

Bundle Audit Committee 15 March 2022

- 1 10:00 - OPENING BUSINESS - OPEN SESSION
- 1.1 10:00 - AC22.01: Apologies for Absence
Apologies received from;
Richard Micklewright, Independent Member
Jo Whitehead, Chief Executive
- 1.2 10:01 - AC22.02: Declarations of Interest
- 1.3 10:02 - AC22.03: Procedural Matters
to confirm the Minutes of the last meeting of the Committee held on 14/12/2021 as a correct record and to discuss any matter arising;
review the Summary Action Log;
note the details of breaches (in terms of publication of Board/Committee papers) to the Standing Orders;
to agree 2022/23 Audit Committee Cycle of Business.
AC22.03a Draft Public Minutes Audit Committee December 2021.docx
AC22.03b Audit Committee Public action log December 2021 meeting.docx
AC22.03c Breach Log.docx
AC22.03d AC Proposed Cycle of Business 2022-23_March23.docx
- 1.4 10:07 - AC22.04: Issues Discussed in Previous Private Session
The Audit Committee is asked to note the report.
AC22.04 Private Session Items Reported in Public_March_22.docx
- 2 10:08 - GOVERNANCE
- 2.1 10:08 - AC22.05: Chair's Assurance Report: Risk Management Group
The Audit Committee is asked to note the report.
AC22.05 Chair's Assurance Report- Risk Management Group - v3.docx
- 2.2 10:18 - AC22.06: Board Assurance Framework and Clinical Audit Plan Verbal Update
- 2.4 10:33 - AC22.07: Standing Orders And changes to the SORD
The Audit Committee is asked to note and endorse the updated Master Scheme of Reserved Delegation
AC22.07a Master Scheme of Reserved Delegation.docx
AC22.07b Draft Master SoRD 080322.docx
- 3 10:43 - FINANCE
- 3.3 10:43 - AC22.08: Schedule of Financial Claims (Public)
The Committee is asked to note the report
AC22.08 Schedule of Financial Claims Public Report.docx
- 3.4 10:48 - AC22.09: Policies for Consent
The audit Committee is asked to review and approve the;
Counter Fraud Policy (periodic review).
Standards of Business Conduct (periodic review).
AC22.09a Local Counter Fraud Bribery and Corruption Policy F03.docx
AC22.09b EqIA_Counter Fraud Bribery and Corruption Policy F03 07-10-2021.docx
AC22.09c Standards of Business conduct policy cover.docx
AC22.09d OBS02 - Standards of Business Conduct Policy - V1.05 090322 .doc
AC22.09e EqIA_Standards of Business Conduct Policy.docx
- 4 10:58 - INTERNAL AUDIT
- 4.1 10:58 - AC22.10: Internal Audit
Internal Audit Progress Report
Review and approval of internal audit plan and the Internal Audit Charter.
Limited Assurance Reports:
Standards of Business Conduct
integrated service boards audit
AC22.10a Internal Audit Committee cover sheet March 2022.docx
AC22.10b BCUHB Audit Committee progress report March 2022 v2.docx

AC22.10c Internal Audit plan 2022-23 BCUHBv2.docx

AC22.10d Final Internal Audit Report - Standards of Business Conductv2.pdf

AC22.10e Audit Report - Integrated Service Boards Governance.pdf

5 11:13 - EXTERNAL AUDIT

5.1 11:13 - AC22.11: Audit Wales

The Audit Committee is requested to receive and discuss:

Auditor General's (external audit) progress report and the following external reports;

Review of Quality Governance

Commissioning Older People's Care Home Placements

Commissioning Care Home Placements, BCUHB Management Response.

AC22.11a Audit Wales Coversheet.docx

AC22.11b Audit Wales BCU AC Update March 2022.pdf

AC22.11c Audit Wales _Review_of_Quality_Governance_Arrangements_report.pdf

AC22.11d Audit Wales_north_wales_councils_older_people_care_home_placements_english.pdf

AC22.11e CHC Commissioning Management Response. DRAFT docx.docx

AC22.11f APPENDIX 1_NWC_BCUHB_Placements_Management_Response_Eng (002).docx

8 11:28 - CLOSING BUSINESS

8.2 11:28 - AC22.12: Issues of Significance for reporting to Board

Members of the Committee are invited to provide an update/feedback from their respective

Committee/Panel/Group attendance during the preceding cycle highlighting any key risks or issues that the Audit Committee ought to be aware of for inclusion in the Audit Committee Chair's Assurance Report up to the Health Board.

8.3 11:29 - AC22.13: Date of Next Meeting: 13/06/22

9 11:29 - Exclusion of Press and Public

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

AUDIT COMMITTEE PUBLIC MEETING

Draft Minutes of the Meeting Held on 14.12.21

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)
Richard Micklewright	Independent Member
Jacqueline Hughes	Independent Member
Lyn Meadows	Independent Member

In Attendance	
Jo Whitehead	Chief Executive
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
Dave Harries	Head of Internal Audit, NWSSP
Nicola Jones	Acting Deputy Head of Internal Audit, NWSSP
Sue Hill	Executive Director of Finance
Tim Woodhead	Finance Director of Operational Services
Molly Marcu	Interim Deputy Board Secretary

Agenda Item	Action
AC21.73: Opening Business and Apologies for Absence.	

Agenda Item	Action
<p>The Chair welcomed Members and attendees to the meeting. Apologies were received from Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery.</p> <p>The Committee Chair thanked Lyn Meadows for her contributions as a longstanding member of the committee and also a member of the Health Board.</p> <p>This was echoed by members and executive colleagues in attendance. The Committee Chair extended a welcome to Richard Micklewright to his first meeting as an Audit Committee member.</p>	
<p>AC21.74: Declarations of Interest.</p> <p>No declarations of interest were made at the meeting.</p>	
<p>AC21.75 Procedural Matters.</p> <p>AC21.75a Draft minutes</p> <p>The Committee resolved to approve the minutes of the meeting of the 28th of September 2021 as an accurate record, subject to a slight amendment to section 21.5.1.0</p> <p>AC21.75b Summary Action Log</p> <p>The Committee reviewed the actions pertaining to the accountability performance framework. It was confirmed that the work was still on track to be delivered in March 2022.</p> <p>AC21.75C Breach Log</p> <p>AC21.75d Remuneration and Terms of Service Committee terms of reference</p> <p>The Board Secretary reported that the terms of reference were submitted to the committee for approval due to a recommendation from a September 2021 internal audit report recommendation on Upholding Professional Standards in Wales to incorporate a Designated Board member as a formal member of the Committee.</p> <p>Following submission of the revised terms of reference to the Remuneration Committee, the Audit committee was now asked to approve this amendment on behalf of the Board, in line with the BCUHB governance processes.</p> <p>The Audit Committee resolved to approve the revised terms of reference of the Remuneration and Terms of Service Committee.</p>	

Agenda Item	Action
<p>AC21.75e Overview of Procurement regulations</p> <p>The Finance Director of Operational Finance provided a verbal update on procurement regulations.</p> <p>He reported that the procurement regulations had been amended due to the removal of the Value Added Tax (VAT) element, which however did not warrant an adjustment to the Health Board's standing orders, standard financial instructions.</p> <p>In terms of impact, it was clarified that this change would slightly reduce the OJEU limits.</p> <p>Richard Micklewright enquired whether the Health Board was still subject to OJEU rules post Brexit.</p> <p>The Finance Director of Operational Finance confirmed that the European Regulations were still applicable to Public Sector bodies, in the same manner as they were previously.</p> <p>The Committee noted the verbal update on procurement regulations.</p>	
<p>AC21.76: Issues Discussed in Previous Private Committee Session.</p> <p>RESOLVED: That the report on issues discussed in the previous Private Committee session be noted.</p>	
<p>AC21.77: Chair's Assurance Report : Risk Management Group</p> <p>The Interim Director of Governance presented the Risk Management Group Chair's report on behalf of the Deputy Chief Executive and Executive Director of Nursing and Midwifery.</p> <p>Members of the Committee were informed the Risk Management Group was quorate when it met in October 2021, with good representation.</p> <p>There were a few matters to bring to the attention of the Committee. Firstly, the Chairmanship of the Group had been revised from the Deputy Chief Executive and Executive Director of Nursing and Midwifery to the Executive Medical Director.</p> <p>This change provided a degree of segregation of duties from the Deputy Chief Executive (with operational responsibility for risk management) whilst enhancing the arrangements for scrutiny and challenge of the risk management arrangements.</p> <p>Secondly, the Interim Director of Governance reported that the group had undertaken deep dives on BAF 21-12 (Security) and BAF 21-13(Health and safety risks)</p>	

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<p>Meetings had progressed for the purposes of undertaking deep dives on cyber security and clinical capacity at the tier 1 (corporate risk register) level.</p> <p>Ten divisional risk reports had been reviewed by the Risk Management Group (as part of its cycle of meetings) in order to ascertain the effectiveness of the risk management processes across the divisions reviewed.</p> <p>The remainder of the report reflected business as usual activity in relation to the risk management improvement plan, as well as the risk management training plan, with the latter now slightly off track, but on course to be achieved at the end of March 2022.</p> <p>In response to an enquiry from Richard Micklewright, the Interim Director of Governance confirmed that the target of training 1000 staff members was still feasible to be achieved by the end of March 2022.</p> <p>To date, half of the target had been delivered, however it was recognised that this was at risk of non-delivery by March 2022, due to sickness within the team and the focus of the organisation in terms of delivering on the national priorities of the vaccination programme and the impact of winter. However, all efforts would be put towards achieving this target.</p> <p>The Chief Executive explained that she had indeed had a similar discussion with the Interim Director of Governance, and was assured by mitigations put in place to achieve compliance.</p> <p>She stated that the impact of COVID would need to be considered and factored into the activities of the organisation more generally, although it was very familiar to colleagues who were with the organisation during the last wave of the pandemic.</p> <p>The Health Board had already received an instruction from Welsh Government to stand down all non-essential meetings, and then there would be further consideration of the set-up of gold command, as well as how the organisation would manage and maintain good governance during COVID.</p> <p>The Committee noted and received the Corporate risk register report</p>	
<p>AC21.78: Board Assurance Framework</p> <p>The Board Secretary presented the Board Assurance Framework report. Members were informed that that this iteration of the BAF constituted the sixth monthly and full board assurance framework submitted to the audit committee as part of the assurance processes.</p> <p>There were 21 risks on the BAF, which was considered a high number, however this would be resolved as part of the refresh process aligned to</p>	

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<p>the Integrated Medium Term Plan (IMTP) in the fourth quarter of the 2021/22 financial year.</p> <p>This work would also focus on the appropriateness of risks and their alignment to the strategic objectives.</p> <p>Whilst this work was underway it was proposed to suspend presentations on the BAF in quarter 4 until the completion of the refresh process, leading up to a Board workshop in February 2022, aligned to a reset alongside the strategic objectives and the IMTP.</p> <p>It was acknowledged that there was a significant amount of work to be done in order to update the BAF, including the alignment of target risks with the organisation's risk appetite.</p> <p>Members were invited to comment.</p> <p>Lyn Meadows noted that there was a need to take into consideration the impact of COVID on the delivery of this work.</p> <p>The Committee noted the BAF report and approved the suspension of quarterly reports to committees for quarter 4 of the 2021/22 period</p>	
<p>AC21.79: Corporate Risk Register</p> <p>The Interim Director of Governance presented the key highlights from the risk register report.</p> <p>The Committee was informed that there were four new risks raised since the last report, and one additional risk (pertaining to the Health Board's resilience to uncertainties) was currently being drafted at the time of the meeting, at the request of the Quality Safety Experience Committee.</p> <p>The Committee was informed that 4 risks had decreased in rating, with one remaining unchanged.</p> <p>Jacqueline Hughes proposed consideration of a legionella risk specifically relating to Health Board premises, addition that there was possibly an exposure to risk in other sites occupied by BCUHB</p> <p><i>Action : Interim Director of Governance</i></p> <p><i>Consideration to be given to expanding the legionella risk to be expanded to incorporate non BCU sites</i></p> <p>Richard Micklewright requested clarification on why risk CRR20-08 was confined to vision and not wider issues as a result of COVID.</p> <p>The Interim Director of Governance clarified that this risk was focussed on capacity issues within ophthalmology, where there was an enhanced difficulty to recruit within this specific service as a result of the pandemic. This risk was being monitored at the Quality and Safety Experience Committee, and remained prevalent, however it had not crystallised as yet.</p>	

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<p>The Chief Executive stated that the Trust was working with a private sector provider in the North West region to provide additional ophthalmology activity in order to mitigate the risk.</p> <p>The Chief Executive acknowledged Richard Micklewright's observations, and she requested that the risk should be broadened to incorporate the impact on COVID in light of Omicron, and the ability of the private provider to reduce waiting times to manage this risk.</p> <p><i>Action : Interim Director of Governance</i></p> <p>The Interim Director of Governance explained that the COVID risks on the whole were regularly monitored by the operational group responsible for managing the Trust's response to COVID.</p> <p>In addition, the governance structures around gold command were currently under development, with a key element of this being COVID related risks.</p> <p>Richard Micklewright observed that there appeared to be 21 mitigations aligned to risk 13 (diminishing nursing workforce) that were operational in nature.</p> <p>It appeared that there were some medium term controls that were missing, such as processes for managing workforce numbers in the medium to long term future.</p> <p>Richard Micklewright further enquired whether members were content that the controls captured against this risk were sufficient.</p> <p>The Interim Director of Governance explained that he would facilitate a review of this risk by the Executive Director of Nursing and Midwifery in their capacity as risk owner and provide an assurance update to the Quality, Safety and Experience Committee.</p> <p><i>Action : Interim Director of Governance</i></p> <p>The Chief Executive added that there were medium term challenges associated with nursing workforce planning, which applied to medical and allied health professional workforce.</p> <p>Therefore the first piece of work underway to address this was associated with the integrated medium term plan, which was the immediate work to ensure that the plans put in place (which had formed part of previous board workshops discussions) were correlated with associated financial and workforce plans.</p> <p>This process would aid clarity that the Board was only approving plans that could be delivered immediately (due to be available workforce), from the current intakes associated with professional training in terms of the shorter to medium term with regard to workforce planning.</p> <p>The Chief Executive added that there were processes in place which enabled reviews of likely retirements, (built on history around resignations), or short to medium term absences, in order for the Health</p>	

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<p>Board to link in with Health Education and Improvement Wales , (the organisation in Welsh Government who provide and pay for the numbers of staff needed to train) in order to manage and mitigate future exposure to risk.</p> <p>It was acknowledged that despite significant expenditure amounting billions of pounds, being additionally put into the teaching and training environment through Welsh Government, it was unlikely that the organisation would be always able to ensure in the future that sufficient nurses, doctors and allied health professionals in the broadest terms are being trained in order to always to fulfil the Health Board's future workforce requirement.</p> <p>Therefore, there were significant pieces of work in play with regard to retention and also role substitution (which needed to be carefully managed in partnership with BCUHB union partners) to try and identify in traditionally hard to recruit to posts, where it was known that were insufficient training numbers across the whole of the United Kingdom to fill gaps.</p> <p>The Chief Executive stated that the organisation was working to develop new roles that will enable the provision of safe staffing, adding that had she been present in the meeting, the Executive Director of Nursing and Midwifery would be able to talk much more eloquently about the practical arrangements in place within nursing to drive the Health Board's medium term plans, which were also supported by a workforce strategy .</p> <p>The Committee Chair enquired whether the Trust was unique in experiencing staffing shortages in comparison with neighbouring organisations of a similar size.</p> <p>The Executive Director of Workforce confirmed that the benchmarking indicated that the Trust numbers were in line with peers.</p> <p>Potential risks were in relation to the age profile, the model of delivery (medicalised bed based model) which placed a higher staffing requirement .</p> <p>Moving towards a closer to home services would result in a more sustainable requirement.</p> <p>Workforce performance reports provided detailed assurance on this , and these were considered at the Performance, Finance and Information Governance Committee meeting.</p> <p>The committee noted and received the corporate risk register report</p>	
<p>AC21.80: Internal Audit Progress Report</p> <p>The Committee were provided with an overview of the findings from the main internal audit report by the NWSSP Audit and Assurance Services</p> <p>The Acting Deputy Head of Internal Audit summarised the position relating to reports completed since the last meeting.</p>	

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<p>There had been six reports issued as final, of which three were given a 'reasonable' rating, one was limited in relation to leavers managements. Whilst no assurance rating had been allocated to the Secondary Care Division – YGC audit, there were concerns around the governance arrangements, which in practice tended to bypass of the hospital management team with no clear lines of reporting.</p> <p>The YGC audit had also found that there were some outstanding actions from the quality governance review, which had not been implemented for a considerable amount of time, despite some initial traction.</p> <p>It was acknowledged that there had been some changes in senior management , which could be a contributing factor, and also that there could be a similar gap at other sites, therefore exposing the Health Board to a wider concern around some of the governance arrangements.</p> <p>The Acting Deputy Head of Internal Audit also highlighted a further report for the committee's attention, pertaining to Maternity cross border arrangements, which was broadly speaking cited as a positive review. As part of the review, NWSSP Audit and Assurance Services had asked the Health Board to get some clarity in terms of what choices should be given to women in terms of where they can give birth as this was impacting on the cost of contracts.</p> <p>In addition, a further recommendation had been made in relation to carrying out some analysis on the data in terms of reasons behind where women are giving birth and why some appeals were successful.</p> <p>It was also highlighted that the Health Board was currently at 56% compliance with responses to internal audit recommendations, as at the end of November, which was expected to further increase over the next few weeks.</p> <p>The Acting Deputy Head of Internal Audit highlighted another targeted intervention report had also just been issued, whilst a KPMG report was now at its final stage.</p> <p>Finally, The Acting Deputy Head of Internal Audit reported that internal audit had started meetings with counter-fraud to review plans and enable cross working on areas of focus and priority.</p> <p>The Committee went into detail into the findings of the report pertaining to leavers' management.</p> <p>Lynn Meadows asked the Chief Executive whether there were any additional mitigations being considered at Executive team level given the longstanding issues with YGC</p> <p>The Chief Executive reported that members of the Executive Team had met with colleagues from the YGC.</p> <p>The Executive Team was quite keen to work with YGC over a range of complex issues, which were being appropriately managed. One of the</p>	

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<p>benefits of a revised operating model incorporated closer working directly as part of the Executive Team.</p> <p>The Chief Executive explained that each District General Hospital had its own challenges, however the issues pertaining to YGC were particular and specific to the organisation itself.</p> <p>In response to a question by Lynn Meadows, the Board Secretary was asked to clarify whether the issue relating to YGC should be escalated to the Board. The Board Secretary responded that this was within the discretion of the committee to determine.</p> <p>Richard enquired whether the Chief Executive was confident that the matters of concern at YGC would be resolved within the next 12 months. The Chief Executive explained that there were some early signs that some of the cultural challenges had been addressed</p> <p>The Interim Director of Governance explained that he had undertaken a piece of work across the three sites, and the report was welcome and timely, and lessons learnt feeding into the new governance model.</p> <p>Members agreed that this matter would be escalated to the next meeting of the Board.</p> <p><i>Action : Chair of the Audit Committee</i></p> <p>Lynn enquired about the capital scheme being postponed , and whether the delay was acceptable to the committee.</p> <p>In response to a query from the Committee Chair, members confirmed that they had no questions was highlighted that there were no questions in relation to the maternity</p> <p>The Committee were then invited to consider the findings of the leavers audit, which had been issued with a limited assurance audit opinion. The Internal Audit Manager highlighted that the main finding was in relation to failure by staff to comply with clear guidance was in place, however operational compliance was not in place.</p> <p>Operational management were expected to complete forms once notification of a pending leaver was given, however the issue was more in relation to policing compliance.</p> <p>The Head of Internal Audit reported that the findings of the audit reflected a gradual increase in salary overpayments due to the late submission of leavers' paperwork by operational managers.</p> <p>Clear guidance had been issued by workforce however there was a lack of operational compliance with expected controls around leavers, with the backstop control being to generate a debtor accounts for overpayments.</p> <p>This mitigation was not deemed satisfactory as it relied upon the Finance department raising debts that were in some instances written off.</p>	

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<p>The Committee were informed that the key control incorporated management receiving a resignation or termination, which was then the trigger for the completion of relevant leaver's documentation.</p> <p>The Head of Internal Audit stated that there were opportunities to utilise the self-service aspect of the ESR system, which was positively viewed as an effective control by operational management.</p> <p>This particular control was required to be embedded, however the review had ultimately resulted in a limited assurance audit opinion due to a failure by operational management to comply with the appropriate policies and procedures.</p> <p>The Director of Workforce stated that the findings were based on a sample of 27 cases, of which a high proportion were non-compliant, however it was a relatively small sample that was representative of a systemic issue that was not widespread within the organisation.</p> <p>It was acknowledged that the gaps were mainly within clinical areas, therefore this was a systemic issue that was routinely discussed by workforce staff with operational managers through their roster management meetings.</p> <p>Additional support had been put in place to those areas who were largely non-compliant.</p> <p>The Director of Workforce explained that there was evidence that this was not a widespread issue, but rather, they were pockets of non-compliance.</p> <p>The HR teams provided the business partnering service, and were well integrated into the senior management teams, where performance against this metric was monitored. Therefore it was important to recognise that this metric was owned at senior management team level.</p> <p>Operational management provided information to the business partners to enable them to raise this with the Chief Finance Officer and leadership teams.</p> <p>The Chair invited questions.</p> <p>Richard Micklewright observed that the report was highlighting systemic organisational wide issues, with some financial losses that were deemed significant.</p> <p>Richard Micklewright expressed his view was that 89% of the forms were late, and one was 126 days late, with a potential £1m impact.</p> <p>The Executive Director of Workforce responded that this was indeed a priority, and reiterated that actions had been put in place to re escalate this as part of the divisional performance reports.</p> <p>The salary overpayments metric was included in the performance dashboard which was monitored and scrutinised at the senior leadership teams.</p>	

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<p>The Executive Director of Workforce stated that this was also included in the recruitment improvement review, which incorporated actions which would be completed the actions by the 31st of January 2022 and evidence of this completion would be reported back to the Committee.</p> <p>This four week timeline would provide the committee with assurance on the level of prioritisation on this area as well as their completion, given the context of other priorities at this point in time, and other constraints caused by COVID.</p> <p>Richard Micklewright enquired how much was owed to the Health Board due to salary payments to date.</p> <p>The Executive Director of Finance reported that the total salary overpayments figure amounted to £637,000, of which £160,000 was with collection agencies.</p> <p>This amount had been outstanding over a long time period as some of those debts were of a historic nature, due to instalment plans were put in place over a very long period, however a small proportion was written off.</p> <p>The Executive Director of Finance stated that further enhancements could be made to the process, focussing on key aspects such as cut off dates and improvements in communicating the process better to operational management.</p> <p>The payroll service was managed through NWSSP, which presented an opportunity to resolve the issue as a 'triumvirate' to ensure a coordinated communications approach.</p> <p>There was already a process in place about communicating to managers about the late form, and a further process could be put in place to enable managers to process payroll forms on time, more easily .</p> <p>The Committee Chair stated that the Committee was keen to monitor the effectiveness of the mitigations proposed as part of the management responses to the audit, recognising that the Health Board should be in a much improved position within 12 months' time.</p> <p>In seeking this assurance the Committee would take into account the work of the internal audit function to monitor implementation of these actions.</p> <p>The Committee noted and received the Internal Audit Progress reports</p>	
<p>AC21.80 External Audit - Audit Wales Reports</p> <p>Andrew Doughton highlighted the Committee's attention to page seven of the progress report, which outlined the four reviews that were finished and discussed with the board secretary, and shared with the Executive Team, who were cited on the full reviews that were being recommended for deferment.</p>	

