant drop in these figures may indicate that money is being retained by the dentist.

In one case the dentist was offering free check-ups at a University site. When inputting the claims some of the patients were not entitled to exemption. To avoid having the patient charge deducted from his claim he marked them as ‘Full

Remission'. This is usually a status of a low income patient not on benefit and as such not very common; suspicion was aroused due to high numbers of claims showing this status.

Fraud Type Six

Balancing of Units of Dental Activity

Description

A dentist contracted to provide work under the NHS can be employed under more than one contract. They may be a provider within many contracts and a performer at many as well. 'Balancing' is a way of using UDAs performed in one practice to increase and bolster the UDAs in an underperforming practice. Whilst a common defence is to say that the work has been done, it is a breach of their contract.

The benefits to the dentist are that they can be seen to be choosing the better priced UDA as this can vary dependent upon the contract value and UDA target set. This can also lead to the situation when BCUHB is paying for the treatment of patients occurring in another NHS Health Board or Clinical Commissioning Group area.

Offences Committed

Offences to be considered from this type of fraud are:

- Fraud by False Representation contrary to Section 2 of the Fraud Act 2006
- False Accounting contrary to Section 17(1) (a) of the Theft Act 1968.
- Evasion of a Liability by Deception contrary to Section 2 of the Theft Act 1978.

Fraud Indicators

The following are potential indicators that could lead to a referral of this type of fraud:

Reports from the eReporting system include useful data, including one that shows the distance the patients address is from the dental practice they have been supposedly treated at. In some cases this can be over 50 miles and although there is nothing to stop the patient travelling any distance they want to receive treatment, the frequency of the instances will determine the risk involved.

Where a large dental organisation has many contracts, it has been known for them to buy up unsuccessful practices and supplement the UDAs with claims performed elsewhere. This can be very evident where one of the contracts has a domiciliary element. In these cases the dentist will not only control the placement of the claims but also the flow of work going to the domiciliary element when needed.

A common indicator of this type of fraud would be the increase of claims in the last few months of the contractual year. Checks to be undertaken would be a comparison of the percentage of UDAs completed in first 6 months against those completed in last 6 months.

When checking for Domiciliary claims good indicators are a large number of claims on the same day in the same post code, especially if the patients are elderly.

This Local Management Procedure for the Reporting of Dental Fraud facilitates examples to be reported to the Health Board's Local Counter Fraud Service team, by the Health Board's Assistant Director of North Wales Dental Services and his NHS Dental Contract Monitoring team.

- All potential examples of the types of fraud listed above, which may be identified through the Management of NHS Dental Contracts in North Wales.

  And / Or

- All potential examples of the types of fraud listed above, which may be identified as Inappropriate Dental Claims which have been submitted for payment to NHS Wales by Dental Performers in North Wales.

To ensure the Health Board's financial resources are directed to dental care and services including orthodontics treatment to NHS patients and that these resources are safeguarded from potential fraud, bribery and corruption, a closer working relationship should be developed within the Health Board.

In order to provide assurance to the Audit Committee that all potential NHS dental fraud has been referred to the Health Board's Local Counter Fraud Service team, and inappropriate Dental claims have not been 'withdrawn', it is essential that all inappropriate Dental claims are shared with the Health Board's Local Counter Fraud Service team for their review and advice on whether fraud has occurred.