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<p>The rationale was included within the progress reports seeking the Committee's approval to defer those as part of the risk based planning process for 2020 /23.</p> <p>A formal request had also been received on the 13th of December 2021 from the Executive director of primary and community care around deferring the value based health care review, due to ongoing recruitment into the team, therefore at this stage there was no value in undertaking an audit.</p> <p>On this basis Audit Wales had supported that approach and were now seeking the Audit Committee's approval to defer this review.</p> <p>Assurance was given that there would still be enough reviews in the plan to maintain continuity, however it was worth noting that this relied in part on the impact of COVID and whether there was flexibility in approach on whether the Health Board was issued a narrative or a full opinion. Andrew Doughton added that this matter was now being flagged following the Chief Executive's earlier advice about COVID.</p> <p>The Committee approved the deferment of the following reviews:</p> <ul style="list-style-type: none"> • Digital strategy • Digital Transformation of services preparedness • Climate change decarbonisation • Value based health care <p>Audit Wales update</p> <p>Audit Wales highlighted Committee members' attention to the financial audit work, and commenced the report by highlighting that the funds held on trust audit was now currently progressing with the report anticipated to be issued in January 2022.</p> <p>A planning exercise was also underway on both the financial audit work and the performance audit.</p> <p>Audit Wales were working alongside internal audit meeting with a range of stakeholders to further their understanding of progress ahead of the committee meeting in March 2022.</p> <p>Exhibit two highlighted the work completed that featured in the meeting, whilst exhibit three illustrated the work currently underway.</p> <p>Members welcomed the useful report.</p> <p>Structured Assessment</p> <p>Audit Wales reminded members that this report had formed part of a recent board development discussion, therefore it would be considered in summary form in the committee meeting.</p>	

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<p>Structured assessments were designed to help the auditor general discharge his duties on the extent that the bodies have proper arrangements to secure value for money.</p> <p>The Phase One report considered the health boards' operational planning arrangements and how they were helping to support improvement and ultimately recovery.</p> <p>The second phase of this work (which had just recently been reported) was focussed on the corporate governance arrangements and the financial management arrangements have been adapted and continued to be adapted currently.</p> <p>In terms of the overall conclusion, members were informed that this was deemed quite a positive report.</p> <p>The report highlighted a very promising start by the board demonstrating strong leadership, towards making significant improvements as part of targeted intervention, which were recognised as significantly better than what was originally adopted as part of special measures.</p> <p>Governance and risk management arrangements were developing as the approach for supporting change and transformation and improvement.</p> <p>It was acknowledged that some of those were still in the process of being embedded.</p> <p>Despite this, Audit Wales had been able to gain visibility of these building blocks started to be put in place, which was in the context of considerable ongoing service pressures, waiting list backlogs, as well as tensions and challenges with IT services at the present time.</p> <p>Committee members applauded the positive findings in the report. Richard Micklewright emphasised the need to acknowledge and celebrate the positive outcomes and improvements, in spite of the development improvement process that the Health Board was currently undergoing.</p> <p>Audit Wales then presented the financial aspects of the report. The receipt of the additional income alongside improved financial planning had contributed towards strengthening the health board's financial outlook.</p> <p>Audit Wales had highlighted risks within the report around Liberty capital funding.</p> <p>It was confirmed this was not unique to the health board, although it did present challenges in areas such as diagnostic and treatment centre, as well as the regional treatment centre.</p> <p>The concern was that the health board was receiving quite substantial amounts of additional funding at some point that might not continue to flow.</p> <p>As there was also an additional challenge about financial sustainability there was therefore merit in the consideration of putting in place the right building blocks as soon as possible, to ensure that once that income started reducing again, the Health Board would have financially sustainable services rather than being in a recurrent deficit position.</p>	

Agenda Item	Action
<p>Audit Wales further made one additional recommendation pertaining to reporting of financial deficiencies.</p> <p>In addition, the report also provided a progress update against the previous year's recommendations.</p> <p>The Committee were then informed of the findings of the eye care services review.</p> <p>In summary, the review was less positive than that of the structured assessment.</p> <p>The reported highlighted substantial deterioration in eye care service performance. The review indicated referral demand increasing to pre-COVID levels, at a higher rate than capacity was recovering, therefore creating additional waits, which had increased by 50% during the pandemic.</p> <p>The report clearly identified the need to improve service efficiency, which was highlighted as being below average for the pandemic and persons who rated it.</p> <p>There was a clear business case in building strong relationships with primary care and community services as well as exploring ways to present hope to different alternatives. Reference was also made to consideration of regional treatment centres that provide longer term additional capacity.</p> <p>However, it was recognised that these would take time to develop. As previously mentioned by the Chief Executive, the Health Board had taken an interim measure by working collaboratively with a third sector provider in order to provide additional outputs to outsource services. This was a one year contract that had scope for extension by a further two years.</p> <p>It was anticipated that this arrangement should provide some breathing space however, it was reliant on the Health Board enhancing its resilience by building up his own internal capacity moving then on to longer term models for acute care.</p> <p>The Eye Care Service was going to require a stronger workforce than was currently in place, which was a significant challenge given the current workforce gaps in the service.</p> <p>The report highlighted vacancies in clinical leadership that needed to be filled, as well as an opportunity that stopped to bring together technology and optometry clinical leadership in a more coordinated way.</p> <p>Finally, another challenge had been highlighted in terms of at the constraints presented by the estate, across the three sites, therefore the issues were not unique to any one particular site.</p> <p>It was crucial for the health board to gain sufficient understanding of the change that was needed to be made to its estate as this could aid the attainment of efficiency gains and build capacity.</p>	

Agenda Item	Action
<p>Richard Micklewright enquired about the graph in section 30, (which outlined the trends on the number of operating theatre sessions) and whether the data enabled an understanding of the level of productivity was, and whether the Health Board was an outlier.</p> <p>The Executive Director of Finance explained that the Executive Team had detailed discussions before the impact of COVID on Client Care and Use of our theatres, and the impact of ensuring robust infection prevention control protocols were appropriately in place.</p> <p>It was confirmed that the proportion of productivity lost as a result of these measures was estimated at 30% .This review also indicated that the Health Board was not an outlier across the UK or NHS Wales.</p> <p>The Committee was informed that the other two reports pertaining to Taking Care of the Carers and A Picture of HealthCare were submitted for information and assurance to the committee.</p> <p>Audit Wales highlighted the findings of the report on commissioning old people's home placements, which was submitted to the private session of the committee as it had to be submitted to the Local Government Executive before it could be published publicly.</p> <p>In terms of the report, it's a cross cutting regional review undertaken across north Wales, with the Northwest councils and the health board, focusing very much on the commissioning of cabin placements.</p> <p>In addition, the audit highlighted that the partners are working individually collectively to provide a calf replacement, however this made it as it created complex national processes.</p> <p>There's a significant focus on costs, which appeared to cause division amongst partners and has the potential to impact adversely on service users and their families.</p> <p>In the report, Audit Wales had highlighted the need to strengthen accountability and more joined up regional strategic approach and plan that creates the potential to drive positive change, stronger partnership working. Partners have developed market shaking statements in 2018. But there hasn't really been any real reporting and agreed to follow this up with the Deputy Chief Executive after the meeting.</p> <p>The Committee noted and received the report.</p>	
<p>AC21.82:Schedule of Financial Claims</p> <p>The Finance Director of Operational Services presented the Schedule of Finance Claims report.</p> <p>He informed the committee that the report incorporated appropriate authorisations have been given for claims over the value of 50,000.</p> <p>There was a very tight process around authorised signatories, which were verified within the Finance department before any payments were made.</p>	

Agenda Item	Action
<p>Claims were also managed in accordance with the national legal and risk service risk score standards which was audited every year, with the most recent audit opinion allocated as substantial assurance.</p> <p>Every case we also submit nationally case management report and learning from events report, which is scrutinised by a learning panel awash with support and then the Welsh responsibility. The team continued to operate within the outlined process and have that assurance that is the case.</p> <p>There were a number of claims reported on this quarters report more than previous reports due to the legal system recovering normalcy.</p> <p>Questions were invited.</p> <p>Richard Micklewright enquired whether the Health Board was liable for some claims that dated back to 2006 and 2008. It was clarified that the Trust was liable for these two predecessor maternity claims that tended to be longstanding in nature.</p> <p>The Committee noted and received the Schedule of Claims report</p>	
<p>AC2183: Issues of Significance for Reporting to Board</p> <p>It was agreed that the Committee would escalate the concerns around the YGC audit to the January Board meeting.</p> <p>The Committee noted and approved the matter of significance for reporting to the January Board.</p>	
<p>AC21.84: Date of Next Meeting: 15/03/2022</p>	
<p>AC21.85: Exclusion of Press and Public</p> <p>RESOLVED:</p> <p>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.</p>	



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PUBLIC AUDIT COMMITTEE MEETING

REPORT ON MATTERS ARISING

Matters arising including items from the meeting held on 14th December 2022

Item no	Minute ref. no	Action	Lead Director	Original Completion Target Date	Action Status	Revised Completion Date
1	AC21.60: Performance Accountability Report (PAF)	Review and build in the PAF into the mandatory framework.	Executive Director of Finance	December 2021	Ongoing The PAF is being incorporated into the accountability framework, which may be subject to change in line with the revised operating model.	June 2022
2	AC21.60: Performance Accountability Report	Review arrangement in place for holding corporate functions to account on the PAF, to align with the Divisions.	Executive Director of Finance	December 2021	The accountability framework schedule is being revised to include a corporate function review for the next round of quarterly meetings. It will be submitted to the Board as part of the assurance to support the Operating Model.	
3	AC21.79 Corporate risk register	Consideration to be given to expanding the legionella risk to be expanded to incorporate non BCU sites	Interim Director of Governance	March 2022	Completed The Director of Estates and Facilities and the Health and Safety Team have reviewed arrangements for managing the legionella risk which is held by the Local Authority (as landlord)	March 2022

					Clarification has been given that the premises owned have had a legionella audit, which gave reasonable assurance .	
4	AC21.79 Corporate risk register	To review the controls aligned against the diminishing workforce risk, (to incorporate more strategic and medium term controls), and submit the output to Quality Safety Experience Committee	Interim Director of Governance	March 2022	<p>Action Completed</p> <p>A meeting was held by the risk team in the week commencing the 21st of February 2022 and:</p> <ol style="list-style-type: none"> 1. Controls in place reviewed to align with current position. 2. Gaps updated to reflect the current position of the risk 3. 2 new actions identified 4. Risk updated to incorporate feedback from the Audit Committee. 	Completed
5	AC21.80 Internal Audit Progress Report	Audit Committee chair to escalate YGC governance concerns to the January Health Board	Audit Committee Chair	January 2022	Completed, incorporated within Audit Committee Chair's report	Completed

Audit Committee**15.03.22****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
18.11.21	Health Board	Publication of papers 7 days before meeting	Range of private papers not signed off by publication date - published 2 working days after. Covid slides prearranged to follow as per usual arrangement. Welsh translation of 2 documents not available on publication day.	Welsh September minutes Welsh PFIG report Covid 19 RTC update - private Robotics update - private
9.12.21	Partnerships People Population Health Committee	Publication of papers 7 days before meeting	3 papers to follow rest of papers published after close of business publication date	Sustainability & Decarbonisation Developing People and OD draft strategy Staff Wellbeing report
17.12.21	Mental Health and Capacity Compliance Committee	Publication of papers 7 days before meeting	Whole agenda breached as lead Director involved in Covid Omicron work	All

Philippa Peake-Jones

Head of Corporate Affairs

20.01.22	Health Board	Publication of papers 7 days before meeting	Covid slides prearranged to follow as per usual arrangement.	Covid Update
01.03.22	Quality, Safety & Experience Committee	Publication of papers 7 days before meeting	Delay in publication of one agenda item by three days due to further advice on contents of report.	External Serious Incident Reviews

Philippa Peake-Jones
Head of Corporate Affairs

Audit Committee: Proposed Cycle of Business 2022/23

Agenda Item	24/05/22 May workshop	13/06/2022	27/09/2022	13/12/2022	21/03/2023	Public or Private
Opening Business						
Members discussions with internal and external audit		√	√	√	√	Private
Apologies for absence		√	√	√	√	Public
Minutes of previous meeting for accuracy & matters arising and review of summary action plan		√	√	√	√	Public
Governance						
Chair's Assurance Report RMG		√	√	√	√	Public
Board Assurance Framework		√				Public
Risk Management Strategy Review		√				Public
Review of Corporate Risk Register		√		√		Public
Performance Accountability Framework			√			Public
Note business of other committees and review inter-relationships	review cttee annual reports					Public
Review of amendments to Standing Orders		√	√	√	√	Public
Details of Breaches of SOs (late papers etc.)		√	√	√	√	Public
Review draft Annual Governance Statement	draft	approval				Public

Agenda Item	24/05/22 May workshop	13/06/2022	27/09/2022	13/12/2022	21/03/2023	Public or Private
Review organisation's annual report	draft	approval				Public
Annual review of gifts & hospitality and DoI registers			√			Public
Special Measures Progress Update on relevant areas (Revised schedule awaited for Targeted Intervention reporting)						Public
Legislation Assurance Framework			√		√	Public
Annual review of submissions on Database to capture externally commissioned reports etc. Eg DU, CHC etc.			√			Public
Finance						
Review of amendments to SFIs		√	√	√	√	Public
Details of Breaches of SFIs		√	√	√	√	Private
Post payment verification progress report			√		√	Private
Dental Assurance Report		√		√		Public
Financial Conformance report (inc review of losses & special payments, review of risks and controls and reporting of any SFI breaches)		√	√	√	√	Private

Agenda Item	24/05/22 May workshop	13/06/2022	27/09/2022	13/12/2022	21/03/2023	Public or Private
Financial Conformance Report bi-annual update: Details of Chairs Actions		√		√		Private
Review annual accounting progress and note financial accounting timetable				√		Public and Private
Schedule of Financial Claims		√	√	√	√	Public and Private
Review of audited annual accounts and financial statements including Charitable Funds if ready		√		CF final		Public
Internal Audit						
Internal Audit progress report		√	√	√	√	Public
Report from IA tracker tool		√	√	√	√	Private
Review and approval of internal audit plan including Internal Audit Charter					√	Public
Receive annual internal audit report (head of IA opinion)		√				Public
Review effectiveness of internal audit		√	√	√	√	Public
Any no assurance or limited assurance reports as a substantive item		√	√	√	√	Public
External Audit						
Auditor General's (external audit) progress reports		√	√	√	√	Public

Agenda Item	24/05/22 May workshop	13/06/2022	27/09/2022	13/12/2022	21/03/2023	Public or Private
Report from EA tracker tool		√	√	√	√	Private
National audit reports for information		√	√	√	√	Public
Review and approval of Auditor General's (external audit) plan					√	Public
Structured Assessment				√		Public
Receive Auditor General's report to those charged with governance (through letter of representation)		√				Public
Receive the Auditor General's annual audit report				√		Public
Review the effectiveness of external audit (through quarterly WAO progress reports)		√	√	√	√	Public
Counter Fraud						
Review counter fraud progress reports		√	√	√	√	Private
Agree counter fraud annual work plan		√				Private
Review effectiveness of LCFS Specialist (through Counter Fraud Authority Quality Assessment)			√			Private
Counter fraud annual report		√				Private
Clinical Audit						
Clinical audit plan		√			√	Public
Audit Committee						
Plan how to discharge audit committee duties					Agree Cycle of Business	Public

Agenda Item	24/05/22 May workshop	13/06/2022	27/09/2022	13/12/2022	21/03/2023	Public or Private
Undertake self-assessment of Committee effectiveness	review	sign off				Public and Private
Briefings and update sessions (as appropriate)	√	√	√	√	√	
Produce Committee annual report including refresh of ToR	x draft	x final				Public
Members discussion with Head of Counter Fraud				√		Private
Closing Business						
Summary of In Committee business to be reported in public		√	√	√	√	Public
Issues of Significance		√	√	√	√	Public
Date of Next meeting(s)		√	√	√	√	Public

Cyfarfod a dyddiad: Meeting and date:	Audit Committee 15/03/22				
Cyhoeddus neu Breifat: Public or Private:	Public				
Teitl yr Adroddiad Report Title:	Summary of Business Considered in Private Session to be Reported in Public				
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary				
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager				
Craffu blaenorol: Prior Scrutiny:	Board Secretary				
Atodiadau Appendices:	None				
Argymhelliad / Recommendation:					
The Audit Committee is asked to note the report.					
Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)					
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	Er gwybodaeth For Information
					✓
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable					N
<i>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.</i>					
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 14/12/21:					
<ul style="list-style-type: none"> Minutes of the Private Session of Audit Committee held on 28/09/21 and Action Log Schedule of Financial Claims 					

- Corporate Risk Register
- Financial Conformance Report
- Counter Fraud Progress Report
- Update on Internal/External Audit Actions (Tracker Tool).
- Audit Wales Report: Commissioning Older People's Care Home Placements

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.



Bwrdd Iechyd Prifysgol
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University Health Board

Cyfarfod a dyddiad: Meeting and date:	Audit Committee: 15/03/22						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Chair's Assurance Report, Risk Management Group						
Name of Chair	Dr Nick Lyons Executive Medical Director						
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans, Interim Director of Governance						
Awdur yr Adroddiad Report Author:	David Tita, (Head of Risk Management)						
Craffu blaenorol: Prior Scrutiny:	Risk Management Group on 7th February 2022						
Atodiadau Appendices:	N/A						
Argymhelliad / Recommendation:							
The Audit Committee is requested to note this 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	
Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.							
Sefyllfa / Situation:							
<p>The Risk Management Group (RMG) met on 7th February 2022. The Group was quorate with good representation. The Chair expressed the need for everyone across the Health Board to place effective risk management at the heart of how they work. The Chair further informed members that risk management is not a sideline issue but a tool that we can effectively use in driving change, enhancing better decision-making, shaping investment, continuously improving the quality of clinical care and services and ensuring financial viability and sustainability. Members were asked to note the Chair's Action Report of 13th December 2021.</p> <p>This paper presents highlights of the discussions that took place at the RMG while underlining any key recommendations that were made.</p>							

Cefndir / Background:

- **Minutes**

The minutes from the meeting on the 11th November 2021 were approved as an accurate record; the meeting due on 13th December 2021 was stood down due to Covid-19 pressures.

- **Meeting Action Tracker**

Scrutiny of the Risk Management Action Tracker took place, with proposals for comprehensive action chasing to take place outside of future meetings. The Chair then advised members to send updates to the RMG administrator/minute taker on any outstanding actions so as to allow focussed discussions on risks and reports that were being presented at the meeting.

- **Board Assurance Framework (BAF) Risk Reviews**

The updated BAF report was presented to the Board in January 2022 and it highlights the top strategic risks to the Health Board. A review was undertaken on the BAF risks, noting the ongoing piece of work to refresh the BAF, which will see some risks aggregated, others de-escalated onto the CRR for continuous management, new ones added and the Risk Appetite Statement reframed in line with the IMTP and new Operating Model. Controls and mitigations of the BAF risks which were presented for deep dive were checked and challenged, and assurance provided that further work will be undertaken to strengthen the risks in line with the recommendations articulated by members.

Members then undertook deep dives into the following three BAF risks in order to provide check and challenge, scrutiny and gain assurance while further updates were provided by the risk lead officers:

- BAF 21-04 Planned Care (Timely Access to Planned Care) - Members discussed the above risk and talked about the fact that our position has deteriorated due to Winter as we had a Covid spike in December 2021 and as the Health Board took a decision to prioritise the Vaccination Programme. We have maintained the Cancer position but non-urgent cases have continued to grow in number.
Work within Directorates to re-start work has begun and we will not have a full programme of work in place until the end of the financial year.

Members also noted the following other mitigating actions that are being implemented:-

- We are presenting a business case on the Model Ward Option(s), which will give us a medium term sustainable solution pending the delivery of the regional treatment centres.
- The GIRFT process within Orthopaedics started last week, and it is believed it will be a major step forward in terms of how to better utilise resources and reduce waiting lists quicker. Two other specialities Urology and Ophthalmology will follow at the end of this month, with General Surgery and Gynaecology to follow later.
- Members also noted a number of initiatives that are being considered to streamline the follow-up review list to minimise bringing patients back unnecessarily. A validation process is being embarked upon in order to further mitigate .

Members recommended that this BAF risk should be updated to align with strategy priority 2: (Recovering access to timely planned care pathways).

- BAF 21-17 Estates and Asset Development - Members discussed the challenges raised by our ageing estate and the level of investment required. Members noted the plans in place to update the Estate Strategy. Members also noted our learning from Covid-19 especially around social distancing and the impact that is having on how we manage our estates going forward

concerning suitability, sufficiency and capacity. There has been an increase in the current score of this risk to reflect the backlog of maintenance but this will be tackled through solutions like partnership working and the use of Corporate Hubs. Members also noted the significant number of risks that are being held and managed as Tier 2 within Estates and Facilities as these are more topic specific. Members also noted the current state of Primary Care estate and how this links to the BAF risk around Primary Care sustainability and were assured that there is a read across between Estates and Facilities risks and Health & Safety risks as most Health and Safety risks are held on the Estates and Facilities risk register.

- BAF 21-21 Estates and Assets - The close relationship and connection between BAF 21-17 and BAF 21-21 was noted as whilst the former is about the condition of the estate, this risk focuses on the level of capital available to modernise our estate. Members noted that BAF 21-21 highlights some of the synergy, which runs across both risks and recognise the need to bring some of these together in the new BAF. These risks are driving our estate modernisation programmes and the business cases we are submitting to the WG. Members recommended that both BAF risks 21-17 and 21-21 be amalgamated to make them sufficiently strategic while ensuring the main thrusts of both risks are highlighted in the new BAF risk to include the prioritisation of capital.

- **Review of the Tier 1 Corporate Risk Register (CRR)**

A review was undertaken of the CRR risks, noting that the Corporate Risk Team regularly meets with the lead risk officers to support them in reviewing and updating their risks on the CRR. 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.

In reviewing the CRR 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 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 March to June 2022, with presentation to the Board in June 2022.

A deep dive session took place into the following CRR risks, with assurance and further updates provided by the risk lead officers:

- CRR20-05 – Timely Access to Care Homes - Members noted the challenges around accessing some of BCU's independent placement providers and recognised that there is a related piece of work that's being done across Wales. The report regarding market stability has been delayed slightly due to the last wave of the pandemic, but the service is working closely with providers and local authorities to help identify gaps in commissioned placements. Members also noted challenges in relation to Continuing Health Care (CHC) because of the need to prioritise support to the care sector especially in the light of the last wave of Covid. The CHC Quality Assurance Framework is due by the end of March 2022. Members also noted the progress that has been made around the medically fit for discharge process through the use of IT solutions and the appointment of a staff to lead on the discharge policy.
- CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients. - This risk was not initially due as part of the deep dive and will be further discussed at the next RMG, however members noted the progress that has been made as the

controls and gaps in controls have been reviewed to align with current risk position. Members also noted the identification of a new action ID 20995, which focuses on training additional non-medical Intra Vitreal Therapy (IVT) injectors in order to reduce waiting times, hence the likelihood of the risk crystallising.

- CRR21-11 – Cyber Security - Members recognised the further updates that have been made to this risk since the papers for the RMG were published and noted that all actions were on track. The title of this risk has now been reframed to read ‘ransomware and Zero Day attacks’ while its description has also been refreshed to align with the Health Board’s structured approach for describing risks. Some members challenged the high score of the risk and queried if there are incidents to underpin it but the service argued that while we haven’t recorded any incidents at BCU, other healthcare organisations especially in Ireland have witnessed large ransomware attacks which justifies its score.
- CRR21-14: There is a risk that the increased level of Deprivation of Liberty Standards (DoLS) activity may result in the unlawful detention of patients - Members noted that the deep dive into this risk has been postponed as the changes that have been made to it have not yet received Executive approval.

5. New risks for escalation consideration

- Risk ID 3552 – Physical and environmental controls to support social distancing - Members discussed this risk noting that although there is a waiting room in the Emergency Department (ED, WMH) to keep people socially distanced, it can only accommodate 17 people, this room quite often holds considerably more than 17 people. Members noted that lateral flow testing for people attending ED at the door is only picking up a very small number of Covid-19 positive cases. Members also agreed that this risk should be held at Tier 2 because of the current mitigations that have been put in place, hence did not recommend it for escalation.
- Risk ID 3873 – Inability to deliver safe, timely and effective care - Members discussed this risk around flow and highlighted its strong link to the wider system as the challenge with Care Home admissions. Members also noted the ongoing work by the newly started Task and Finish group meeting that brings together the ED team, clinicians, consultants, nurses, head of nursing and operational managers on a weekly basis to explore new ways of facilitating flow. The current action plan and interventions in place include ambulance offloads and timely review of patients on ambulance. Members agreed that whilst there may be individual issues, which relate to particular sites, this risk spans across the whole Health board and should be reviewed to reflect an organisation-wide footprint.

Members then had some wider discussions on the distinction between a risk and an issue as understanding these two concepts is fundamental to strengthening and improving risk descriptions, calibration and the Health Board’s overall risk management landscape.

6. December Risk Reports – Summary Report presentation

This report underlines the continuous effort and engagement demonstrated by Divisions in updating and reviewing their risks despite challenges like the pressures created by Covid-19. The Corporate Risk Team is continuing to support Divisions in reviewing and updating their risk registers.

7. Directorate Risk Register Reports

Six Directorate Risk Register Reports were presented for discussion in line with the RMG's Cycle of Business. The reports reflect the level of risk management maturity and compliance with the Risk Management Strategy within. The Corporate Risk Team is in regular contact with Directorates across the Health Board to provide support with ensuring that their risks are often reviewed and in date. Members raised concerns about the low number of clinical risks on the CRR and advised Directorates to capture new risks as they review their risk registers and recommend any high ones for escalation. The Corporate Risk Team is supporting Directorates in exploring reports e.g. Performance, External Reviews/Visits and Quality & Safety, as sources of new and emerging risks while assessing, capturing them on Datix and managing them in line with our Risk Management Strategy.

8. Risk Management Performance and Assurance for Quarters 2 and 3 combined Report (incorporating progress on the improvement plan)

Members noted the report that was presented recognising that its content and indicators were in line with the Risk Management Strategy. The report highlighted organisational-wide compliance against each risk management key performance indicator as per the different risk Tier held and managed across the Health Board. The report also captured progress against the Risk Management Annual Improvement Plan and compliance with the risk Management training trajectory while noting that the Corporate Risk Team is providing support to those Directorates with low compliance. 704 staff have successfully attended our risk management training although 1030 had initially booked but some had to cancel due to work pressures.

9. The following emerging risks were identified from reports for further work-up:

- Capacity of EDs to deliver safe and sustainable services – to be articulated with lead officers and presented for approval at the next meeting.
- Ability to provide a safe and sustainable Endoscopy Service across the Health Board – to be articulated with lead officers and presented for approval at the next meeting.
- Lost to follow up – to be discussed and articulated with lead officers for BAF consideration and inclusion.
- Capacity and sustainability of current workforce – work to be undertaken to link local risks to overarching BCU wide workforce risks.
- Risk that the Health Board could fail to effectively manage and reduce estates and facilities backlog maintenance.
- Risk that Plant and Equipment will fail causing major disruption to clinical services if not enough capital funding and investment.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

This report aligns with the Health Board's Risk Management Strategy.

Opsiynau a ystyriwyd / Options considered

N/a

Goblygiadau Ariannol / Financial Implications

There are no financial implications linked to or highlighted in the report.

Dadansoddiad Risk / Risk Analysis

This report underlines the importance of appropriate and dynamic risk management, governance and report as key for embedding a positive risk aware culture and delivering assurance to the different stakeholders.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

There are no legal implications related to this report.

Asesiad Effaith / Impact Assessment

Due diligence and regards has been taken to ensure that this report aligns with the Impact Assessment embedded in the Risk Management Strategy.



Cyfarfod a dyddiad: Meeting and date:	Audit Committee 15 March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Master Scheme of Reserved Delegation						
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton, Board Secretary						
Awdur yr Adroddiad Report Author:	Molly Marcu, Interim Deputy Board Secretary						
Craffu blaenorol: Prior Scrutiny:	Director; Operational Finance, Board Secretary						
Atodiadau Appendices:	Appendix 1: Master Scheme of Reserved Delegation						
Argymhelliad / Recommendation:							
The Audit Committee is asked to note and endorse the updated Master Scheme of Reserved Delegation							
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	✓
Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
The purpose of this report is to enable the Committee to review proposed changes to the Standards of Business Conduct Policy which was due a review in August 2021.							
Cefndir / Background:							
The Master SORD is submitted to the Audit Committee ahead of a review by the Board at the 30 th March meeting.							
In updating the document, consideration has been given to the need for a transitional approach to implementing the operational model, which will impact on financial spend limits.							
A further review of the document will be submitted of the June meeting of the committee in order to determine whether changes are required as a result of its implementation.							
Key proposed amendments to highlight are :							
<ul style="list-style-type: none"> The standardisation of the assistant and associate director financial limits 							

- The application of a similar limit for the CEO, Deputy CEO and Executive Director of Finance, in order to add resilience to the operational approval process, in case of a period of absence.
- It is also proposed that the Performance, Finance and Investment Committee is delegated an authority limit of £850,000 to sign off business cases.
- In addition, it is also proposed that the Audit Committee's authority to approve losses and special payments is formally incorporated within the Master SORD

Strategy Implications

There are no specific strategy implications within this report.

Options considered

There are no further options for consideration.

Financial Implications

There are no specific financial implications within this report.

Risk Analysis

Non-compliance with Standing Orders and Corporate Governance processes pose a number of risks to the organisation. This report seeks to provide assurance that the requirements of the Standing Orders concerning the SORD is being appropriately complied with.

Legal and Compliance

As above, non-compliance with Standing Orders poses a risk to the corporate governance standards of the organisation.

Impact Assessment

An impact assessment is not required to support this report.

SECTION 2: SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The LHB Standing Orders and Standing Financial Instructions specify certain key responsibilities of the Chief Executive, the Executive Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the Standing Financial Instructions form the basis of the LHB's Scheme of Delegation to Officers.

Delegated Matter	Table Reference No.
STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS	1
MEETINGS	2
FINANCIAL PLANNING/BUDGETARY RESPONSIBILITY	3
BANK/PGO ACCOUNTS (EXCLUDING CHARITABLE FUND ACCOUNTS)	4
UNALLOCATED	5
NON PAY EXPENDITURE	6
STORES AND RECEIPT OF GOODS	7
CAPITAL INVESTMENT MANAGEMENT	8
QUOTATIONS, TENDERING & CONTRACT PROCEDURES	9
FIXED ASSETS	10
PERSONNEL & PAY	11
ENGAGEMENT OF STAFF (NOT ON THE ESTABLISHMENT)	12
CHARITABLE FUNDS HELD ON TRUST	13
PRIMARY CARE PATIENT SERVICES/HEALTHCARE AGREEMENTS	14
INCOME SYSTEMS, FEES & CHARGES	15
DISPOSAL AND CONDEMNATIONS	16
LOSSES, WRITE-OFFS & COMPENSATION AND EX-GRATIA PAYMENTS	17
REPORTING INCIDENTS TO THE POLICE	18
FINANCIAL PROCEDURES	19
AUDIT ARRANGEMENTS	20
LEGAL PROCEEDINGS	21
INSURANCE POLICIES AND RISK MANAGEMENT	22
CLINICAL AUDIT	23
PATIENTS' PROPERTY	24
PATIENTS' & RELATIVES' COMPLAINTS	25
SEAL	26
GIFTS & HOSPITALITY	27
DECLARATION OF INTERESTS	28
INFORMATICS AND THE DATA PROTECTION ACT	29
RECORDS	30
AUTHORISATION OF NEW DRUGS	31
AUTHORISATION OF RESEARCH PROJECTS	32
AUTHORISATION OF CLINICAL TRIALS	33
INFECTIOUS DISEASES & NOTIFIABLE OUTBREAKS	34

Delegated Matter	Table Reference No.
REVIEW OF FIRE PRECAUTIONS	35
HEALTH & SAFETY	36
MEDICINES INSPECTORATE REGULATIONS	37
ENVIRONMENTAL REGULATIONS	38
LEGAL & RISK PAYMENTS	39
INVESTIGATION OF FRAUD/CORRUPTION OR FINANCIAL IRREGULARITIES	40
COMMERCIAL SPONSORSHIP	41
COSTS/NOTIONAL RENT/THIRD PARTY DEVELOPER/IMPROVEMENT GRANTS	42
FREEDOM OF INFORMATION	43
COMPLIANCE LEAD ROLES: CALDICOTT GUARDIAN, DPO, SIRO	44
EMERGENCY PLANNING	45
NHS ACT 2006 (WALES) SECTION 33 AGREEMENTS	46
STATUTORY COMPLIANCE WITH RESPECTIVE LEGISLATION	47
APPOINTMENT OF MEDICAL & DENTAL CONSULTANT POSTS	48
INDIVIDUAL PATIENT FUNDING REQUESTS	49
CARBON REDUCTION COMMITMENT ORDER	50
HUMAN TISSUE ACT 2004	51
IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS 2017 [IR(ME)R]	52
NURSE STAFFING LEVELS (WALES) ACT 2016	53
WELSH LANGUAGE STANDARD REPORTING	54
CONTROLLED DRUGS ACCOUNTABLE OFFICER	55
UPHOLDING PROFESSIONAL STANDARDS IN WALES (UPSW)	56

Schedule 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS

Table A – Scheme of Delegation to Officers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. Standing Orders / Standing Financial Instructions		
a) Final authority in interpretation of Standing Orders	Chair	Chair
b) Notifying Directors, employees and agents of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Executive Director of Finance/Board Secretary	Directors
c) Responsibility for the security of the LHB's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial Instructions and financial procedures	Executive Director of Finance	Directors
d) Ensuring Standing Orders are compatible with Welsh Government requirements re building and engineering contracts	Chief Executive	Executive Director of Finance
2. Meetings		
a) Calling meetings of the LHB	Chair	Board Secretary
b) Chair all LHB Board meetings and associated responsibilities	Chair or Vice Chair in Chair's absence	Chair or Vice Chair in Chair's absence
3. Financial Planning/Budgetary Responsibility		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a) Setting:		
Submit Three Year Plan and Annual Operating Plan to the LHB Board	Chief Executive	Executive Director of Transformation and Improvement
Submit budgets to the LHB Board	Chief Executive	Executive Director of Finance
Submit to Board financial estimates and forecasts	Chief Executive	Executive Director of Finance
b) Implementing financial policies, plans and procedures, providing advice and co-ordinating any corrective action necessary	Executive Director of Finance	Director: Operational Finance
c) Issuing Budgets	Executive Director of Finance	Finance Director: Operational Finance
d) Monitoring:		
Monitor performance against budget	Executive Director of Finance	Executive and Associate Directors
Submit monitoring returns	Chief Executive	Executive Director of Finance
Effective budgetary control and a balanced budget	Executive Director of Finance	Executive and Associate Directors
Preparation of annual accounts and returns	Executive Director of Finance	Executive Director of Finance
Identifying and implementing cost improvements and income generation initiatives	Executive Director of Finance	Executive and Associate Directors
e) Authorisation of Virement It is not possible for any officer other than the Executive Director of Finance to vire from non-recurring headings to recurring budgets or from capital to revenue/revenue to capital. Virement <u>between</u> different budget holders (Directors) requires the agreement of <u>both</u> parties <u>and</u> the Executive Director of Finance	Executive Director of Finance	Please refer to Table B – Delegated Limits
f) Maintaining an effective system of internal financial control	Chief Executive	Executive Director of Finance
g) Delivery of financial training to budget holders (Directors)	Executive Director of Finance	Finance Director: Operational Finance
4. Bank/PGO Accounts (Excluding Charitable Fund Accounts)		
a) Operation:		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Managing banking arrangements and operation of bank accounts	Executive Director of Finance	Finance Director: Operational Finance
Opening bank accounts	Executive Director of Finance	Finance Director: Operational Finance
Authorisation of transfers between LHB bank accounts	Executive Director of Finance	Finance Director: Operational Finance
Authorisation of: -PGO/GBS Schedules -BACS Schedules -Automated cheque schedules -Manual cheques	Executive Director of Finance	Finance Director: Operational Finance
5. Non Pay Expenditure		
For details of Delegated Limits please refer to Table B		
a) Completion of an Operational Scheme of Delegation and Authorisation by each Budget Holder ensuring maintenance of a list of officers authorised to place requisitions/orders (including emergency verbal orders) and record receipts within the E-Financials Business Suite.	Executive Director of Finance	Executive and Associate Directors
b) Obtain the best value for money when requisitioning goods/services	Executive Director of Finance	Executive and Associate Directors
c) Ensuring expenditure is within budget	Chief Executive	Executive and Associate Directors
d) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive	Executive Director of Finance
e) Orders exceeding 12 month period	Executive Director of Finance	Finance Director: Operational Finance
f) Prompt payment of accounts	Executive Director of Finance	Executive Director of Finance
g) Financial Limits	Executive Director of Finance	Please refer to Table B – Delegated Limits
h) Maintenance of sufficient records to explain the LHB's transactions and report on the LHB's financial position	Executive Director of Finance	Finance Director: Operational Finance
i)		
j) Provision of electronic signatures within the E-Financials Business Suite in accordance	Executive Director of Finance	Finance Director: Operational Finance

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
with each Budget Holder's Operational Scheme of Delegation and Authorisation		
6. Stores and Receipt of Goods		
a) Responsibility for the systems of financial control over all stores including receipt of goods and returns	Executive Director of Finance	Directors
b) Responsibility for the control of stores and receipt of goods, issues and returns: All stores (excluding pharmaceutical, – see following)	Executive Director of Finance	Directors
Pharmaceutical Stores	Executive Medical Director	Chief Pharmacist
c) Stocktaking arrangements	Executive Director of Finance	Directors
7. Capital Investment Management		
For details of Delegated Limits for Delegated Matter 8d, please refer to Table B – Leases. In accordance with Welsh Government guidance:		
a) Programme:		
Preparation of Capital Investment Programme	Chief Executive	Executive Director of Finance
Completion and signing off of a business case for approval	Executive Director of Finance	Director of Finance; Operations
Appointment of Project Directors	Chief Executive	Executive Director of Finance with support from relevant Directors
Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Executive Director of Finance	Executive Director of Finance /Executive Director of Planning & Performance Executive Director of Finance with support from relevant Directors.
Issuing of guidance on management of capital schemes	Executive Director of Finance	Executive Director of Finance with support from relevant Directors.
b) Contracting – Selection of 3 rd party developers, architects, quantity surveyors,	Chief Executive	Executive Director of Finance

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
consultant engineers and other professional advisors within EC regulations and LHB tender procedures		
c) Private Finance – Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector	Chief Executive	Executive Director of Finance
d) Leases – Granting and termination of leases	Chief Executive	Executive Director of Finance
e) Financial control and audit- Arrangements are in place to review building and engineering contracts and property transactions comply with Welsh Government guidance.	Chief Executive	Executive Director of Finance
8. Quotations, Tendering & Contract Procedures For details of Delegated Limits, please refer to Table B – Quotations/Tenders.		
a) Services:		
Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Directors
Nominate officers to oversee and manage the contract on behalf of the LHB	Chief Executive	Directors
b) Quotations – Total value of the contract over its entire period:		
Seeking quotations up to £5,000 in value	Executive Director of Finance (per SFI 11.7.1)	Directors - For details of delegated limits, please refer to Table B
Obtaining minimum of 3 written quotations for goods/services of value between £5,000 and £25,000	Executive Director of Finance (per SFI 11.1.2)	Directors - For details of delegated limits. Please refer to Table B
c) Competitive Tenders – Total value of the contract over its entire period:		
Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and the OJEU threshold (in compliance with EC Directives as appropriate)	Executive Director of Finance	Relevant Directors - For details of delegated limits, please refer to Table B
Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of the OJEU threshold (in compliance with EC Directives as appropriate)	Executive Director of Finance	Relevant Directors - For details of delegated limits, please refer to Table B

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Receipt and custody of tenders prior to opening	Executive Director of Finance	Relevant Directors - For details of delegated limits, please refer to Table B
Opening Tenders and Quotations	Executive Director of Finance	Relevant Directors - For details of delegated limits, please refer to Table
Decide if late tenders should be considered	Executive Director of Finance	Relevant Directors - For details of delegated limits, please refer to Table
d) Waiving the requirement to request quotes or tenders – subject to SFI Schedule 1 Para. 4.2 & 4.3 – Formally reported to the Audit Committee	Executive Director of Finance	Finance Director: Operational Finance (who can escalate to the Executive Director of Finance or Chief Executive if necessary) The Chief Executive and Director of Finance cannot approve their own waiver and must seek approval from one other Executive Directors
9. Fixed Assets		
a) Maintenance of asset register	Executive Director of Finance	Finance Director (Operational Finance)
b) Calculate and pay capital charges in accordance with Welsh Government requirements	Executive Director of Finance	Finance Director (Operational Finance)
c) Responsibility for fixed assets – Land & Buildings	Executive Director of Finance	Director of Estates
d) Responsibility for all other fixed assets (Plant, Machinery, Transport, IT assets including software, Furniture & Fittings)	Executive Director of Finance	Director of Estates and Director of Digital, Deputy CEO with support from relevant Directors.
e) Responsibility for security of LHB assets including notifying discrepancies to the Director of Finance and reporting losses in accordance with LHB procedures	Chief Executive	Executive Director of Finance, with support from relevant Directors.
10. Personnel & Pay		
a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts in accordance with the “Policy for the Safe Recruitment and	Chief Executive	Executive Director of Workforce & OD

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Selection Practices" together with accompanying guidance, particularly the need for pre-employment checks.		
b) Approve the commencement of employment prior to all pre-employment checks being completed.	Executive Director of Workforce & OD	Deputy Director of Workforce & OD
c) Authority to fill funded post on the establishment with permanent staff.	Executive Director of Workforce & OD	Directors
d) The granting of additional increments to staff within budget in accordance with Terms & Conditions of Service	Executive Director of Workforce & OD	Executive Directors with advice from Executive Director of Workforce & OD
e) All requests for upgrading/ regrading/ major skill mix changes shall be dealt with in accordance with LHB Procedure	Executive Director of Workforce & OD	Executive Directors with advice from Executive Director of Workforce & OD
f) Authority to agree acting up salaries for staff other than Executive Directors, within budget (Approval of acting up salaries for interim Executive Directors to be retained by Remuneration & Terms of Service Committee)	Chief Executive to agree acting up arrangements of Band 9 and above (Excluding Executive Directors)	Executive Directors lead for acting up salaries up to Band 8d or equivalent.
g) Establishments:		
Locum/additional staff to the agreed establishment with specifically allocated finance	Executive Director of Finance	Directors with support from the Director of Finance (Operational)
Locum/additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Executive Director of Finance
Variation to the funded establishment	Chief Executive	Directors with approval from Executive Director of Finance
h) Pay		
Authority to complete standing data forms effecting pay, new starters, changes and leavers	Executive Director of Workforce & OD	Directors, and approved managers
Authority to complete and authorise timesheets and payroll returns	Executive Director of Workforce & OD	Directors, and approved managers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Authority to authorise overtime	Executive Director of Workforce & OD	Directors, and approved managers
Authority to authorise travel & subsistence expenses	Executive Director of Workforce & OD	Directors, and approved managers
Maintenance of a list of managers authorised to sign payroll and travel expense documentation.	Executive Director of Workforce & OD	Directors, and approved managers
i) Leave		
Approval of annual leave in accordance with LHB policy	Executive Director of Workforce & OD	Directors, and approved managers
Carry-over of annual leave in exceptional circumstances up to a maximum of 5 days	Executive Director of Workforce & OD	Directors, and approved managers
Compassionate leave	Executive Director of Workforce & OD	Directors, and approved managers
Special leave arrangements (to be applied in accordance with All Wales Policy)	Executive Director of Workforce & OD	Directors, and approved managers
Leave without pay	Executive Director of Workforce & OD	Directors, and approved managers
Medical Staff Leave of Absence – paid and unpaid	Executive Director of Workforce & OD	Directors, and approved managers
Consultants Special Leave	Executive Medical Director	Directors, and approved managers
Time off in lieu	Executive Director of Workforce and OD	Directors, and approved managers
Maternity / Paternity Leave – paid and unpaid	Executive Director of Workforce & OD	Directors, and approved managers
j) Annualised hours/flexible working hours system- maintenance of adequate records	Executive Director of	Directors, and approved managers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Workforce & OD	
k) Sick Leave		
Extension of sick leave on half pay up to three months	Executive Director of Workforce & OD	Directors, and approved managers , in conjunction with Executive Director of Workforce & OD/delegate
Return to work part-time on full pay to assist recovery	Executive Director of Workforce & OD	Directors, and approved managers , in conjunction with Executive Director of Workforce & OD/delegate
Extension of sick leave on full pay	Executive Director of Workforce & OD	Directors, and approved managers , in conjunction with Executive Director of Workforce & OD/delegate
l) Study Leave		
Study leave outside the UK (non-medical staff excluding clinical staff)	Executive Director of Workforce & OD	Directors, and approved managers
Medical staff study leave (UK)	Executive Medical Director/ Executive Director of Workforce & OD/ Executive Director of Integrated Clinical Delivery	Directors, and approved managers
Consultant Medical Staff Leave (UK)	Executive Medical Director	Directors
All Medical and non-Medical Clinical Staff study leave outside the UK	Executive Medical Director/ Executive Director of Nursing & Midwifery/ Executive Director of Therapies & Health Science/	Directors

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Executive Director of Integrated Clinical Delivery	
All other study leave (UK)	Executive Director of Workforce & OD	Directors, and approved managers
m) Removal Expenses		
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Executive Director of Workforce & OD	Directors, and approved managers accordance with BCU HB policy/approval from the Executive Director of Workforce & OD
n) Grievance Procedure	Executive Director of Workforce & OD	Directors, and approved managers
o) Professional Misconduct/Competence- Medical and Dental Staff	Executive Medical Director/ Executive Director of Workforce & OD	Assistant Medical Director supported by Workforce & OD
p) Suspension of Doctors employed directly by the LHB	Executive Medical Director	Assistant Medical Director supported by Executive Director of Workforce & OD
q) Removal of Practitioner from the Performers List	Chief Executive	Executive Medical Director supported by Executive Director of Workforce & OD and Executive Director of Integrated Clinical Delivery
r) Requests for new posts to be authorised as car users	Executive Director of Finance	Directors and Managers
s) Renewal of Fixed Term Contract	Executive Director of	Directors and Managers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Workforce & OD	
t) Voluntary Early Release Scheme	Remuneration and Terms of Service Committee (supported by Executive Director of Workforce & OD)	Executive Director of Workforce & OD, with Executive Director of Finance for sign off of financial viability
u) Settlement on termination of employment	Executive Director of Workforce & OD	Executive Director of Workforce & OD with approval from Welsh Government where the payment is Ex-gratia and exceeds the delegated limit of £50,000
v) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from Workforce & OD Department	Executive Director of Workforce & OD	Executive Director of Workforce & OD
w) Disciplinary Procedure(excluding Executive Directors)	Executive Director of Workforce & OD	Directors and approved managers
11. Engagement of Staff Not On the Establishment		
For details of Delegated Limits, please refer to Table B		
a) Non clinical Consultancy Staff	Executive Director of Finance	Director accountable for relevant service
b) Medical Locum staff	Executive Medical Director	Director accountable for relevant service.
c) Booking of Agency Nursing Staff	Executive Director of Nursing & Midwifery	Director accountable for relevant service
d) Booking of Bank Staff:		
Nursing	Executive Director of Nursing & Midwifery	Director accountable for relevant service
Other	Executive Director of	Director accountable for relevant service

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Workforce & OD	
12. Charitable Funds Held on Trust		
For details of Delegated Limits, Please refer to Table B		
a) Management: Funds held on Trust are managed appropriately	Executive Director of Finance	Directors
b) Maintenance of authorised signatory list of Authorised Fund Holders	Executive Director of Finance	Executive Director of Finance
c) Expenditure	Executive Director of Finance	Refer to Table B – Delegated limits
d) Fundraising Appeals – Preparation/Monitoring/Reporting progress and performance	Director of Communications and Partnerships	Fundraising manager,
e) Operation of Bank Accounts:		
Managing banking arrangements and operation of bank accounts	Executive Director of Finance in conjunction with Corporate Trustees	Executive Director of Finance
Opening bank accounts	Corporate Trustee	Executive Director of Finance
f) Investments – Policy and Arrangements	Executive Director of Finance in conjunction with Corporate Trustees	Executive Director of Finance
g) Authority to accept the discharge of a donor's estate	Executive Director of Finance	Executive Director of Finance
13. Primary Care Patient Services/ Healthcare Agreements		
For details of Delegated Limits, please refer to Table B – Healthcare Agreements		
a) Contract negotiation and provision of service agreements	Executive Director of Finance / Executive Director of Integrated	Executive Director of Finance / Executive Director of Integrated Clinical Delivery

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Clinical Delivery	
b) Reporting actual and forecast contract income	Executive Director of Finance	Executive Director of Finance
c) Pricing of all contracts and SLAs	Executive Director of Finance	Executive Director of Finance with relevant Director
d) Signing agreements	Chief Executive	Chief Executive or Executive Director of Finance in Chief Executive's absence/Executive Director of Integrated Clinical Delivery for all primary care related agreements
14. Income Systems, Fees and Charges		
a) Private Patients, Overseas Visitors, Income Generation and other patient related services	Executive Director of Finance	Executive Director of Finance
b) Pricing of NHS agreements	Executive Director of Finance	Assistant Directors of Finance
c) Informing the Director of Finance of monies due to the LHB	Executive Director of Finance	Directors, and approved managers
d) Recovery of debt	Executive Director of Finance	Finance Director: Operational Finance.
e) Security of cash and other negotiable instruments	Executive Director of Finance	Finance Director : Operational Finance., Directors and approved managers
f) Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due	Executive Director of Finance	Director of Finance: Operational Finance
g) Non patient care income	Executive Director of Finance	Finance Director: Operational Finance.
15. Disposal and Condemnations		
Disposal of all property and land requires formal approval by the Minister for Health and Social Services		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a) Issuing procedure for the disposal of assets obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	Executive Director of Finance	Executive Director of Finance
b) Notification to Director of Finance prior to disposal	Executive Director of Finance	Directors, and approved managers
16. Losses, Write-offs & Compensation		
a) Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response plan and informing Counter Fraud Operational Services of frauds.	Executive Director of Finance	Finance Director: Operational Finance.
b) Losses of cash due to theft, fraud, overpayment of salaries, fees, allowances & other causes up to £50,000	Chief Executive	Executive Director of Finance
c) Fruitless payments (including abandoned Capital Schemes) up to £250,000	Chief Executive	Executive Director of Finance
d) Bad debts and claims abandoned: Private patients; overseas visitors & other cases up to £50,000	Chief Executive	Executive Director of Finance
e) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other up to £50,000	Chief Executive	Executive Director of Finance
f) For personal and public liability claims, under the Legal & Risk scheme, authorisation from Legal & Risk is required before admissions may be made and monetary compensation offered. (Ex-gratia settlements offered by the LHB are by definition not payments based upon legal liability and are, therefore, not reimbursable under the WRP scheme)	Chief Executive	Executive Director of Nursing & Midwifery supported by the relevant Director after seeking appropriate legal advice, up to a max £150,000
g) Compensation payments made under legal obligation:	Chief Executive	Chief Executive, Executive Director of Finance or Executive Director of Nursing & Midwifery
h) Extra contractual payments to contractors – Up to £50,000 as specified within the Losses and Special Payments Manual of Guidance	Chief Executive	Executive Director of Finance with reporting to the Audit Committee
16.1 Ex-Gratia Payments:		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a) Patients and staff for loss of personal effects up to £50,000	Chief Executive	Executive Director of Finance- Refer to Finance Policy on Losses and Special Payments
b) For clinical negligence up to £250,000 (negotiated settlements)*. Report to Board > £50,000 (see also table B para.15)	Chief Executive	Executive Director of Finance/Executive Director of Nursing & Midwifery
c) For clinical negligence over £250,000 and up to £1,000,000* (negotiated settlements). Report to Board > £50,000 (see also table B para.15)	Chair Board	Chief Executive/ Executive Director of Finance/Executive Director of Nursing & Midwifery
d) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £250,000 (including plaintiff's costs) Report to Board > £50,000	Board	Chief Executive/ Executive Director of Finance/Executive Director of Workforce & OD/ Executive Director of Nursing & Midwifery
e) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £1,000,000 Report to Board > £50,000*	Board	Chief Executive/Executive Director of Finance/Executive Director of Nursing & Midwifery
f) Other, except cases for maladministration where there was no financial loss by claimant, up to £50,000	Chief Executive	Executive Director of Finance/Executive Director of Nursing & Midwifery
* For all clinical negligence and personal injury cases(including Court cases) the use of structured settlements should be considered involving costs to the NHS of £250,000 or more – All structured settlements require approval from the Welsh Government	Board	Chief Executive Executive Director of Finance/Executive Director of Nursing & Midwifery
17. Procedure to follow after reporting of incidents to the Police		
a) Where a criminal offence is suspected	Executive Director of Finance	Directors and approved managers
Criminal offence of a sexual or violent nature	Executive Director of Workforce & OD	Directors and approved managers
Arson or theft	Executive Director of Finance	Appropriate Director and approved managers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Other	Chief Executive	Directors (dependent upon the nature of the suspected offence)
18. Financial Procedures		
a) Maintenance & Update of LHB Financial Procedures	Executive Director of Finance	Finance Director : Operational Finance
19. Audit Arrangements		
a) Review, appraise and support in accordance with Internal Audit standards for NHS Wales and best practice	Chair of the Audit Committee	Board Secretary/Head of Internal Audit
b) Provide an independent and objective view on internal control and probity	Board Secretary	Head of Internal Audit/ Audit Wales
c) Ensure Cost-effective external audit	Chair of Audit Committee	Executive Director of Finance
d) Ensure an adequate internal audit service	Chief Executive	Board Secretary
e) Implement recommendations	Board Secretary	All relevant Directors
20. Legal Proceedings		
a) Engagement of LHB's Solicitors	Chief Executive	Board Secretary for all Board related matters/Executive Director of Workforce & OD for all employment related matters/Executive Director of Finance for all estate related matters/Executive Director of Integrated Clinical Delivery for all Primary Care related matters.
b) Approve and sign all documents which will be necessary in legal proceedings	Chief Executive	Any Executive Director of the Board or an officer formally nominated by the Chief Executive
c) Sign on behalf of the LHB any agreement or document not requested to be executed as a deed	Chief Executive	Any Executive Director of the Board or an officer formally nominated by the Chief Executive

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
21. Insurance Policies and Risk Management	Chief Executive	Executive Director of Finance and Executive Medical Director
22. Clinical Audit	Chief Executive	Executive Medical Director
23. Patients' Property (in conjunction with financial advice)		
For details of Delegated Limits, please refer to Table B – Petty Cash/Patients Monies		
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Executive Director of Nursing & Midwifery	Executive and Associate Directors and approved managers
b) Prepare detailed written instructions for the administration of patients' property	Executive Director of Nursing & Midwifery	Executive and Associate Directors and approved managers
c) Informing staff of their duties in respect of patients' property	Executive Director of Nursing & Midwifery	Executive and Associate Directors and approved managers
d) Issuing property valued >£5,000 only on production of a probate letter of administration	Executive Director of Finance	Director: Operational Finance.
24. Patients & Relatives Complaints		
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Executive Director of Nursing & Midwifery
b) Responsibility for ensuring complaints are investigated thoroughly	Chief Executive	Executive Director of Nursing & Midwifery
c) Medical – Legal Complaints Co-ordination of their management	Chief Executive	Executive Director of Nursing & Midwifery
25. Seal		
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Board Secretary
b) Attestation of seal in accordance with Standing Orders	Chief Executive/ Chair	Board Secretary
26. Gifts and Hospitality		
a) Keeping of gifts and hospitality register	Chief Executive	Board Secretary

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
27. Declaration of Interests		
a) Maintaining a register of interests	Chief Executive	Board Secretary
28. Informatics and the Data Protection Act		
a) Review of LHB's compliance with the Data Protection Act	Chief Executive	Director of Digital
b) Responsibility for Informatics policy and strategy	Executive Medical Director	Director of Digital
c) Responsibility for ensuring that adequate management (audit) trails exist in Informatics systems	Executive Medical Director	Director of Digital
29. Records		
a) Review LHB's compliance with the Retention of Records Act and guidance	Chief Executive	Director of Digital / Executive Medical Director
b) Approval for the destruction of records	Chief Executive	Director of Digital / Executive Medical Director
c) Ensuring the form and adequacy of the financial records of all departments	Executive Director of Finance	Director: Operational Finance
30. Authorisation of New Drugs	Chief Executive	Executive Medical Director on the advice of the appropriate professional bodies
31. Authorisation of Research Projects	Executive Director of Therapies & Health Sciences	Director of Research & Development
32. Authorisation of Clinical Trials	Chief Executive	Medical Director
33. Infectious Diseases & Notifiable Outbreaks – outbreak control / public health monitoring and surveillance / provision of public health advice	Chief Executive	Executive Director of Public Health
34. Review of Fire Precautions	Chief Executive	Executive Director of Finance
35. Health & Safety		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Executive Director of Workforce & OD
36. Medicines Inspectorate Regulations		
Review Regulations Compliance	Chief Executive	Executive Medical Director supported by Chief Pharmacist
37. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Executive Director of Finance	Director of Estates
38. Legal & Risk Payments	Chief Executive	Executive Director of Nursing & Midwifery/Executive Director of Finance
39. Investigation of Fraud/Corruption or Financial Irregularities	Executive Director of Finance	Lead Local Counter Fraud Specialist
40. Commercial Sponsorship		
Agreement to proposal in accordance with BCU HB procedures	Chief Executive	Executive Director of Finance
41. Cost/Notional Rent/Third Party Developer/Improvement Grants		
Approval of all schedules of payments	Chief Executive	Executive Director of Integrated Clinical Delivery
Submission to Welsh Government for all new GP premises or major extensions in accordance with BCU HB Primary Care Estates Strategy	Chief Executive	Executive Director of Integrated Clinical Delivery
42. Freedom of Information	Chief Executive	Director of Digital
43. Compliance Lead Roles:		
a) Caldicott Guardian	Executive Medical Director	Senior Associate Medical Director
b) Data Protection Officer	Chief Executive	Assistant Director of Information

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
c) Senior Information Risk Owner	Chief Executive	Governance and Assurance Executive Director of Finance
44. Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)	Chief Executive	Executive Director of Transformation and Improvement
45. National Health Services (Wales) Act 2006 Section 33 Agreements: Arrangements between NHS Bodies and Local Authorities	Chief Executive	Executive Director of Finance
46. Statutory compliance with respective Legislation	Chief Executive	Board Secretary
47. National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 (Statutory Instrument 2005: 3039) Appointment of all Medical and Dental Consultant posts. Consultant posts within Public Health that are open to both medically qualified and those qualified in other disciplines other than medicine should follow this process, even though they fall outside of the requirements of the Statutory Instrument.	Chief Executive	Executive Directors
48. All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR)	Chief Executive	WHSSC IPFR Panel £300,000 to £1,000,000; Chief Executive up to £299,999; Chair and Vice Chair of Health Board IPFR Panel together sign up to £125,000
* The IPFR Panel cannot make policy decisions for the health board. Any policy proposals arising from their considerations and decisions must be reported to the Health Board Quality, Safety & Experience Committee		
49. Carbon Reduction Commitment Order (Phase 2) Agency Registration	Chief Executive	Executive Director of Finance
50. Human Tissue Act 20014	Chief Executive	Executive Director of Therapies & Health Sciences

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
51. Ionising Radiation (Medical Exposure) Regulations 2017	Chief Executive	Executive Director of Therapies & Health Sciences
52. Nurse Staffing Levels Act (Wales) 2016	Chief Executive	Executive Director of Nursing & Midwifery
53. Welsh Language Standard Reporting	Chief Executive	Executive Director of Public Health
54. Controlled Drugs Accountable Officer	Chief Executive	Chief Pharmacist
55. Upholding Professional Standards in Wales (UPSW):		
Responsible Officer	Executive Medical Director (Responsible office)	Deputy Medical Director (Deputy Responsible Officer)
Appointing a Designated Board Member	Health Board Chair	Vice Chair

Table B – Scheme of Financial Delegation

Financial Limits are subject to funding available within relevant budget(s) and are inclusive of VAT irrespective of recovery arrangements.

All purchases must ensure compliance with Standing Financial Instruction Schedule 1 -

Procurement of Works, Goods and Services with regard to the required quotation or Tendering exercise.

	Budget changes	General expenditure	Healthcare agreements	Capital (Business Case and Contractual Commitment approvals)			Specialist				Charitable Funds		Procurement waivers	Staffing	
		Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.													
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)
WG (In advance of contract planning)	No requirement	£1m plus	£1m plus (Private sector)	£1m plus	£1m plus	£1m plus	No requirement	£1m plus	See Manual of Guidance for losses and SFIs, as special rules apply for certain losses and ex gratia payments.	No requirement	No requirement	No requirement	No requirement	No requirement	No requirement
Board following Chief Executive approval	£1m plus	£1m plus	Over £10m approved in advance, below £10m retrospectively reported. Over £1m for Private sector.	£1m plus	£1m plus	£1m plus	£0.5m plus or any which need signing under seal (Reservation of Power, Number 33)	£0.5m plus		£1m plus	No requirement	No requirement	No requirement	No requirement	No requirement
Audit Committee													Retrospective reporting		
Charitable Funds Committee (all Executives can authorise use of charitable funds up to £5k)											Over £5k (Up to £25k scrutinised by CF Advisory Group)	Over £5k (Up to £25k scrutinised by CF Advisory group)			
CEO through Executive Team	£0.5m to £1m	£0.5m to £1m	New or contract variation to £10.0m.	£0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£250k to £0.5m	£250k to £0.5m	£0.5m to £1.0m	£0.5m to £1.0m	Up to £5k	Up to £5k	As escalated by DoF	Can approve new posts across LHB	No requirement
Deputy CEO	£0.5m to £1m	£0.5m to £1m	New or contract variation to £10.0m.	£0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£250k to £0.5m	£250k to £0.5m	£0.5m to £1.0m	£0.5m to £1.0m	Up to £5k	Up to £5k	As escalated by DoF	Can approve new posts across LHB	No requirement
Any 2 of CEO, Executive Director of Integrated Clinical Delivery and DoF (must include DoF)		Up to £0.5m	New or contract variation to £5.0m (to £1m for Private sector).					Up to £250k		Up to £0.5m			As escalated by DoF		
Executive Director of Finance	£0.5m to £1m	£0.5m to £1m	New or contract variation to £10.0m.	£0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£250k to £0.5m	£250k to £0.5m	£0.5m to £1.0m	£0.5m to £1.0m	Up to £5k	Up to £5k	As escalated by DoF	Can approve new posts across LHB	No requirement

	Budget changes	General expenditure	Healthcare agreements	Capital (Business Case and Contractual Commitment approvals)			Specialist				Charitable Funds		Procurement waivers	Staffing		
		Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.														
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishments)	Agency and Waiting List Initiatives (all values)	
Executive Directors, Board Secretary (unless noted below)		Up to £250k						Up to £100k					Waivers must be approved by FD: OF and Exec.Director of Finance or Chief Executive if escalated by FD: OF	Can approve new posts within own structure.	Must approve in advance in own structure.	
Executive Director Transformation and Improvement		Up to £250k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.	
Executive Medical Director		Up to £250k						Up to £100k							Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Public Health		Up to £250k						Up to £100k								
Executive Director of W&OD		Up to £250k						Up to £100k	Terminations up to £50k (over this to WG)						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Nursing & Midwifery		Up to £250k						Up to £100k	Up to £150k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Therapies & Health Sciences		Up to 250k				Up to £150k		Up to £100k								

	Budget changes	General expenditure	Healthcare agreements	Capital			Specialist				Charitable Funds		Procurement waivers	Staffing	
		Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.													
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations only approved by Exec Director of W&OD; VERS require RATS Committee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishments)	Agency and Waiting List Initiatives (all values)
Integrated Health Care Directors , Health Community Director of Operations, Director of Mental Health & Learning Disabilities		Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med Mgt Group	Up to £5k			Can approve new posts within own team.	As escalated by Direct Reports*
Associate Directors		Up to £150k			Up to £150k			Up to £150k			Up to £5k				Medical staff*
Assistant Directors		Up to £75k	Up to £75k		Up to £75k			Up to £75k			Up to £5k				
Head of Investigations and Redress									Up to £20k						
Claims Managers									Up to £5k						
Authorised fund holder (Charitable Funds)											Up to £5k				
Medicines Management Group										All new drugs, unless cheaper than existing					

	Budget changes	General expenditure	Healthcare agreements	Capital			Specialist				Charitable Funds		Procurement waivers	Staffing	
		Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.													
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations only approved by Exec Director of W&OD; VERS require RATS Committee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishments)	Agency and Waiting List Initiatives (all values)
Regional Director/ Director of Partnerships, Communication & Engagement/ Director of Transformation/ Director of Governance/ Director of Performance/ Director of Midwifery & Women's Services / Director of MHLDT? Other Assistant Directors/Chief Pharmacist/Deputies Board Sec Asst CEO															
* Agency and Waiting List Initiatives must generally be approved in advance. However, in exceptional circumstances when staff are required out of hours, they can be approved retrospectively.															

This scheme only relates to matters delegated by the Board to the Chief Executive and Directors, together with certain other specific matters referred to in Standing Financial Instructions. Each Director is responsible for delegation within their department. They should produce an Operational Scheme of Delegation and Authorisation for matters within their department, which should also set out how departmental budget and procedures for approval of expenditure are delegated.



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 3 2021/22					
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Nursing and Midwifery/Deputy CEO Acting Associate Director of Quality					
Awdur yr Adroddiad Report Author:	Claims Managers					
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality					
Atodiadau Appendices:	Schedule of closed claims and financial value for quarter 3 of 2021/22 (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:						
<p>The attached report sets out total payment information for any claims against the Health Board with a spend of over £50,000 closed during Quarter 3 (October-December) of the 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.</p> <p>This report is presented to the Audit Committee to support the discharge of its responsibility to ensure the provision of effective governance.</p> <p>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.</p>						
Cefndir / Background:						
<p>All Health Boards in Wales contribute to a liability fund and have a risk share agreement, known as the Welsh Risk Pool (WRP).</p> <p>The Health Board employs a team of Claims Managers who sit within the Quality 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</p>						

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 Quality 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)
W16-2432	Clinical Negligence	BCUHB West	Gynae Surgery (Secondary)	05/01/2016	£93,584.80
CLA18-3587C	Personal Injury	BCUHB Central	Urology (Secondary)	07/05/2018	£57,881.01
C14-1537	Clinical Negligence	BCUHB Central	ENT (Secondary)	06/10/2010	£3,026,905.47
C15-1847	Clinical Negligence	BCUHB Central	Radiology (Secondary)	31/07/2013	£1,522,089.50
CLA2511	Clinical Negligence	BCUHB Central	Community Hospital (Area)	20/05/2015	£69,985.69
ZG-CLA17-3096	Clinical Negligence	BCUHB East	General Surgery (Secondary)	01/04/2017	£53,477.30
CLA17-2905	Clinical Negligence	BCUHB East	Trauma/Orthopaedics (Secondary)	01/07/2015	£311,797.33
ZG-CLA17-2941	Clinical Negligence	BCUHB East	Emergency Department (Secondary)	01/11/2016	£66,264.80
ZG-CLA16-2279	Clinical Negligence	BCUHB East	Trauma/Orthopaedics (Secondary)	01/12/2013	£83,123.64
					£5,285,109.54

LOCAL COUNTER FRAUD, BRIBERY AND CORRUPTION POLICY

Date to be reviewed:	August 2024	No of pages:	44
Author(s):	Karl Woodward, Sjef Molmans and Graham Jones	Title:	Local Counter Fraud, Bribery and Corruption Policy
Responsible Dept. / Director:	Finance Department – Local Counter Fraud Service		
Approved by:	Audit Committee		
Endorsing body:	BCUHB Board		
Date endorsed:			
Date activated (live):			

Statutory Authorities to be read alongside this policy:	<ul style="list-style-type: none"> • The Criminal Procedure Investigation Act – 1996 • The Fraud Act – 2006 • The Bribery Act – 2010 • The Police and Criminal Evidence Act – 1984, Codes of Practice • Directions to NHS Bodies on Counter Fraud Measures issued on 1st December 2005 to NHS Bodies in Wales
Documents to be read alongside this policy:	<ul style="list-style-type: none"> • WP4A All Wales Raising Concern (Whistleblowing Policy) • WP6 – Code of Conduct (Disciplinary Rules and Standards of Behaviour) • WP9 – All Wales Disciplinary Policy • WP11 – NHS Wales Managing Attendance at Work Policy • OBS02 – Standards of Business Conduct • MD14 – Private Practice Policy • Welsh Government document Countering Fraud in the NHS in Wales – September 2001 • NHS Counter Fraud Authority Counter Fraud Manual • NHS Counter Fraud Authority – Applying appropriate sanctions consistently – Policy statement (April 2013) • NHS Counter Fraud Authority – Parallel criminal and disciplinary investigations – Guidance for Local Counter Fraud Specialists (April 2013) • Standing Orders and Standing Financial Instructions • Memorandum of Understanding with Association of Chief Police Officers of Wales

Current review changes:

To comply with the Welsh Government's strategy to countering fraud within NHS Wales published in September 2001 and to update the policy with the most recent guidance from the NHS Counter Fraud Authority on countering fraud within the NHS. Further to update the policy for the requirements of the Bribery Act 2010 and the advice on corruption indicators published by

the NHS Counter Fraud Authority and Counter Fraud Service Wales. To review the policy routinely and update where with NHS requirements as stipulated in the Government Functional Standard 013 Counter Fraud (GovS013) published by the Cabinet Office in June 2020.

Summary:

Betsi Cadwaladr University Health Board requires all employees, hired staff, contractors and suppliers to act with absolute integrity and honesty, and to treat others with dignity and respect. All assets and public funds entrusted to the Health Board to deliver the commissioning and provision of Health Care to patients in their care, should be protected against crime and/or loss. This document sets out the mechanisms and process the Health Board will implement when there is suspicion that such protection has failed and action is required to minimise the risk of financial loss and to prosecute those who commit economic crime against the NHS and recover the assets or public funds taken.

First Operational:	November 2009				
Previously Reviewed:	Nov 2009	Jul 2013	Mar 2014	May 2018	Aug 2021
Updated yes/no:	Yes	Yes	Yes	Yes	Yes

PROPRIETARY INFORMATION

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Annex B - Who to contact to report suspected fraud, bribery or corruption? A guide of the dos and don'ts

Annex C - Local Counter Fraud Specialist (LCFS) and Human Resources (HR) liaison protocol

Annex D - Fraud financial redress procedure

1 Executive Summary

Betsi Cadwaladr University Health Board (BCUHB) is fully committed to reducing fraud, bribery and corruption in and aimed against the NHS. The Health Board will seek the appropriate disciplinary, regulatory, civil and criminal sanctions against fraudsters and attempt to recover all losses and costs to help provide patient care and front line services.

One of the basic principles of public sector organisations is the stewardship and appropriate use of public funds. The Health Board does not tolerate fraud, bribery or corruption and is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, maintaining public resources for patient care and better patient services.

The Health Board believes that the vast majority of people who work in and use the NHS are honest and professional; however, fraud committed even by a small minority is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care, treatment and services.

To achieve this goal the Health Board fully accepts that it must comply with the Statutory Authorities which have been introduced by both the UK and Welsh Governments including:

- The Criminal Procedure Investigation Act (CPIA) – 1996: This Act of Parliament lays down the procedures which must be followed by the Health Board's Disclosure Officer, during a criminal investigation to ensure that investigations are conducted properly and in particular ensuring that the correct level of disclosure, to ensure that verdicts which are reached in court are safe and robust.
- The Fraud Act – 2006: This Act lays down the statutory offences by which fraud is committed in the UK.
- The Bribery Act – 2010: This Act lays down the statutory offences by which bribery and corruption is committed in the UK.
- The Police and Criminal Evidence Act – 1984, Codes of Practice: This Act lays down the statutory codes of practice governing key areas of investigatory procedure and to which criminal investigators lawfully have to adhere to, in the UK.
- Welsh Government Directions to NHS Bodies on Counter Fraud Measures issued on 1st December 2005 to NHS Bodies in Wales: The Directions provide the requirements which are to be put in place by Health Boards in Wales, to

ensure that successful Counter Fraud Measures are introduced and maintained.

By ensuring that the above Statutory Authorities are followed, the Health Board is able to demonstrate that it is fully committed to ensuring that the criminal investigation process it has in place, is designed to support the Criminal Justice System in delivering safe and robust prosecutions.

This policy is endorsed by the Health Board and is fully supported by the Executive Board of Directors and Senior Management within the Health Board. The policy demonstrates the Health Board's commitment to supporting the public service values of accountability, probity and openness and, in particular, recognises the need to ensure the highest standards by pro-actively reducing the risk of NHS fraud, bribery and corruption.

The NHS Counter Fraud Authority-Welsh Government agreement

In 2001, NHS Counter Fraud Authority entered into a joint working agreement with Welsh Government (WG) to provide specialist counter fraud support services to NHS Wales. The terms of the agreement under section 83 of the Government of Wales Act 2006 set out arrangements for NHS Counter Fraud Authority to:

- undertake responsibility for counter fraud, bribery and corruption issues in NHS Wales as delegated by WG
- provide WG with specialist investigation support services purchased via an annual contract agreement

Under the agreement NHS Counter Fraud Authority provides NHS Wales with:

- **Specialist counter fraud support services** which include specialist dental advice, policy advice, communications and media services, quality assurance services, IT services, operational management services and specialist operational support
- **Controlled access to restricted information** via national gateway arrangements with various investigative bodies, which includes access to databases maintained by the Police, HMRC, DWP and the DVLA.

The NHS Counter Fraud Service (CFS) Wales team is a division of the NHS Wales Shared Services Partnership (NWSSP). The CFS Wales team Manager reports to the NWSSP Director of Finance on budgetary and performance issues and reports to the NHS Counter Fraud Authority on professional and operational management issues.

The CFS Wales team is made up of experienced investigators and their role includes:

- investigating and prosecuting large scale, sensitive and complex fraud and bribery cases, and all corruption cases in NHS Wales.
- raising awareness of current fraud risks in NHS Wales by highlighting successful prosecutions, circulating intelligence bulletins, conducting proactive work and presentations within NHS Wales and regular liaison with key partners.
- conducting financial investigation and restraint actions under the Proceeds of Crime Act 2002.
- providing specialist support and guidance to a network of Local Counter Fraud Specialists (LCFSs) who are employed by Health Bodies in Wales and report to their individual directors of finance.

1.1 Aims and objectives

The Health Board aims to meet both the statutory requirements and good practice guidance with regard to the Government Functional Standard 013 for Counter Fraud (GovS013).

- Playing a full part in an integrated national programme of action to combat fraud in the NHS;
- Building on existing responsibilities for undertaking counter fraud, bribery and corruption work locally.

The Government Functional Standard GovS013 was published by the Cabinet Office in June 2020 and exists to create a coherent, effective and mutually understood way of doing business within government organisations and across organisational boundaries, and to provide a stable basis for assurance, risk management, and capability improvement.

NHS requirements of GovS013 consist of 12 individual Counter Fraud components and detailed information on how these are applied across the NHS and wider health group are provided in the Functional Standard.

The Health Board wishes to encourage anyone having genuine suspicions of fraud, bribery or corruption to report them and it is the Health Board's policy that no employee will suffer in any way as a result of reporting such suspicions.

All genuine suspicions of fraud, bribery and corruption can be reported to the Local Counter Fraud Specialist (LCFS) direct or through the NHS Fraud and Corruption

Reporting Line (FCRL) by dialling freephone number 0800 028 40 60 or online by visiting <https://cfa.nhs.uk/reportfraud>

The Health Board has a zero tolerance to fraud, bribery and corruption and aims to reduce the levels of fraud, bribery and corruption to a minimum and to hold it at that level permanently.

The Welsh Government issued Directions to NHS Bodies on Counter Fraud measures to enable the Health Board to undertake the work required to support the zero tolerance approach.

This policy document aims to:

- Improve the knowledge and understanding of everyone in the Health Board, irrespective of their position and role, about the risk of fraud, bribery and corruption within the Health Board and its unacceptability;
- Assist in promoting an open, honest and well-intended atmosphere within the Health Board with a culture and environment where staff feel able to raise concerns sensibly and responsibly;
- Set out the duty of each member of staff in terms of their responsibility to prevent fraud, bribery and corruption and how to report it, to allow rigorous investigation of any suspicions of economic crime against the Health Board;
- Ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following: criminal prosecution, civil proceedings or internal and/or external disciplinary action.

1.2 Scope of Policy

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and assist employees, who may have such suspicions. The policy applies to all employees of the Health Board, regardless of position held, as well as consultants, vendors, contractors, and/or any other internal and/or external stakeholders, who have a business relationship with the Health Board.

The policy will be brought to the attention of all employees and forms part of Fraud Awareness training to all staff which is mandatory since the 19th of April 2021, either by staff completing the available e-Learning module or attending the Staff Orientation for new staff or other specific training sessions. This document is intended to provide direction and help to all staff that may encounter fraud, bribery and corruption at work and should be read alongside the Public Interest Disclosure Act 1998 (PIDA), which can be found at <http://www.legislation.gov.uk/ukpga/1998/23/contents>

The Board already has procedures in place to protect the assets of the Health Board that reduce the likelihood of fraud occurring. These include Standing Orders, Standing Financial Instructions, documented policies and procedures, systems of internal control, audit and risk assessment.

In addition, the Health Board engenders a risk and awareness culture to fraud, bribery and corruption through its policies, procedures, articles, training and contractual arrangements with LCFS.

The All Wales Raising Concern (Whistleblowing Policy) is available for staff to report any concerns which they may have and can be accessed at [WP4A - All Wales Raising Concerns procedure for NHS Staff1.pdf](#)

2 Definitions

This section should provide clear definitions of fraud, bribery and corruption. This is essential as not everyone at the Health Board will be familiar with what constitutes these crimes.

2.1 Fraud

The Fraud Act 2006 came into force on 15th January 2007 and focusses on the dishonest behaviour of the suspect and their intent to make a financial gain or cause a loss. The introduction of the offences under the Fraud Act 2006 made it no longer necessary to prove that a person had been deceived.

The Fraud Act 2006 identifies the following main offences:

- Section 2: Fraud by false representation (active fraud; lying about something using any means e.g. by words or actions taken)
- Section 3: Fraud by failing to disclose information (passive fraud; not saying something when you have a legal duty to do so)
- Section 4: Fraud by abuse of position (abusing a position where there is an expectation to safeguard the financial interests of another person or organisation)
- Additional offences under the Fraud Act 2006 can be found at <http://www.legislation.gov.uk/ukpga/2006/35/contents>

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause a gain or loss. The dishonest behaviour to cause the gain or loss does not have to succeed, the mere exposure to the risk of loss is sufficient, as long as the intent is present.

2.2 Bribery and Corruption

The **Bribery Act 2010** came into force on 1st July 2011. It modernised and reformed the criminal law of bribery, making it easier to tackle the offence proactively in the public and private sectors. The Act repealed the UK's existing anti-corruption legislation and provided an updated and extended framework of offences to cover bribery both in the UK and abroad.

The three offences most relevant to the NHS are:

- Section 1: Bribing another Person – offering, promising or giving a bribe to another person to perform a relevant ‘function or activity’ improperly, or to reward a person for the improper performance of such a function or activity
- Section 2: Being Bribed – requesting, agreeing to receive or accepting a bribe to perform a function or activity improperly
- Section 7: Failure of Commercial Organisations to Prevent Bribery (the corporate offence)
- Additional offences under the Bribery Act 2010 can be found at <https://www.legislation.gov.uk/ukpga/2010/23/contents>

The Bribery Act 2010 Section 7 introduced a new offence of failure to prevent bribery. It makes clear that commercial organisations should adopt a risk-based approach to managing bribery risks. Although aimed solely at commercial companies, guidance on this particular section of the Bribery Act 2010 from the Ministry of Justice shows that applying a common sense approach should prevail.

Betsi Cadwaladr University Health Board will be liable to prosecution if a person associated with the Health Board bribes another person intending to obtain or retain business or an advantage in the conduct of business for the Health Board. The organisation will have a full defence if it can show that despite a particular case of bribery it nevertheless had adequate procedures and policies in place to prevent persons associated with it from bribing. In accordance with established case law, the standard of proof which the commercial organisation would need to discharge in order to prove the defence, in the event it was prosecuted, is the balance of probabilities.

The Government considers that procedures put in place by organisations wishing to prevent bribery being committed on their behalf should be informed by six principles, which are set out below;

- 1) Proportionate procedures and policies,
- 2) Top-level commitment,
- 3) Risk Assessment,
- 4) Due diligence,
- 5) Communication (including training) and
- 6) Monitoring and review.

For a more detailed explanation of the six principles and how to achieve these, link to the full downloaded guidance from the Ministry of Justice should assist <https://www.justice.gov.uk/downloads/legislation/bribery-act-2010-guidance.pdf>

Corruption is the offering, promising, giving, accepting or soliciting of inducements, gifts, favours, payments or benefits-in-kind which may then influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however they may use their position unreasonably or perform improperly to give some advantage to another.

The broader term of corruption covers any unlawful or improper behaviour that seeks to gain an advantage through illegitimate means. Bribery is a form of corruption and bribes are the most common tools used in corruption.

2.3 Other offences

Outside the Fraud Act 2006 and Bribery Act 2010, the following other offences of economic crime could be committed against the NHS or in particular BCUHB:

- False accounting (Section 17, Theft Act 1968) – Dishonestly altering a record kept for accounting purposes in order to make a gain or loss.
- Possession of false identity documents (Section 25, Identity Cards Act 2006) – Having possession or control over an identity document that is false, has been improperly obtained or relates to someone else.
- Forgery and Counterfeiting Act 1981 (Sections 1 to 4) – Making, copying, using and using a copy of a false instrument with the intention of inducing somebody to accept it as genuine.
- Computer Misuse Act 1990 (see paragraph 3.5 Information Management and Technology).
- Theft (Section 1, Theft Act 1968) – To dishonestly appropriate, property that belongs to another, with the intention to permanently depriving the other person of that item.

Health Board staff are advised on common acts of Theft, especially when these are occurring and urgent, that their first point of contact at BCUHB is the Security Department which in practice may often mean referring to and the direct involvement of North Wales Police (either by contacting them dialling 101 or 999 in emergencies).

Health Board staff may wish to seek advice from the Local Counter Fraud Service team in historic, non-urgent Theft cases where boundaries with Fraud or other economic crime offences may be more ambiguous.

3 Roles and responsibilities

3.1 Chief Executive and Board of Directors

The Chief Executive has the overall responsibility for funds entrusted to the organisation as the Accountable Officer. This includes a requirement to deal with instances of fraud, bribery and corruption. The Chief Executive must ensure

adequate policies and procedures are in place to protect the organisation and the public funds entrusted to it.

The Chief Executive and the Executive Director of Finance are responsible for the monitoring of and ensuring compliance with the Welsh Government Directions on countering fraud.

The Health Board is responsible for maintaining a named person nominated to act as its Local Counter Fraud Specialist.

If staff have concerns about any procedures or processes that they are asked to be involved in, the Health Board accepts it has a duty to ensure that those concerns are listened to, recorded and addressed.

The Health Board will facilitate and co-operate with its Local Counter Fraud Service team, Counter Fraud Service Wales (CFS Wales) and the NHS CFA, giving them prompt access to Health Board staff, information, workplaces and relevant documentation, particularly in relation to:

- Investigating alleged cases of fraud, bribery or corruption
- Fraud Measurement
- National or Local Proactive Exercises
- Fraud Prevention Notices
- Reporting arrangements
- Publicity

The Health Board acknowledges the corporate offence enshrined in the Bribery Act for organisations who fail to prevent bribery or do not have robust and effective preventative procedures in place. A senior management or board member who consents to or connives in a Section 1 bribery offence will, together with the organisation, be liable for the 'corporate offence' under section 7 (Failure of Commercial Organisations to Prevent Bribery).

Responsibility for the operation and maintenance of controls falls directly to line managers and requires the involvement of all of Health Board employees. The Health Board therefore has a duty to ensure employees who are involved in or who are managing internal control systems receive adequate training and support in order to carry out their responsibilities. Therefore, the Chief Executive and the Executive Director of Finance will monitor and ensure compliance with this policy.

3.2 Executive Director of Finance

The Executive Director of Finance is responsible for monitoring compliance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures and with any other instructions issued by the NHS CFA or NHS CFS Wales.

The Executive Director of Finance is provided with powers to approve financial transactions initiated by anyone from across the Health Board.

The Executive Director of Finance prepares documents and maintains detailed financial procedures and systems and ensures that they incorporate the principles of separation of duties and internal checks to supplement those procedures and systems.

The Executive Director of Finance is the accountable individual and member of the Executive Board of Directors who has a clearly defined responsibility for the strategic management of, and support for counter fraud and counter fraud, bribery and corruption work within the Health Board.

The Executive Director of Finance ensures that relevant and timely information regarding counter fraud, bribery and corruption work is submitted to CFS Wales upon request.

The Executive Director of Finance will report to the Health Board's Executive Board of Directors on the adequacy of internal financial control and risk management including exposure to economic crime as part of the Board's overall responsibility to prepare a statement of internal control for inclusion in the Health Board's annual report.

The Executive Director of Finance will, depending on the outcome of initial investigations, inform appropriate senior management of suspected cases of fraud, bribery and corruption, especially in cases where the loss may be significant or where the incident may lead to adverse publicity.

The Executive Director of Finance retains corporate responsibility for the strategic management of the Health Board's Local Counter Fraud Service and may delegate the operational management of the Local Counter Fraud Service team to his or her deputy.

The Executive Director of Finance ensures the required documentation is provided to NHS CFA to support the nomination process for the Health Board's Local Counter Fraud Specialists.

The Head of Local Counter Fraud Service will retain direct access to the Executive Director of Finance as and when required, to ensure compliance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

The Head of Local Counter Fraud will meet privately with the Chair of the Audit Committee on a quarterly basis, to ensure compliance with good governance arrangements and emerging risks of fraud, bribery or corruption facing the Health Board.

Annual Counter Fraud Workplan objectives are approved and monitored by the Audit Committee via Quarterly and Annual Progress Reports. The Audit Committee meetings are formally minuted. The Audit Committee Chair provides a summary report of Audit Committee activity to the Executive Board of Directors, to strategically

support the counter fraud process. The Audit Committee records require action points to be recorded and their progress monitored on its "Action Tracker" report.

In addition BCUHB have nominated their Fraud Champion in early July 2021. The Fraud Champion's role forms part of the BCUHB's counter fraud provision and is to strengthen the fight against fraud and raise awareness within the organisation. Having a Fraud Champion is an essential part of the Government Functional Standard GovS013.

The Fraud Champion is committed in joining the fight and promoting a zero-tolerance approach to NHS fraud and in particular when aimed against the Health Board.

The role of the Fraud Champion is to:

- Promote and raise awareness of fraud, bribery and corruption within the organisation.
- Understand the threat posed by fraud, bribery and corruption by monitoring the intelligence provided as part of NHS CFA's strategic intelligence assessment.
- Understand the level and quality of counter fraud provision received by the organisation by using the benchmarking information provided by NHS CFA, and raise any successes, concerns or opportunities for improvement with the Executive Director of Finance and/or Audit Committee Chair.
- Support counter fraud colleagues in ensuring that all information relating to fraud is recorded and reported (if this is not undertaken, then it could impact on the NHS organisation as well as the healthcare sector involved, as potential fraud alerts may not be shared).
- Contribute to the sharing of information and best practice on counter fraud via NHS CFA's extranet when this becomes available.
- Raise awareness of fraud at a strategic level and support the work that Local Counter Fraud Specialists already undertake.
- Facilitate and support fraud awareness and fraud prevention work within the organisation and ensure that everyone knows how to recognise and report fraud.
- Ensure that fraud risks are recorded and managed in line with the organisation's risk management policy.
- Escalate any fraud concerns to the Executive Director of Finance and/or Audit Committee Chair.

3.3 External and Internal Audit

The role of External and Internal Audit includes reviewing controls and systems and ensuring compliance with financial instructions. The External Auditor from Audit Wales and Internal Auditors employed by NWSSP have a duty to pass on any suspicions of fraud, bribery or corruption to the Local Counter Fraud Service team.

The External and Internal Auditors will report to the Local Counter Fraud Service team any system weaknesses, which are detected in the course of their work, which may allow fraud, bribery or corruption to take place.

The External and Internal Auditors will inform the Local Counter Fraud Service team of any instances of potential or suspected fraudulent activity identified during the course of their work or from other sources.

Routinely sharing of Audit reports concerning BCUHB with the Local Counter Fraud Service team at the Health Board is considered good practice. This allows the LCFS to report relevant recommendations on fraud, bribery and corruption for consideration, which may derive from key Audit reports. To ensure any potential risk to economic crime exposure is mitigated against.

3.4 Workforce and Organisational Development (W&OD)

The appropriate protocols have been established between the Local Counter Fraud Service team and the HR Department to agree procedures where Health Board employees, involved in cases which indicate that fraud bribery or corruption may be suspected.

The Local Counter Fraud Service team will liaise closely with W&OD, and will advise from the outset on matters relating to fraud, bribery or corruption, in accordance with the Health Board's Local Counter Fraud, Bribery and Corruption policy.

The Assistant Director for Employment Practices shall advise those involved in any investigation of any requirements relating to matters of employment law and in other procedural matters, such as disciplinary and complaints procedures.

The HR corporate function remain responsible for ensuring the appropriate use of all relevant policies and procedures by Health Board staff. Wilful breach of such key documents, by staff may be considered for disciplinary investigation and appropriate sanctions applied where required.

HR and Local Counter Fraud Service team will liaise closely to ensure that any parallel sanctions (i.e. criminal, civil and disciplinary sanctions) are applied effectively and in a coordinated manner as shown in the joined working protocol Annex C and Parallel Investigations flowchart procedure provided.

Referral to Professional Regulatory Bodies will be considered when there are impending concerns with Health Board staff about their ability to practise safely and effectively. The Professional Regulatory Body concerned will in such instances be requested to commence external disciplinary proceedings to investigate if the Fitness to Practice of the registered professional has been impaired and if appropriate sanctions should be applied.

3.5 Information Management and Technology (IM&T)

The Computer Misuse Act 1990 introduced Sections 1 to 3, describing three criminal offences under this Act as:

- Section 1: Unauthorised access to computer material
- Section 2: Unauthorised access with intent to commit or facilitate commission of further offences
- Section 3: Unauthorised acts with intent to impair, or with recklessness as to impairing, operation of computer, etc.

The full act is available at <https://www.legislation.gov.uk/ukpga/1990/18/contents>

The fraudulent use of information technology which involves unauthorised access to the Health Board's computer systems and/or hardware will be reported by the IM&T team to the Local Counter Fraud Service team.

When there is suspicion that the unauthorised access led to electronic records having been compromised, misused or changed, the IM&T team should ensure to also contact the Information Governance (IG) team who will examine if data protection laws under the Data Protection Act (DPA) 2018 and/or General Data Protection Regulation (GDPR) have been breached. The appropriate action will be taken and advice is sought from the Local Counter Fraud Service team to determine if the offences require a criminal investigation led in-house or referral externally to for instance North Wales Police.

If the unauthorised access relates to an employment issue, for example a ghost record was created on the Electronic Staff Record (ESR) system, such issues should be discussed with the HR department who will check with and seek advice from the Local Counter Fraud Service team if criminal offences are suspected and a formal request to investigate the matter criminally should be made.

3.6 Local Counter Fraud Specialist (LCFS)

The Health Board employs a Local Counter Fraud Service team which is led by a Head of Local Counter Fraud Service who has managerial responsibility for the team. The Head of Local Counter Fraud will take forward all counter fraud work locally in accordance with Welsh Government Directions to NHS Bodies on Counter Fraud Arrangements and the NHS CFA Quality Assurance Programme which includes the annual submission of the Counter Fraud Functional Standard Return (CFFSR). NHS CFA validate the CFFSR to provide assurance to the Cabinet Office of the NHS including BCUHB's compliance with the Government Functional Standard 013 for Counter Fraud (GovS013).

The Local Counter Fraud Service team will work with key colleagues and stakeholders to promote counter fraud work and effectively respond to system weaknesses and investigate allegations of fraud, bribery and corruption.

The Head of Local Counter Fraud Service, will notify the Executive Director of Workforce of any fraud investigations at the earliest opportunity. This will be in a confidentially tagged email, so that the confidentiality of the investigation will not be compromised.

The Local Counter Fraud Service team represent the Health Board when dealing with fraud matters. This includes undertaking work across all areas of activity and in accordance with all components of Functional Standard GovS013.

The Local Counter Fraud Service team will adhere to the Counter Fraud Professional Accreditation Board (CFPAB) Principles of Professional Conduct as set out in the “NHS CFA Counter Fraud Manual”.

The Local Counter Fraud Service team and CFS Wales have responsibility for undertaking fraud investigations within NHS Wales and ensuring that all appropriate sanctions are considered and imposed which may include criminal prosecution, civil proceedings or disciplinary sanction, or a combination of all three sanctions. All cases considered for prosecution will be discussed by the Head of Local Counter Fraud Service and the Head of CFS Wales. The approval of the Executive Director of Finance will be required before the case is referred, via CFS Wales to the Specialised Fraud Division of the Crown Prosecution Service.

The Local Counter Fraud Service team will undertake a programme of proactive counter fraud work as agreed in the Annual Counter Fraud Workplan, which is approved by the Audit Committee to prevent and detect cases of fraud, bribery and corruption. Where system weaknesses are identified, appropriate fraud proofing recommendations will be made to ensure that the Health Board is protected in the future and that good governance procedures are in place.

This work undertaken by the Local Counter Fraud Service team will complement the work which is undertaken by the Health Board’s Internal and External Auditor.

In the event of an allegation involving Senior Management, Executive Officers and/or Directors of the Health Board, the allegation will be referred to the Head of CFS Wales for investigation. In these circumstances all communication will be made via the Head of CFS Wales.

Any fraud referrals which are received which involve more than one NHS health body, or cross border enquiries, will be referred to the Head of CFS Wales for investigation. The Local Counter Fraud Service team may be asked for practicality to assist in such cases.

The Local Counter Fraud Service team will ensure that the nominated HR representative is kept apprised of all relevant cases involving a Health Board member of staff and, under such circumstances, will involve the HR representative in agreements and decisions made, as outlined in the Health Board’s Local Counter

Fraud, Bribery and Corruption policy and as per liaison protocol in place between LCFS and HR (Annex C).

The Head of Local Counter Fraud Service or a nominated member of the team will, in consultation with the Head of CFS Wales, report any criminal case not involving fraud to the Police in accordance with the Memorandum of Understanding which has been agreed with the Association of Chief Police Officers or in cases where fraud, bribery or corruption is suspected record the case on the NHS CFA case management system in accordance with NHS CFA recommendations.

The Head of Local Counter Fraud Service will be entitled to attend Audit Committee meetings to provide formal written progress reports on all counter fraud activity undertaken within the Health Board and also to report the number of cases where fraud, bribery or corruption alleged and investigations are being undertaken.

To ensure that good governance arrangements are in place, the Head of Local Counter Fraud Service will have an automatic right of access to the following key personnel:

- The Audit Committee Chairman
- Any Audit Committee non-executive member
- The Chief Executive
- The Executive Director of Finance

The Local Counter Fraud Service team will report to the Audit Committee and the NHS CFA, details of system weaknesses which are identified during criminal fraud investigations or other proactive counter fraud work undertaken which have fraud-related implications.

The Local Counter Fraud Service team will proactively seek and report opportunities where local counter fraud work can be used within presentations or publicity to deter fraud, bribery or corruption against NHS Wales.

To embed zero-tolerance to NHS fraud and ensure a strong counter fraud culture, the Audit Committee and Executive Board of Directors agreed that Fraud Awareness is to be made mandatory for all BCU Health Board staff from the 19th of April 2021. An e-Learning module relating to the awareness, of fraud, bribery and corruption, is available to staff for completion. The Local Counter Fraud Service team will continue to provide Fraud Awareness training to new staff as part of the Health Board's Orientation Programme and also to specific staff groups or as part of management training programmes. The Local Counter Fraud Service team will also provide Fraud Awareness training to Primary Care contractors as requested.

The Local Counter Fraud Service team will not have responsibility for or be in any way engaged in the management of security for the Health Board.

3.7 NHS Counter Fraud Authority

The NHS Counter Fraud Authority (NHS CFA) has been tasked to lead the fight against fraud, bribery and corruption in the NHS. It is charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider healthcare economy. As a special health authority, the NHS CFA has focused entirely on counter fraud work, and is independent from other NHS Bodies and is directly accountable to the Department of Health (DoH).

The NHS CFA investigate the most serious, complex and high-profile cases of fraud, and work closely with the Police and the Crown Prosecution Service to bring offenders to justice. Their specialist financial investigators have powers to recover NHS money lost to fraud, and they have access to their own Forensic Computing Unit who collect and analyse digital evidence.

In Wales the NHS CFA provides specialist counter fraud support functions to the Welsh Government under section 83 of the Government of Wales Act 2006.

3.8 NHS Counter Fraud Service Wales

The NHS CFS Wales team provide specialist criminal investigation and financial investigation services to all Health Bodies in Wales. The CFS Wales team consists of experienced investigators who deal with large scale, cross-border, complex frauds and all issues involving bribery or corruption against NHS Wales.

The team work closely with other investigative bodies including the Police and also provide support and guidance to the network of LCFS who are based at Health Bodies in Wales. The Head of CFS Wales can be contacted by calling telephone number 01495 334101 direct or by e-mail to graham.dainty@nhscfswales.gov.uk

The Head of CFS Wales is responsible for liaison between the NHS CFA and all the LCFS employed or contracted by Health Boards and Trusts within Wales and is responsible for managing the NHS CFS Wales team.

The Head of CFS Wales is additionally responsible for reviewing all local investigation files, evidence and witness statements submitted for the consideration of the Specialised Fraud Division of the Crown Prosecution Service.

The Head of CFS Wales is responsible for ensuring that local investigations are conducted in accordance with legislative guidelines and within the components of the Government Functional Standard GovS013 and guidance provided in the NHS Counter Fraud Manual, to the highest standards in respect of all allegations of fraud, bribery or corruption against NHS Wales.

The Head of CFS Wales provides support and advice to all key stakeholders in Wales including Welsh Government, Health Boards and Trusts, Executive Directors of Finance, Audit Committees and the individual Local Counter Fraud Service teams operating in NHS Wales.

3.9 Managers

All managers are responsible for ensuring that policies, procedures and processes within their area of work are adhered to and kept under regular review.

Managers have a responsibility to ensure that staff are aware of fraud, bribery and corruption and understand the importance of protecting the organisation against it. Managers will also be responsible for the enforcement of disciplinary action for staff who do not comply with policies and procedures.

Managers must take all allegations of fraud, bribery and corruption seriously, but must not conduct any investigation into the allegation themselves. While some employees may raise concerns with their manager; managers must not attempt to investigate such allegations. It is the duty of the manager that all instances of suspected or actual fraud, bribery or corruption directed at the Health Board or the wider NHS, must be reported immediately to the Local Counter Fraud Service team.

Managers must be vigilant and ensure that procedures and controls to guard against fraud, bribery and corruption are followed. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery or corruption. Managers should risk-assess current procedures and controls in place regularly to ensure they continue to be robust and the best defence against financial loss. If they have any doubts, they must seek advice from the Health Board's nominated Local Counter Fraud Specialist.

Managers must understand, when drafting new procedures, processes or controls for their area of work, any responsibility which may change or have effect on financial resources. It is recommended that managers seek appropriate advice from the Local Counter Fraud Service team, with a view to fraud proofing new procedures, processes and controls to ensure these are robust and provide the best defence to any improper use or loss of public funds.

Managers are responsible for establishing a counter fraud culture within their team and ensuring that information on procedures is made available to all staff. The Local Counter Fraud Service team will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise levels of fraud awareness.

Managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud, bribery and corruption therefore primarily rests with managers, but requires the co-operation of all employees.

As part of that responsibility, line managers should:

- Take steps at the recruitment stage to establish, as far as possible, the previous employment record of potential employees, as well as the verification of required qualifications and memberships of professional regulatory bodies. In this regard, temporary and fixed-term contract employees will be treated in the same manner as permanent employees.
- Be aware of and inform their staff of the Health Board's Code of Conduct, Standards of Business Conduct including Private Practice, All Wales Managing Attendance at Work, Disciplinary Policies and the Local Counter Fraud, Bribery and Corruption policy as part of their induction process and

regularly at management meetings with staff, paying particular attention to the need for accurate and timely completion of personal records and forms.

- Assess the types of risk involved in the operations for which they are responsible.
- Ensure that adequate control measures are put in place to minimise risks to the Health Board. This must include clear roles and responsibilities and may include supervisory checks, staff rotation and separation of duties wherever possible, to confirm that a key function is not controlled by one individual and regular reviews, reconciliations and checks are undertaken, to ensure that control measures continue to operate effectively and that good governance procedures are in place.
- Ensure that use of computers and work mobile phone by employees is linked to the performance of their official NHS duties.
- Be aware of Health Board financial Standing Orders and Standing Financial Instructions covering items including:
 - Requisitioning and procurement of goods and services
 - Invoicing, receipting and banking of Health Board income
 - Use of petty cash floats
 - Use of patient's monies and patient's property
 - Compliance with internal controls
 - Risk assessments being undertaken within their area of responsibility, to mitigate fraud risks.

3.10 All Employees and Workers

This section is intended to cover all employees and workers which may include: Consultants, vendors, contractors and those with a business relationship with the Health Board.

The Standards of Business Conduct for NHS staff states:

It is a long established principle that public sector bodies which include the NHS; “must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion.”

This is supported by:

The need for Health Board staff to be aware of the Code of Conduct and Standards of Business Conduct and that breach of these policies may render them liable to criminal prosecution and disciplinary sanctions which if proven may lead to

prosecution, dismissal and financial recovery of NHS losses which may include loss of NHS Pension rights.

All employees and workers are required to comply with the Health Board's policies and procedures. Breach of the Health Board's policies and procedures may render staff liable to disciplinary action and when economic crime is suspected will lead to a referral to the Local Counter Fraud Service team for investigation. This may lead to a criminal prosecution, dismissal and financial recovery of NHS losses which may include loss of NHS Pension rights.

All employees and workers have a duty to protect the assets of the Health Board. Assets include buildings, equipment, vehicles, monies, information and goodwill.

All employees and workers have a duty to ensure that public funds are safeguarded, whether or not they are involved with cash or payment systems, receipts or dealing with contractors or suppliers.

All employees and workers should apply best practice in order to prevent fraud, bribery or corruption against the Health Board and wider NHS. The Local Counter Fraud, Bribery and Corruption policy should be used by staff as a guide to apply best practice.

Employees and workers have a responsibility to comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts (including bequests in patients' Wills that become known to staff) and hospitality. This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always:

- Make appropriate and timely declarations on the Health Board's Declaration of Interest and Gift & Hospitality electronic registers, which can be accessed at <http://howis.wales.nhs.uk/sitesplus/861/page/41930> relating to any self-employment or other employment or where any outside interest, offers by patients, suppliers or third parties may be considered as a cause for concern or may be considered to create a conflict of interest against the Health Board.
- Avoid acting in any way that might cause others to allege or suspect them of dishonesty.
- Behave in a way that would not give cause for others to doubt that the Health Board's employees deal fairly and impartially with official matters.
- Be alert to the possibility that others might be attempting to deceive.
- Employees and workers are also expected to act in accordance with the standards laid down by their Professional Bodies where applicable.

If an employee or worker suspects that fraud, bribery or corruption has taken place against the Health Board or wider NHS, they have a duty to ensure it is reported to by contacting the Local Counter Fraud Specialist directly or by using the other reporting methods explained below.

All employees and workers of the Health Board have a right and a duty to bring to their manager's attention, any matter which they consider to be damaging to the interests of patients, members of the public or other staff. However, where these concerns relate to potential fraud, bribery or corruption, the report should be made to the Local Counter Fraud Specialist or the NHS Fraud and Corruption Reporting Line, freephone **0800 028 40 60** or online at <https://cfa.nhs.uk/reportfraud>

It is not usually possible for informants to be made aware of the outcome of any investigation unless the matter is progressed criminally through the criminal justice system, in which case the proceedings will be in the public domain.

These arrangements do not replace Health Board's procedures for handling complaints, grievances, incident reporting or matters reported through the All Wales Raising Concern Whistleblowing Policy (Public Interest Disclosure Act 1998) found at [WP4A - All Wales Raising Concerns procedure for NHS Staff1.pdf](#)

4 The response plan

4.1 Reporting fraud, bribery or corruption

The action to be taken if fraud, bribery or corruption is discovered or suspected is outlined in Annexes A, B and C with LCFS contact details shown in Annex B.

If there is a concern that the LCFS, or the Executive Director of Finance themselves may be implicated in suspected fraud, bribery or corruption then employees can report the allegations to the Head of CFS Wales. If there is a reason to believe that the referral has not been investigated properly then employees can contact the Head of CFS Wales to discuss their concerns. The Head of CFS Wales can be contacted by telephone on 01495 334101 or by e-mail to graham.dainty@cfsms.gsi.gov.uk

Suspected fraud, bribery and corruption can also be reported using the NHS Fraud and Corruption Reporting Line on freephone **0800 028 40 60** or by filling in an online form at <https://cfa.nhs.uk/reportfraud> as an alternative to internal reporting procedures and can be used, if staff wish to remain anonymous.

All reports of fraud, bribery and corruption will be taken seriously and thoroughly investigated.

4.2 Disciplinary action

Disciplinary procedures at the Health Board will be initiated under the All Wales Disciplinary Policy, by management under the guidance of HR Department where an employee is suspected of breaching policies and/or procedures or being involved in a fraud, bribery, corruption or illegal act.

In all cases where fraud, bribery, or corruption is suspected by the Disciplinary Investigating Officer; such cases should be referred to the Health Board's Local Counter Fraud Service team for advice and guidance on whether there is a requirement for a Criminal Investigation to being undertaken in addition to the Disciplinary Investigation.

The Disciplinary Investigation will be a separate investigation, which might run simultaneously, to the Criminal Investigation into the alleged fraud, bribery or corruption and the LCFS and HR Department liaison protocol (Annex C) clarifies the liaison roles for information sharing between the LCFS and the appointed Disciplinary Investigating Officer.

In cases where it is suspected that the professional conduct of a staff member might be impaired, recommendation is given to referring the matter to the staff member's Professional Regulatory Body for them to start an independent and impartial Fitness to Practice investigation.

Referral to Professional Regulatory Bodies will be considered when there are impending concerns with Health Board staff about their ability to practise safely and effectively. Reporting a case of Fitness to Practice to the regulator is appropriate and necessary when the conduct, competent practice, character and behaviour or health of a registrant is impaired to the extent that public protection may be compromised. For all potential referrals, advice must be sought from health board Professional Leads and internal referral procedures followed.

5 Review

5.1 Ownership and Consultation

Responsibility for the development, maintenance and review of this policy lies with the Executive Director of Finance and the Local Counter Fraud Service team.

5.2 Monitoring and auditing of policy effectiveness

It is essential that this policy is monitored to ensure that controls are appropriate and are robust enough to prevent or reduce fraud, bribery and corruption.

Risk-assessment of all policies, procedures, processes and controls should be common practice and conducted regularly by managers to ensure the Health Board maintains the highest level of defence against fraud, bribery and corruption. Where deficiencies are identified, urgent remedial measures should be initiated to mitigate those risks to ensure the Health Board is fully protected against the latest threats.

Appropriate advice should be sought from the Local Counter Fraud Service team who may additionally advise for a Local Proactive Exercise to be undertaken, to determine if the risk of fraud against the Health Board has caused a financial loss.

The effectiveness of this policy will be reviewed via the Audit Committee who will receive regular progress reports from the Head of Local Counter Fraud Service on counter fraud activity which has been undertaken by the Health Board.

Arrangements might include reviewing system controls on an ongoing basis and identifying weaknesses in systems and processes.

Where deficiencies are identified as a result of monitoring, the Health Board Audit Committee will ensure that the appropriate recommendations and action plans are developed and implemented.

This will be achieved via the Audit Committee Tracker Tool.

5.3 Ratification Details

The Counter Fraud, Bribery and Corruption Policy requires the approval by the Audit Committee.

5.4 Dissemination of the policy

This policy document is a freely available document without any restrictions of confidentiality and is located on the Health Board's intranet site at <http://howis.wales.nhs.uk/sitesplus/861/page/44942>

The Health Board's Local Counter Fraud, Bribery and Corruption Policy will form part of the Health Board's staff Orientation (Induction) training programme.

The Health Board has made Counter Fraud training mandatory and this will be achieved via the completion of a Fraud Awareness e-learning module which is available to Health Board staff.

The Local Counter Fraud Specialists will also conduct an on-going programme of fraud awareness presentations to raise the awareness of staff groups across all health care sectors.

The Local Counter Fraud Specialists will also conduct fraud awareness presentations at Primary Care contractors as requested.

5.5 Equality and Welsh Translation

An Equality Impact Assessment has been undertaken in accordance with BCUHB Policy on Policies and WP7 - Procedure for Equality Impact Assessment (EqIA). BCUHB will not discriminate on grounds of age, disability, gender or gender reassignment, pregnancy or maternity, race, religion, belief and non-belief, sex, sexual orientation or marital status.

Appropriate and reasonable adjustments will be made where possible in relation to the investigation of fraud, which may include Interviews Under Caution (IUC); in accordance with the Police and Criminal Evidence Act (PACE) – 1984 Codes of Practice. An example of this would be to ensure that an Appropriate Adult is present, during an IUC to support the person being interviewed. Please see the link below for more information on Appropriate Adults.

[guidanceappadultscustody.pdf \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/guidance/appadultscustody.pdf)

This policy will be submitted for translation once approved and available in both Welsh and English.

5.6 Review of the policy

The Head of Local Counter Fraud Service will review the policy 3-yearly or more frequently as required by changing legislation and will link in with other Health Board policy changes that impact on this policy.

6 Associated Documentation

This policy should be read in conjunction with the following policies:

- NHS Standards of Business Conduct
- Standing Orders and Standing Financial Instructions
- Financial Procedures

Additionally, readers should refer to the Health Board policies which cover:

- Whistleblowing / Public Interest Disclosure Act (PIDA)
- Disciplinary Action
- Absence
- Corporate Governance
- Staff Code of Conduct / Conflicts of Interest
- Private Practice
- Gifts
- Hospitality

- Purchasing
- Use of electronic communications and other mobile communications equipment e.g. mobile phones

Adherence to these policies is mandatory and is integral to ensuring that a strong counter fraud, bribery and corruption culture is maintained within the Health Board.

7 Policy Annexes

Annex A - Reporting Fraud and or Corruption

Annex B - Who to contact to report suspected fraud, bribery or corruption? A guide to the dos and don'ts

Annex C - Local Counter Fraud Specialist (LCFS) and Human Resources liaison protocol

Annex D - Fraud financial redress procedure

Annex A - Reporting Fraud, Bribery or Corruption

This section is designed to be a reminder of the key “what to do” steps to be taken where fraud or other illegal criminal acts are discovered or suspected. Managers are encouraged to copy this to staff and to place it on staff notice boards in their department.

Staff concerned about how to raise their suspicion can receive independent and confidential advice from the NHS Fraud and Corruption Reporting Line, from the charity "Public Concern at Work" or from the Health Board's Whistleblower contact.

DEFINITIONS

FRAUD

Fraud is a term used to describe a range of different offences:

- Fraud by false representation
- Fraud by failing to disclose information
- Fraud by abuse of position
- Obtaining services dishonestly

Examples of NHS frauds that have been discovered in the past are as follows:

- Submitting false or forged timesheets
- Working elsewhere in NHS contracted hours
- Falsifying travel and/or expense claims
- People working for other agencies whilst off sick from the NHS
- Patient falsification of prescription claim forms
- Outside agencies duplicating invoices for payment by the NHS
- Contractors claiming payment for merchandise they have not delivered
- The unauthorised selling of NHS property or assets

The Serious Fraud Office has published the schedule of indicators which may provide an indication of fraud and which may alert management and staff to the following:

- Altered documents (correcting fluid, different pen or handwriting)
- Duplicate claim forms
- Claim form details not readily checkable
- Changes in normal patterns, of e.g. cash takings or travel claim details
- Erratic text or difficult to read narrative or with details missing
- Delay in completion or submission of claim forms
- Lack of vouchers or receipts in support of expense claims, etc.
- Staff seemingly living beyond their means
- Staff under constant financial or other stress
- Staff choosing not to take annual leave (and so preventing others becoming involved in their work), especially if solely responsible for a ‘risk’ area
- Complaints from public or staff

- Always working late
- Refusal of promotion
- Insistence on dealing with a particular individual

BRIBERY

The three bribery offences most relevant to the NHS are:

- Section 1: Offering, promising or giving a bribe to another person to perform a relevant 'function or activity' improperly, or to reward a person for the improper performance of such a function or activity.
- Section 2: Requesting, agreeing to receive or accepting a bribe to perform a function or activity improperly.
- Section 7: Failure of a commercial organisation to prevent bribery (the corporate offence).

CORRUPTION

This is the offering, giving, soliciting or acceptance of an inducement or reward which may influence a person to use their position unreasonably or to perform improperly to give some advantage to another.

WARNING SIGNS

The Serious Fraud Office has published the schedule of indicators which cover signs that bribery and corruption maybe occurring and are outlined below:

- Abnormal cash payments
- Pressure exerted for payments to be made urgently or ahead of schedule
- Payments being made through a third party country - for example, goods or services supplied to country 'A' but payment is being made, usually to a shell company in country 'B'
- An abnormally high commission percentage being paid to a particular agency. This may be split into two accounts for the same agent, often in different jurisdictions
- Private meetings with public contractors or companies hoping to tender for contracts
- Lavish gifts being received
- An individual who never takes time off even if ill, or holidays, or insists on dealing with specific contractors himself or herself
- Making unexpected or illogical decisions accepting projects or contracts
- The unusually smooth process of cases where an individual does not have the expected level of knowledge or expertise
- Abuse of the decision process or delegated powers in specific cases
- Agreeing contracts not favourable to the organisation either because of the terms or the time period
- Unexplained preference for certain contractors during tendering period
- Avoidance of independent checks on the tendering or contracting processes
- Raising barriers around specific roles or departments which are key in the tendering or contracting processes

- Bypassing normal tendering or contracting procedures
- Invoices being agreed in excess of the contract without reasonable cause
- Missing documents or records regarding meetings or decisions
- Company procedures or guidelines not being followed
- The payment of, or making funds available for high value expenses or school fees (or similar) on behalf of others

THEFT

The definition of theft has five elements to it and all need to be present in order for the offence to be committed. The definition is as follows:

- Dishonestly,
- Appropriately,
- Property,
- Belonging to another,
- With the intention of permanently depriving the other of it.

The Security department at the Health Board deal with theft that does not involve fraud and this can cover direct stealing, (e.g. from staff desks or lockers or the hospital cash machine) malicious damage, and actual or attempted break-ins.

In the event of a security or car parking incident please report it immediately to the Security Officer in your locality, details can be found at <http://howis.wales.nhs.uk/sitesplus/861/page/55497>

Annex B - Who to contact to report suspected fraud, bribery or corruption? A guide of the **dos** and **don'ts**!

FRAUD is the intent to obtain a financial gain from, or cause a financial loss to, a person or party through false representation, failing to disclose information or abuse of position.

BRIBERY & CORRUPTION is the deliberate use of payment or benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

DO

- **Note your concerns as soon as possible**- Record details such as the nature of your concerns, names, dates, times, locations, details of conversations and potential witnesses. Time, date and sign your notes.
- **Report your suspicions**- Please find contact details of your Local Counter Fraud Service team or for the NHS Fraud, Bribery and Corruption Reporting Line on the next page
- **Provide as much information as possible**- All reports are assessed for content and accuracy. It is important that you provide as much information as possible (date, time, location, witnesses, evidence etc.) as this will give the LCFS the best start in looking into the matter and may provide valuable intelligence to help improve overall understanding of NHS fraud.
- **Know that confidentiality will be respected**- There are a number of ways to report suspected fraud, bribery or corruption against the NHS including reporting anonymously, if you chose to report in this way. You may also report as a Whistle-blower. To consider if you are covered to report under the Public Interest Disclosure Act 1998 (PIDA) please read the WP4A All Wales Raising Concern (Whistle-blowing) Policy or visit online: <https://www.gov.uk/whistleblowing>
- **Do act!**

DO NOT

- **Confront the suspect or convey concerns to anyone other than those authorised (please see next page; LCFS or staff from the NHS Fraud, Bribery and Corruption Reporting Line)**- Never attempt to confront or question a suspect yourself. This could either alert the fraudster or cause an innocent person being unjustly accused.
- **Do not discuss your suspicions or concerns with other people**- If you are unsure about what to do if you suspect a fraud, discuss your suspicions with your LCFS.
- **Do not start your own investigation or gather evidence yourself**- Never attempt to gather evidence yourself. Contact your LCFS as soon as possible or call the NHS Fraud, Bribery and Corruption Reporting Line if you suspect a fraud even if you are not sure about everything, or do not know all the fact.
- **Be afraid of raising your concerns**- The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.
- **Do nothing!** Depending on the nature and severity of the allegation, any delay in reporting may lead to further financial or reputational loss.



If you suspect that fraud against the NHS has taken place, you must report it immediately to:

- Your nearest Local Counter Fraud Specialist (LCFS) or
- If your locality LCFS is out of office, to the next nearest LCFS who can be contacted as per below or
- Alternatively the Director of Finance
- Or by telephoning the national number or logging the allegation online, details on the right.

Do you have concerns about a fraud taking place in the NHS?

NHS Fraud, Bribery and Corruption Reporting Line: 0800 028 40 60

Calls will be treated in confidence and investigated by professionally trained staff.

Online: <https://cfa.nhs.uk/reportfraud>

Your nearest Local Counter Fraud Specialist is best placed to deal with allegations of fraud against the NHS and can be contacted via:

Wrexham – **Karl Woodward**

Mobile: 07900 052554

e-mail:

Karl.Woodward@wales.nhs.uk

Abergele – **Sjef Molmans**

Mobile: 07711 205628

e-mail:

Sjef.Molmans@wales.nhs.uk

Abergele – **Graham Jones**

Mobile: 07900 052557

e-mail:

Graham.Jones6@wales.nhs.uk

Generic e-mail inbox: BCU.CounterFraudTeam@wales.nhs.uk

Or visit the BCUHB LCFS intranet page at <http://howis.wales.nhs.uk/sitesplus/861/page/41684>

Please help protect BCUHB from NHS fraud by telephoning your locality LCFS in confidence

Annex C - Local Counter Fraud Specialist (LCFS) and Human Resources liaison protocol

1 Introduction

1.1 Scope

The protocol is a framework for general interaction, including the liaison responsibilities whenever potential fraud, bribery or corruption is highlighted. Applying the protocol will ensure that the full range of sanctions (e.g. criminal, civil and disciplinary sanctions) available to the organisation can be considered at the earliest opportunity. To pursue these sanctions effectively there needs to be a close and supportive liaison between the LCFS, the HR Representative and appointed Disciplinary Investigating Officer (DIO) while still maintaining the independence of concurrent Investigating Officers. This includes the sharing of information where appropriate and lawful to avoid both duplication of effort and potentially compromising the use of other sanctions by well-intentioned actions.

This protocol is not a definitive procedural document as individual investigations may highlight specific issues requiring an adaptation to the procedure. However, despite any case-by-case adaptations that may be required, the organisation should remain mindful of the need to conduct potential fraud investigations in accordance with criminal, civil and employment laws.

1.2 Purpose and Objectives

The purpose of the protocol is to establish effective interaction between the LCFS, HR Managers and the DIO appointed by the Health Board to achieve the objectives below:-

- To enable regular interaction and joint working between the LCFS and HR, and DIO at all times,
- To ensure close and supportive interaction and lawful information sharing between the LCFS, HR, and DIO where a potential fraud has been highlighted and is investigated,
- To ensure that criminal and disciplinary investigations are carried out effectively and in accordance with relevant legal frameworks,
- To help deter future incidents of fraud by allowing for sanctions to be pursued effectively, where appropriate.

1.3 Related legislation, policies and procedures

To maintain a high deterrent effect against NHS fraud, bribery and corruption, it is important to consider the full range of sanctions available.

This may result in criminal sanctions being applied at or around the same time as any civil and/or disciplinary sanctions. Whenever sanctions are to be run simultaneously (termed parallel sanctions), close liaison must exist between the LCFS, HR and DIO, as findings from one investigation might be important to the success of another. Generally, the criminal investigation will determine the actions

and timing of other related investigations, due to the higher standard of proof placed upon criminal investigations and the resultant due process legislative requirements that cover the gathering of evidence. However, the fact that a criminal investigation is being conducted does not negate the fact that a decision can be made on a disciplinary or civil matter. This action should be taken after consultation with the LCFS leading on the criminal investigation.

Further, this protocol takes into account relevant legislation including:

- Welsh Government directions to Counter Fraud in the NHS in Wales (2005),
- Data Protection Act 2018 (DPA),
- The Police and Criminal Evidence Act 1984 (PACE),
- The Criminal Procedure and Investigations Act 1996 (CPIA),
- The Public Interest Disclosure Act 1998. (PIDA)

In addition, policy statements and guidance issued by NHS CFA which includes the following:-

- The NHS CFA Counter Fraud manual,
- Parallel criminal and disciplinary investigations (Policy statement, April 2013),
- Parallel criminal and disciplinary investigations (Guidance for LCFS, April 2013),
- Applying appropriate sanctions consistently (Policy statement, April 2013).

The Local Counter Fraud Service team should refer to the NHS CFA documents in conjunction with this protocol especially where further clarity maybe required on information sharing or regarding the liaison between separate criminal and disciplinary investigations being run in parallel.

Further, the NHS CFA Applying appropriate sanctions consistently policy statement provides specialist and legal advice on how to conduct investigations to ensure the full range of sanctions is considered and can be applied in all fraud, bribery or corruption investigations.

In addition, the Local Counter Fraud, Bribery and Corruption Policy refers HR Managers and appointed DIO to this protocol and states the role of the Local Counter Fraud Service team, the reporting lines and the fact that investigations might be conducted to achieve disciplinary, civil and criminal sanctions. Other relevant Health Board policies and procedures that should be referred to include:-

- Raising staff Concerns / Whistle-blowing policy,
- Disciplinary policy, Standing financial instructions,
- Code of conduct (Disciplinary rules and standards of behaviour),
- E-Rostering guidelines,
- Overpayments protocol,
- Expenses policy,
- Sickness Policy,

- Information Management and Technology Security Policy.

Please note the above list of policies and procedures is not exhaustive.

2 General principles

The general principles that should govern investigations and the sharing of information are:-

The criminal and disciplinary investigations must be conducted separately and by different people. Criminal investigations must be conducted in accordance with PACE, the CPIA, and other relevant criminal legislation; disciplinary investigations must be carried out in accordance with the Health Board disciplinary policy which follows the ACAS Code of Practice on Disciplinary and Grievance Procedures and relevant employment law. The criminal investigation may be given precedence over the disciplinary investigation, if there is a risk of serious prejudice to the former from running the two processes concurrently. However there may be a compelling public interest in suspending or removing an individual from his/her post before the conclusion of the criminal case; in this situation, a case conference should be held to discuss the circumstances and relevant disclosure issues. Information may be shared between the LCFS and DIO where and when it is lawful and appropriate.

3 Roles and responsibilities

The Local Counter Fraud Service team will be responsible for conducting criminal investigations into allegations of fraud, bribery and corruption where a criminal offence is suspected to have been committed.

Management are responsible for appointing the DIO in liaison with their departments HR Manager to conduct the separate disciplinary investigation into allegations of fraud, bribery and corruption where breach of Health Board policy and/or misconduct is suspected.

4 Joint working protocol

4.1 DIO and HR Manager liaison responsibilities

To liaise regularly with the Local Counter Fraud Service team to discuss requirements and monitor the Interaction process, ensuring it remains effective and fit for purpose.

Assist the Local Counter Fraud Service team, as appropriate, in any fraud reviews undertaken to detect and prevent potential fraud from entering the organisation's systems.

All referrals received that may have an element of suspected fraud must be reported immediately to the Local Counter Fraud Service team. This can be verbally, in writing or by email

Inform the Local Counter Fraud Service team of any possible system weaknesses that could allow fraud or corruption to occur. This includes weaknesses discovered

as part of any DIO investigation that did not warrant the commencement of a fraud investigation.

Liaise regularly with the Local Counter Fraud Service team for updates on investigations whenever parallel sanctions are being conducted to ensure a flow of information and avoid potential duplication of effort. While in most cases it will be acceptable for DIO to pass information to the LCFS leading the investigation, disclosure in the opposite direction may be problematic. Where investigations are to run in parallel, these must be entirely separate (refer to General Principles outlined in section 2).

Inform the LCFS whenever health and safety risks (e.g. not holding appropriate clinical qualifications) or allegations relating to vulnerable clients must take precedence over any potential fraud investigation that may be undertaken.

To usually allow the LCFS to interview the suspect under caution (IUC) before a DIO Initial Assessment interview and disciplinary hearing takes place. In this way, first reactions to the allegations of fraud are captured under caution, which can then be used if the matter proceeds to a prosecution.

Where the disciplinary investigation has identified patient or public safety issues the DIO fact Initial Assessment interview may take place before the IUC and the DIO should agree with the LCFS for the DIO fact find interview (on a case by case basis) to take place before the IUC.

When appropriate, and in liaison with the LCFS, undertake disciplinary sanctions even if a criminal sanction may still be ongoing. Advise the LCFS leading the investigation of the outcome of such disciplinary hearings as this may have an impact on the criminal investigation and a referral to the CPS to consider a prosecution.

Where necessary, and available, provide information that maybe unknown to the LCFS that may assist the criminal investigation.

Liaise with the LCFS whenever a decision has been made to suspend an employee who is subject to a fraud investigation. The decision to suspend will rest with HR Representative and the DIO, but should be taken in consultation with the LCFS to ensure this action may not adversely affect the success of a criminal investigation. For example, it may warn the suspected person and allow them time to interfere with evidence or witnesses.

4.2 Local Counter Fraud Service team liaison responsibilities

Liaise on a regular basis with HR Representative and DIO to undertake case discussions as required.

Acknowledge receipt of HR referrals and arrange to meet with the appropriate HR Manager to discuss. The LCFS leading the investigation will undertake an initial and timely review to establish the validity of the allegation.

Meet at regular intervals with the DIO for updates on investigations whenever parallel sanctions are being considered to ensure a flow of information and avoid potential duplication. An accurate record should be recorded regarding the precise nature of the information that is being shared and the reasons why it is being shared.

Liaise with the Head of CFS Wales throughout the investigation, passing relevant advice to DIO for consideration.

Where necessary and lawful to do so, the LCFS leading the investigation will provide sufficient evidence to the DIO in order that a disciplinary investigation can be taken forward as appropriate. (E.g. a witness statement of LCFS investigation findings).

4.3 Referral of allegations of fraud, bribery or corruption and the criminal investigation process

From the referral received by the LCFS leading the investigation, the following will be considered (see Parallel Investigations flowchart procedure):

- **No case to answer no evidence of fraud found**

The LCFS leading the investigation will record on the NHS CFA Case Management system that no fraudulent action has been identified and a concluding report will be filed.

- **No evidence of fraud found but system controls require strengthening**

The LCFS leading the investigation will record on the NHS CFA Case Management system, that no fraudulent action has been identified and a concluding report will be filed and Audit Committee will be informed of the recommendations to strengthen controls in identified areas of weakness and recommendations will be followed up by the LCFS as part of future fraud prevention work.

The Audit Committee will monitor progress on LCFS recommendations to eliminate system weaknesses that expose systems to fraud via the LCFS tracker tool report to the Audit Committee.

In most cases any work that is undertaken to strengthen controls in identified areas of weakness should not involve the disclosure of personal information or information relating to why policies or systems are being changed.

- **No evidence of fraud found but matter needs to be referred to DIO to undertake a disciplinary investigation for disciplinary sanction to be considered**

The LCFS leading the investigation will record on the NHS CFA Case Management system that no fraudulent action has been identified, but the matter requires a referral to Human Resources (HR) for discussion with the line manager, to allow the LCFS leading the investigation, to decide that all appropriate processes are considered.

The LCFS leading the investigation will liaise with the appropriate HR Manager to discuss the findings and pass on the file of evidence gathered to date to be liaised with an appointed DIO. Disclosure should only take place following a thorough review of the file on a document by document basis (it is highly unlikely that a file compiled as part of a criminal investigation could be disclosed in full). The appointed DIO should use this file of evidence to establish if further consideration / action is required.

The Local Counter Fraud Service team will take no further part in any additional investigation undertaken by the DIO regarding a suspected breach of procedures, as under Welsh Assembly directions the Local Counter Fraud Service team is only charged with investigating fraud-related matters.

A concluding report will be filed with recommendations to strengthen controls in identified areas of weakness and the recommendations will be followed up by the LCFS as part of future fraud prevention work reported to the Audit Committee.

- **Reasonably held suspicion/information/evidence of suspected fraud received requiring criminal investigation (resulting in case to answer and appropriate sanction being considered)**

The LCFS leading the investigation will ensure that the investigation will be conducted in accordance with all relevant legislation, which is required by the Criminal Justice System, such as the Police and Criminal Evidence Act 1984 (PACE) and the Criminal Procedure and Investigations Act 1996 (CPIA). Instructions outlined in the NHS Counter Fraud and Corruption Manual will be followed and confidentiality will be respected during the course of the investigation process.

Criminal investigations will be recorded on the NHS CFA case management system, undertaken in a timely and professional manner ensuring that the pursuit of other potential sanctions is not compromised.

Regular case liaison will be held, within the Local Counter Fraud **Service** team, the Head of CFS Wales and the Crown Prosecution Service. At the conclusion of the investigation the LCFS leading the investigation will file an approved case closure report on the NHS CFA case management system, identifying the findings, recommendations to mitigate any systems weaknesses which have been identified during the investigation.

4.4 Information sharing

In general, it is not problematic for the DIO to share information obtained during a disciplinary investigation with the LCFS leading the criminal investigation to help further the criminal investigation enquiries. However, the Local Counter Fraud Service team should endeavour as much as possible to obtain the information needed through its own investigation.

The Health Board will take account of its responsibilities under the Data Protection Act 2018 and the European Union General Data Protection Regulation (GDPR).

The Information Governance policy which covers the process for requesting information from a system accessed by an employee should be referred to and can be found at <http://howis.wales.nhs.uk/sitesplus/861/page/46715>.

The Local Counter Fraud Service team and DIO should be mindful of "Employment Practices Data Protection Code" issued by the Information Commissioner which highlights that:-

- Personal information to be used as evidence to support disciplinary proceedings must not be obtained by deception or by misleading those from whom it is obtained as to why it is required or how it will be used.
- It is a criminal offence under the Data Protection Act to use deception to obtain personal data, such as might be included in a reference, where the data controller would not have agreed to the disclosure involved.
- Disclosure of information must take account not only the data protection rights of the subject of the investigation but also those of third parties.

Additionally, the disclosure of certain material, particularly where it is confidential and/or originates from a third party, can be problematic and no routine or blanket sharing of information should take place by the Local Counter Fraud Service team. In circumstances where it may be problematic to share information the Local Counter Fraud Service team should follow the national guidance, which is available from NHS CFA.

Advice on the problem areas are summarised below:-

- **Transcripts or tapes from an interview under caution (IUC) conducted under PACE.**

Information from an Interview under Caution (IUC) will not be disclosed but where the criminal process has been concluded or discontinued, it is possible that the information obtained via an IUC may be disclosed for disciplinary purposes in certain limited circumstances, where there is a sufficiently compelling public interest. Such public interest factors might include public health and safety and the rights of others. Each disclosure must be considered on a case-by-case basis by the LCFS leading the investigation with the Head of CFS Wales. If the decision is made by the Head of CFS Wales, to disclose an IUC tape or transcript, the employee should be informed by the LCFS so that he/she is able to either consent or to make an application to the court to prevent the disclosure, if so advised.

In the event that the subject admits to criminal offences at the IUC which are then denied at the disciplinary fact finding interview advice will be sought from the Head of CFS Wales to provide a statement to the DIO but under no circumstances will the LCFS disclose the IUC tapes or transcript to the DIO for the purposes of the disciplinary investigation.

If the DIO decides to delay the disciplinary investigation to await the outcome of a criminal case that proceeds to trial, any part of the IUC used as evidence (i.e. read out or shown in open court) then enters the public domain and may therefore be used for disciplinary purposes following the completion of criminal proceedings, should the DIO considers it appropriate and relevant.

- **Material seized during a search under PACE**

Material seized during a criminal investigation under the provisions of PACE legislation is considered to be confidential, and in the absence of compelling reasons, should not usually be disclosed for the purpose of disciplinary action.

The Crown Prosecution Service guidance on “Disclosure to Third Parties” states that material seized by Police under PACE legislation must not be disclosed to a third party unless the owner has consented or a subpoena has been served on the relevant Police Officer.

Therefore, material seized during search as with information obtained in an IUC (both under PACE legislation), should in general, where matters are straightforward not be disclosed to the DIO unless strong compelling public interest reasons exist for doing so exist. Also, if disclosure of material from a search under PACE legislation is being considered for sharing with the DIO then the same principles apply as to disclosure of information from an IUC held under PACE legislation as explained above.

- **Criminal Justice Witness statements**

Witnesses making statements for the purpose of the criminal investigation must give written consent to the DIO to enable the LCFS leading the investigation to release a criminal justice witness statement for a disciplinary purpose.

Further, the LCFS leading the investigation must consider whether releasing a criminal justice statement to the DIO may prejudice a criminal investigation and in any event criminal justice witness statements must not be released to the DIO while the criminal investigation is pending prosecution.

In the event of a decision not to prosecute or the conclusion of the criminal case, the LCFS leading the investigation may release the criminal justice witness statement to the DIO after the DIO has obtained the written consent of the witness.

- **Personal data obtained from a third party**

At all stages of the investigation (e.g. criminal or disciplinary) it must be made clear by the Local Counter Fraud Service team or DIO when requesting information in any format (e.g. documentary information, CCTV or witness statements) the reason it is being requested and any secondary use, for which the information may be used.

Any information obtained under Schedule 2 part 1 paragraph 2 of the Data Protection Act 2018 and GDPR Article 6(1)(d) will not be disclosed to the DIO for the purpose of the disciplinary investigation by the LCFS unless the LCFS has clearly

stated on the Data Protection Act Indemnity Certificate that the information requested may be shared with the DIO for the purposes of a separate disciplinary investigation.

Otherwise, it will be for the DIO to approach the third party with a separate request not made under the DPA but under the Disciplinary policy to seek a voluntary disclosure of the information held by the third party.

- **Other material collected during the course of a criminal investigation.**

Information may be shared by the LCFS and DIO to prevent duplication of work where this information would have been freely available to the LCFS or DIO had they sought it themselves in connection with their own investigation (e.g. timesheets and other financial or non-financial records).

- **Patient confidential medical notes and records**

The LCFS leading the investigation can only access patient confidential paper medical records following patient consent or by a court order. Patient confidential information obtained during a criminal investigation cannot be shared without the patient's consent to the appointed DIO for the purpose of a disciplinary investigation.

The DIO should make a separate request directly to the patient to obtain consent to access patient confidential notes or medical records.

- **LCFS statement to the DIO and vice-versa**

The DIO may request the LCFS to support the disciplinary investigation as a witness. In these circumstances, the LCFS leading the criminal investigation would then provide a witness statement to support the disciplinary investigation.

The statement would need to be agreed by the Head of CFS Wales, as appropriate where the LCFS intends to disclose information that was obtained under PACE legislation, from a Police search or during an IUC.

In general, the DIO should be able to provide a witness statement of the disciplinary investigation findings to the LCFS leading the criminal investigation. The DIO should inform the Subject that information given at a fact finding interview maybe disclosed to the Local Counter Fraud Service team for the purpose of supporting the criminal investigation.

4.5 Pursuing sanctions

The LCFS leading the criminal investigation will responsible for informing the DIO and HR Manager of any criminal sanctions applied; and likewise the HR Manager should keep the Local Counter Fraud Service team updated on the application of disciplinary sanctions.

Where the imposing of parallel sanctions are being considered, the LCFS will liaise with DIO to share information where proportionate, necessary and lawful to avoid any duplication of work.

An investigation plan setting out the requirements for the imposing of parallel sanctions should be established and maintained throughout the investigation process.

The Health Board may consider the following sanctions in cases where there is prima facie evidence of fraud, bribery or corruption against NHS Wales:

- **Criminal sanction** – A criminal sanction is pursued where evidence of offences has been obtained so that relevant punitive sanctions and redress can be sought. This sanction can only be pursued if signed off by both the Executive Director of Finance and the Head of CFS Wales.
- **Civil sanction** – Where it is cost-effective and desirable for the purpose of deterrence, it may be decided that civil redress is the most appropriate course of action. It is then the responsibility of the Health Board's Solicitor to use the civil law to recover any losses following a referral from the LCFS (please refer to the Fraud financial redress procedure at Annex D).
- **Disciplinary sanction** – Disciplinary procedures are designed to test whether a person should be permitted to practice or continue their employment. Recovery should be considered whenever this action is pursued and the organisation has suffered a financial loss due to inappropriate actions being undertaken. The Health Board disciplinary policy will be followed in these circumstances. Those conducting disciplinary hearings should never make an express or implied statement that criminal proceedings will not be undertaken. Dismissal of an employee need not wait until the conclusion of any simultaneous criminal sanction that may be being pursued by the Crown Prosecution Service.

Either one, a combination or all of the above sanctions may be pursued by the Health Board. The appropriate sanctions to be pursued by the Health Board, will be assessed on a case-by-case basis.

The LCFS leading the investigation will be responsible for establishing a prosecution file. The DIO will be responsible for establishing the disciplinary case file.

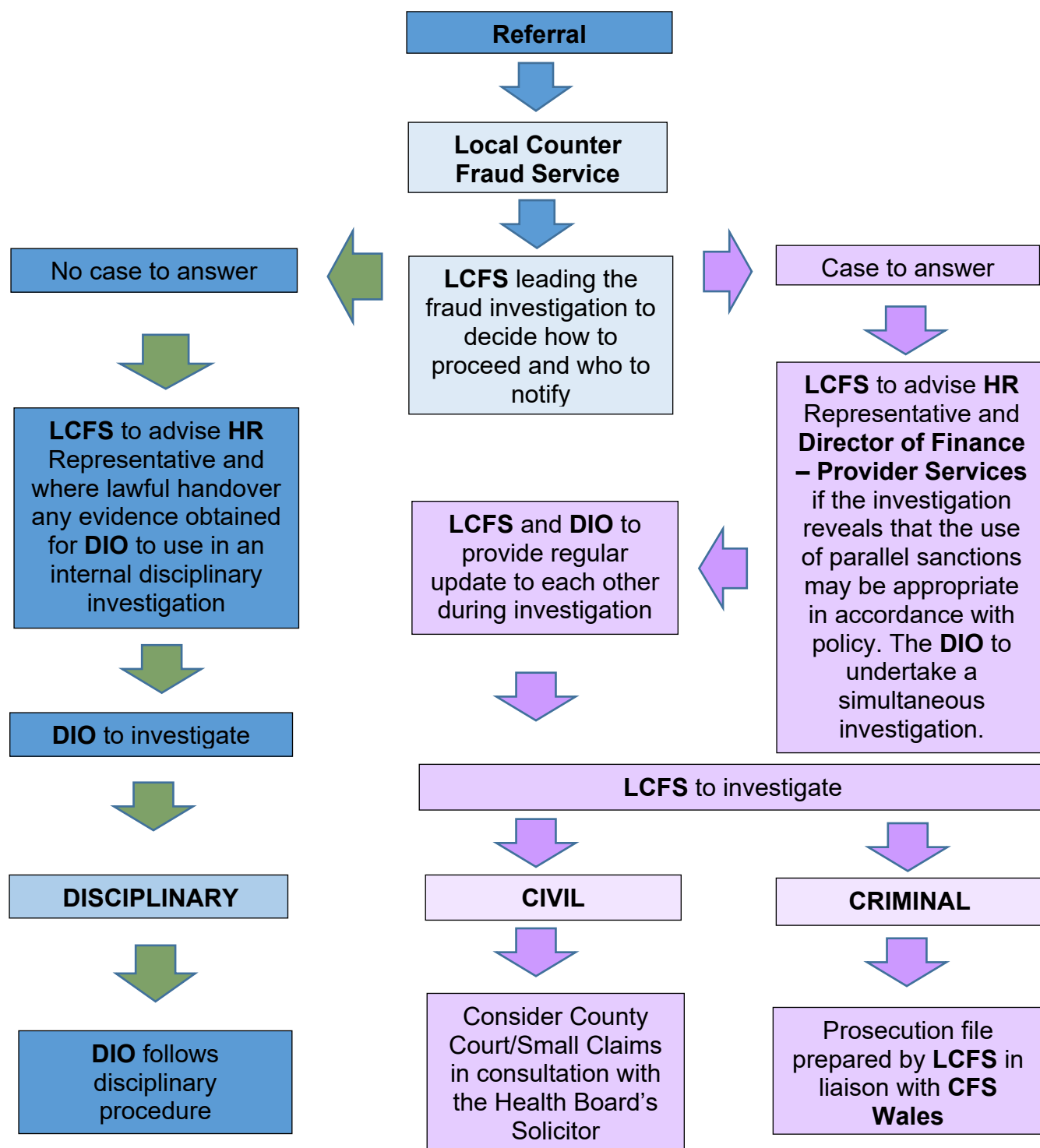
The Local Counter Fraud Service team cannot be assigned as DIO by the appropriate HR Manager/representative into any disciplinary matter as the role of the Local Counter Fraud Service team is to conduct criminal investigations into alleged fraud, bribery or corruption.

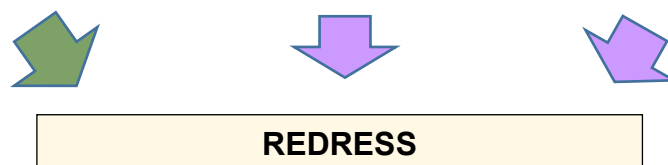
5 Monitoring and review of the protocol

Responsibility for the development, maintenance and review of this protocol lies with the Local Counter Fraud Service team. As an Annex to the Health Board's Counter fraud, bribery and corruption policy the protocol will be disseminated at the same time as the policy and placed on the Health Board's intranet Local Counter Fraud webpage.



Parallel Investigations flowchart procedure





Annex D - Fraud financial redress procedure

The Local Counter Fraud Service team should take the appropriate action during the investigation with the relevant payroll or finance department officer to seek an accurate cost to quantify the value of any monies suspected to have been defrauded from the Health Board.

To liaise with the Accounts Receivable team to raise an invoice for the full value of defrauded monies. To liaise with the Accounts Receivable team through-out the course of any voluntary or legal actions that may be required to recover defrauded monies.

In circumstances where Civil Redress is required to be undertaken for cases which involve fraud, the case will be transferred from the Accounts Receivable team to the Local Counter Fraud team, who will seek Civil Redress from the County Court / High Court, or where applicable from the NHS Pensions Agency.

The LCFS will consider a number of options to recover defrauded monies including the following:-

- To seek voluntary recovery of the defrauded funds on a without prejudice basis to the criminal fraud investigation
- Prosecution - Seek an order of the court under the Proceeds of Crime Act and other relevant criminal legislation to achieve a full financial recovery
- Disciplinary - Seek from the disciplinary panel where a management case is proven and establishes the employee defrauded the NHS that the disciplinary panel decision includes the repayment of defrauded monies.
- Civil action - In the event of no voluntary repayment or that criminal and disciplinary sanctions fail to achieve a full financial recovery to refer the matter to the Health Board appointed Solicitor to consider a recovery through the civil courts, after out of court negotiation attempts by the Solicitor has been exhausted. The Solicitor will advise the investigating LCFS on recovery outcome who will inform the Accounts Receivable Manager of any further action to be taken to recover the monies.

In the event that criminal, disciplinary and civil recovery action have been exhausted without a financial recovery being achieved and where further legal action would be uneconomical to pursue to seek a write off is as follows:

- Up to £5,000 – Approval required by Head of Financial Service
- £5,000 to £50,000 – Approval required by Director of Finance Provider Services
- Over £50,000 – Approval required by Welsh Government

In all cases the requirements of Welsh Government recording of losses must be complied with when writing off a fraud loss and reported as due process to the Health Board.



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Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A (Screening – Forms 1-4) and
B (Key Findings and Actions – Form 5)

<u>For:</u>	Local Counter Fraud, Bribery and Corruption Policy F03
<u>Date form completed:</u>	10 th September 2021



KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "...all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A

Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Local Counter Fraud, Bribery and Corruption Policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The policy has been developed to clearly define the steps that employees of the Betsi Cadwaladr University Local Health Board (BCU LHB) should take in order to report or deal with any suspicion they have of suspected fraud or corruption within the NHS.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Responsibility for the design and development of the policy rests with the Head of Local Counter Fraud. The policy sits under the responsibility of the Executive Director of Finance and will be ratified by the Audit Committee. The policy relates to the work of the Health Board's Local Counter Fraud Team.
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	<p>National legislation – Bribery Act 2010, Theft Act 1968 and 1978, Fraud Act 2006, Proceeds of Crime Act 2002, Criminal Justice Act 1993, Part 1 and relevant common law.</p> <p>Board's Standing Financial instructions</p> <p>Workforce and Organisational Development Policies</p> <p>Whistle blowing Policy</p> <p>Contract of Employment</p>

Part A

Form 1: Preparation

Please answer all questions

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	<p>BCULHB Employees, Contractors, Agency Workers, Volunteers and patients/service users.</p> <p>The document will be subject to a consultation period and distributed to all staff via the BCUHB Corporate Bulletin as well as targeted comms to Key Stake holders - Local Partnership Forum (LPF) / Workforce etc.</p> <p>BCULHB Audit Committee</p> <p>BCULHB Counter Fraud Team</p> <p>BCULHB Board Members</p> <p>Police Service</p> <p>NHS Counter Fraud Service Wales</p>
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	The success of the Counter Fraud, Bribery and Corruption Policy will be dependent upon good communication and/or Fraud Awareness training and the help and co-operation of other individuals within the Health Board.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The aim of this policy is to protect NHS resources from being lost to fraud. The content is dictated by legislation and common law (criminal and civil). The processes contained within the policy have been developed in accordance with the above. There may be additional considerations for the investigation of young people, this is taken into account via national guidance / Code of Practices.

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)	Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?"	How will you reduce or remove any negative Impacts that you have identified?
<p><i>for further direction on how to complete this section please click here training vid p13-18</i></p> <p>Guidance for Completion</p> <p><i>In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered ‘Yes’, you need to indicate if the potential impact will be positive or negative. Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.</i></p> <p><i>The information that helps to inform the assessment should be listed in this column. Please provide evidence for all answers.</i></p> <p>Hint/tip: do not say: “not applicable”, “no impact” or “regardless of...”. If you have identified ‘no impact’ please explain clearly how you came to this decision.</p>			

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

<p>NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.</p> <p>For the definitions of each characteristic please click here</p>						
	Yes	No	(+ve)	(-ve)		
Age	*		*		<p>This policy will apply to all BCUHB Staff, Contractors, Agency Workers, Volunteers and Service Users.</p> <p>This demographic impacted is generally Adults. However, it is acknowledged that BCUHB do employ Apprentices and students (young adults). This would be taken into account for any Interviews and/or Investigations relating to suspected fraud (for example the presence of an Appropriate Adult during an Interview – where required).</p> <p>There is insufficient data to establish whether a particular age group is more impacted than others are in terms of allegations and/or offences. Age demographics are not routinely collected and it is unlikely that any meaningful analysis could be taken from the small sample size.</p>	The October 2021 review of the policy, a section for young adults / Appropriate Adult representation will be included as per the requirements of the Police and Criminal Evidence Act 1984 (PACE) Codes of Practice.
Disability	*		*		Any investigation / interview will be conducted in accordance with Police and Criminal Evidence Act 1984	The October 2021 review of the policy, a section will be

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					(PACE) Codes of Practice and NHS Wales All Wales Respect and Resolution policy. This includes making reasonable adjustments such as access for physical interviews, providing documents / correspondence / evidence in an appropriate format (i.e. visual impairment) etc.	included advising individuals to notify the Health Board if reasonable adjustments are required.
Gender Reassignment	*		*		The assessment is that there is no negative impact on this group. However, it is acknowledged that flexibility regarding Interview dates may be required for those who may be undergoing gender reassignment.	This would be covered by the additional section for reasonable adjustments as per above.
Pregnancy and maternity	*		*		The assessment is that there is no negative impact on this group. However, it is acknowledged that flexibility regarding Interview dates may be required for those who may be pregnant and / or have child care issues.	This would be covered by the additional section for reasonable adjustments as per above.
Race	*		*		Ethnicity demographics are recorded for the purpose of the Criminal Justice system. However, this data is not analysed or centrally recorded by the Health Board and is collected for upward reporting purposes only (requirement of the Police Service).	The document will state that translation services are available under the provisions of the Police and Criminal Evidence Act 1984 (PACE) Codes of Practice and additional support would

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					There may be language barriers where English/Welsh is not the individual's first language. There is insufficient data to indicate whether the document should be available in a language other than English/welsh as standard. This will need to be addressed on a case by case basis.	be covered as per the reasonable adjustments section to be included in the policy.
Religion, belief and non-belief	*		*		The assessment is that there is no negative impact on this group. However, it is acknowledged that an employee may have a religion, belief or non-belief that affects their ability to attend and/or participate fully in the investigation process. For example, during Ramadan where abstinence from all food and drink from dawn to sunset may cause dehydration that could cause headaches, tiredness and difficulty concentrating.	This would be covered by the additional section for reasonable adjustments as per above.
Sex		*			Demographics on Sex are not collected and the assessment is that there is no negative impact on this group (acknowledging that women carry out more childcare duties overall – see Office of National Statistics report , this is covered by the pregnancy and maternity section above).	Not Applicable
Sexual orientation		*			Demographics on Sexual orientation are not collected and the assessment is that there is no negative impact on this group.	Not Applicable

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Marriage and civil Partnership (Marital status)		*			Demographics on Marriage and civil Partnership are not collected and the assessment is that there is no negative impact on this group.	Not Applicable
Socio Economic Disadvantage	*			*	There is a potential negative impact for those individuals who may be experiencing financial difficulties or in receipt of a lower income wherein they are required to repay monies due to salary overpayments. This is provided for by the Health Board's policy F14 – Salary Overpayments and Underpayments. This procedure mandates that all overpayments are dealt with in a fair and consistent way. Where a payment is greater than 20% of an employee's most recent gross monthly pay (excluding expenses), the Finance department will arrange a recovery plan. In circumstances where employees can demonstrate, by providing documentary evidence, that they would not be able to make repayment in either a single period or the period of overpayment, the Finance Department will work with them to establish a fair affordable repayment plan based on their household's income and expenditure account.	Not Applicable

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: <http://howis.wales.nhs.uk/sitesplus/861/page/42166> and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker <https://humanrightstracker.com>.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2* *Right to life*
- *Article 3* *Prohibition of inhuman or degrading treatment*
- *Article 5* *Right to liberty and security*
- *Article 8* *Right to respect for family & private life*
- *Article 9* *Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

[UN Convention on the Rights of the Child](#)

[UN Convention on the rights of people with disabilities.](#)

[UN Convention on the Elimination of All Forms of Discrimination against Women](#)

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
	*			None	The Counter Fraud, Bribery and Corruption policy follows the guidance issued by the UK Cabinet Office which is compliant with the Human Rights Act 1998 and the fundamental rights and freedoms that everyone in the UK is entitled to.	Not Applicable

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	*		*		Enquiries and investigations can be conducted via the medium of Welsh if required.	Not Applicable
Treating the Welsh language no less favourably than the English language		*			Enquiries and investigations can be conducted via the medium of Welsh if required.	Not Applicable

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

<p>What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p>Engagement and consultation to be undertaken with Health Board staff via the Communications team and the staff corporate newsletter.</p> <p>Engagement and consultation to be undertaken with the Local Partnership Forum / WOD.</p>
<p>Have any themes emerged? Describe them here.</p>	<p>Post consultation and engagement, no specific equality themes have been identified (noting that this is a review and that the policy is already extant). All comments related to administrative / language amendments and have been addressed accordingly. In addition, an action from the December 2021 Audit Committee (ensuring Executive Director of WOD oversight of all new CF cases) has been incorporated into the operational process and documented within the revised CF Policy).</p>
<p>If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?</p>	<p>As per above, comments have been addressed / actioned.</p>

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- <http://howis.wales.nhs.uk/sitesplus/861/page/44085>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) <i>for further direction on how to complete this section please click here training vid p13-18</i>	Local Counter Fraud, Bribery and Corruption Policy
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2. Brief Aims and Objectives: (Copy from Form 1)	The policy has been developed to clearly define the steps that employees of the Betsi Cadwaladr University Local Health Board (BCU LHB) should take in order to report or deal with any suspicion they have of suspected fraud or corruption within the NHS.
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From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? Guidance: This is as indicated on form 2 and 3	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/> *
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/> *

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?</p> <p>High significance may mean:</p> <ul style="list-style-type: none"> - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. <p>GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
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Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p>5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?</p>	<p>Yes <input type="checkbox"/></p>	<p><input checked="" type="checkbox"/></p>
<p>6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
	<p>How is it being monitored?</p>	<p>It will be monitored by using the Local Counter Fraud Survey.</p>
	<p>Who is responsible?</p>	<p>Head of Local Counter Fraud Service.</p>
	<p>What information is being used?</p>	<p>Stakeholder feedback from the Local Counter Fraud Survey.</p>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	When will the EqIA be reviewed?	August 2024 (in line with the policy review cycle) or sooner if required
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7. Where will your policy or proposal be forwarded for approval?	Audit Committee
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8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity Senior sign off prior to committee approval:	Name	Title/Role
	Karl Woodward	Head of Local Counter Fraud Service
	Bethan Wassell	Statutory Compliance, Governance & Policy Manager
	Tom Stanford	Finance Director – Operational Finance
	The appropriate approval groups	Consultation with all staff via policies page / corporate bulletin, LPF, WOD policies group, Equality team, Exec Team.

Action Plan

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
	Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.		
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	Not Applicable		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	Post consultation and engagement, no specific equality themes have been identified (noting that this is a review and that the policy is already extant). All comments related to administrative / language amendments and have been addressed accordingly		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.	Who is responsible for this action?	When will this be done by?
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	No negative impact identified		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	The policy will make specific provision for young people and the requirement to make reasonable adjustments		



Cyfarfod a dyddiad: Meeting and date:	Audit Committee 15 March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Draft Standards of Business Conduct Policy						
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton, Board Secretary						
Awdur yr Adroddiad Report Author:	Molly Marcu, Interim Deputy Board Secretary						
Craffu blaenorol: Prior Scrutiny:	Internal Audit						
Atodiadau Appendices:	Appendix 1: Draft Standards of Business Conduct Policy						
Argymhelliaid / Recommendation:							
That the Audit Committee notes and approves the Draft Standards of Business Conduct Policy.							
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	✓
Y/N to indicate whether the Equality/SED duty is applicable							N
Sefyllfa / Situation:							
The purpose of this report is to enable the Committee to review proposed changes to the Standards of Business Conduct Policy which was due a review in August 2021.							
Cefndir / Background:							
The Standards of Business Conduct Policy falls within the remit of the Audit Committee, as part of the assurance arrangements of maintaining an effective system of internal control							
Asesiad / Assessment & Analysis							

The Standards of Business Conduct Policy is submitted to the Audit Committee for approval following a review of the content by internal audit, as part of their review of declarations of interests.

The policy is part of a compliance framework that is aligned to employment contractual provisions which set a requirement for staff to declare interests as and when they materialise. It is also implemented partially via the use of an electronic DOI system, taking into account recommendations and next steps identified in the Internal audit review, which forms part of the agenda.

In summary, the policy has been updated to incorporate provisions within the All Wales policy as recommended by Internal Audit Wales in relation to:

- Hospitality
- Possible disciplinary action in relation to non-compliance with the policy
- Sponsorships
- Monitoring

The detailed revisions are incorporated within **appendix A** of this report.

In addition, the policy has been updated to reference that the scope extends to board members employees, agency and locum staff.

Strategy Implications

There are no specific strategy implications within this report.

Options considered

There are no further options for consideration.

Financial Implications

There are no specific financial implications within this report.

Risk Analysis

Non-compliance with Standing Orders and Corporate Governance processes pose a number of risks to the organisation. This report seeks to provide assurance that the requirements of the Standing Orders concerning declarations of interest, Gifts & Hospitality are being appropriately complied with.

Legal and Compliance

As above, non-compliance with Standing Orders poses a risk to the corporate governance standards of the organisation.

Impact Assessment

An impact assessment is not required to support this report.

OBS02: STANDARDS OF BUSINESS CONDUCT POLICY

Date to be reviewed:	March 2022	No of pages:	36
Author(s):	Molly Marcu	Author(s) title:	Interim Deputy Board Secretary
Responsible director:	Board Secretary		
Approved by:	Audit Committee		
Date approved:	To be confirmed		
Date activated(live):	1 October 2016		
Date EQIA completed:	7 March 2022		
Documents to be read alongside this policy:	<ul style="list-style-type: none">• The Codes of Conduct and Accountability for NHS Boards & Code of Conduct for NHS Managers• Standing Orders relating to declarations of interest and offers of gifts & hospitality• WP6 – Code of Conduct (Disciplinary Rules and Standards of Behaviour Policy)• F03 Local Anti-Fraud, Bribery and Corruption Policy• F14 Salary Overpayments & Underpayments Local Management Procedure• MD14 - Private Practice Policy 2016• Other codes of conduct, including those adopted by specific professional groups (GMC, NMC, HCPC etc.)• RD03 - Policy for Intellectual Property• NHS Wales SSP Procurement Services – Suppliers Policy• Documentation relating to individual's appointment as volunteers to the Health Board		
Purpose of Issue/Description of current changes: This policy has been reviewed and updated in order to incorporate All Wales provisions around the declarations of interests, particularly in relation to gifts and hospitality. The scope of the policy has also been widened to explicitly incorporate agency, locum staff and board members.			

PROPRIETARY INFORMATION

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1. Introduction and Policy Statement

Public service values are at the heart of the NHS. High standards of corporate and personal conduct in public life based on a recognition that patients come first, has been a requirement throughout the NHS since its inception.

The Health Board is committed to the NHS Codes of Conduct and the principles set out in the NHS Wales Values and Standards of Behaviour Framework. This Framework, together with standing orders and standing financial instructions, form the key elements of the governance and accountability framework for the NHS in Wales.

The Board expects all employees to abide by the core values of the Framework (throughout this document, the term 'employees' is used to refer to employees, bank , agency and locum workers, contractors, sub-contractors, students, trainees including Board and Associate Board members).

If you have any doubts about whether a declaration is needed please discuss this with your line manager or contact the Board Secretary. These core values are:

- Putting quality and safety above all else: providing high value evidence based care for our patients at all times
- Integrating improvement into everyday working and eliminating harm, variation and waste
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales
- Working in true partnerships with partners and organisations and with our staff
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

The core values support good governance and help ensure the achievement of the highest possible standards in all that the NHS in Wales does. They are supplemented by policies and also Codes of Conduct for Board Members and NHS Managers which incorporate the Seven Principles of Public Life known as the 'Nolan Principles'.

In support of these principles, employees must be impartial and honest in the way that they go about their day to day functions. They must remain beyond suspicion at all times. They can achieve the seven Nolan Principles by:-

- Ensuring that the interests of service users remain paramount;
- Being impartial and honest in the conduct of their official business;

- Using public funds to the best advantage of the service and the service users, always seeking to ensure value for money;
- Not abusing/using their official position for personal gain or to benefit family or friends;
- Not seeking advantage or further private business or other interests in the course of their official duties;
- Not seeking or knowingly accepting preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board.

As part of the implementation of this policy, employees and Board members attending committees, sub-committees and advisory group members, (directly or indirectly contracted with the Health Board) will apply the Nolan principles.

This policy builds upon the provisions included in Health Board's Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations are made. This policy is intended to complement the various Professional Codes of Conduct relevant to employees and board members of the Health Board.

2. Codes of Conduct

2.1 The Codes of Conduct and Accountability for NHS Boards reinforce the seven principles of public life (Nolan Principles) and focus on the crucial public service values which must underpin the work of the health service.

2.2 The Code of Conduct for NHS Managers sets out the core standards of conduct expected of NHS managers. It aims to serve two purposes: to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make, and to reassure the public that these important decisions are being made against a background of professional standards and accountability.

The Codes of Conduct are available at the following link:

<http://www.wales.nhs.uk/governance-emanual/codes-of-conduct>

2.3 There are also a number of Professional Codes of Conduct, which complement this Policy, which comprise of both clinical and non-clinical staff (such as accountants, procurement staff, company secretaries, human resources professionals).

The main clinical ones are as follows:

General Medical Council

[Home - GMC \(gmc-uk.org\)](http://gmc-uk.org)

General Pharmaceutical Council

[General Pharmaceutical Council \(pharmacyregulation.org\)](http://pharmacyregulation.org)

Nursing and Midwifery Council:

<https://www.nmc.org.uk/standards/code/>

Health and Care Professions Council:

<http://www.hcpc-uk.co.uk/>

NHS Consultants and General Practitioners:

<http://www.gmc-uk.org/guidance/index.asp>

3. Purpose

The purpose of this policy is to set out the organisation's expectations in relation to the standards of conduct expected of all employees in their role.

4. Aims and Objectives

The policy is one of the mechanisms in place to enable the Health Board and its employees in maintaining ethical standards in the conduct of NHS business. It sets out the principles the Health Board expects all employees to uphold, and the steps that the Health Board as an employer will take to safeguard the organisation where conflicts of interest arise. It also describes the arrangements in place to manage declarations of interests, gifts & hospitality. All employees are required to be familiar with the content of this document, and line managers have a responsibility for bringing the policy to the attention of their staff.

The Policy also aims to reflect public acceptability of behaviours of those working in the public sector so that the Health Board can demonstrate to have exemplary practice in this regard.

5. Employee and Employer Responsibilities

- 5.1** It is the responsibility of all staff to ensure they are not placed in a position that risks, or appears to risk, conflict between their private interest and the NHS. This primary responsibility applies to all Health Board staff, including those who commit resources directly by ordering goods or services, and those who do so indirectly.
- 5.2** Appointing officers and /managers must declare any known relationship with potential applicants. If a relationship is declared the appointing officer and /managers must not be involved in any decisions relating to financial aspects of the individual's offer of employment. On an ongoing basis there should not be any involvement in any other financial decisions relating to the individual to whom the manager has declared any relationship. This shall include salaries, re-grading, authorisation of travelling expenses, overtime payments etc.
- 5.3** The Health Board, as an employer, will ensure that staff effectively understand and implemented the key provisions of this policy by putting in place a robust framework of awareness, training.
- 5.4** Staff must be impartial and honest in the conduct of business and remain beyond suspicion. It is an offence under the Bribery Act 2010 for an employee to accept a bribe in his or her official capacity, or to corruptly show favour or disfavour in the handling of contracts or other business. Staff need to be aware

that a breach of the provisions of this Act may render them liable to prosecution and disciplinary action (see Section 6 for further detail).

5.5 Volunteers' Responsibilities

It is important that all volunteers adhere to Health Board policies and procedures. This policy is consistent with the Wales Council for Voluntary Action Code of Practice for organisations involving volunteers:

<https://www.wcva.org.uk/advice-guidance/volunteers>

6. Prevention of Fraud, Bribery and Corruption

All employees must abide by the Health Board's Anti-Fraud, Bribery and Corruption Policy. This can be accessed via the link below:

<http://howis.wales.nhs.uk/sitesplus/861/page/44942>

The Bribery Act 2010 came into force on the 1st July 2011 and bribery is defined as the giving or taking of a reward in return for acting dishonestly and/or in breach of the law. The six possible offences are:

- Bribing another person- active bribery - the giving, promising or offering a bribe to another;
- Being bribed - passive bribery - the requesting, agreeing to receive or accepting any bribe;
- Bribing a foreign public official;
- Failure to prevent bribery;
- Also, under Section 7 of the Bribery Act - 2010 NHS Organisations are considered commercial organisations and may commit a criminal offence if they or their employees acting on their behalf fail to prevent a bribe.

Employees, agency staff and board members are therefore expected to:

- Report any issues relating to fraud, bribery or corruption to a Local Counter Fraud Specialist;
- Declare any interest which may result in the employee or persons known to the employee gaining direct or indirect financial advantage as a consequence of their work, which could influence any decisions made by the employee, or which could interfere with contractual obligations to the organisation;
Submit a declaration of interest annually, either as a nil return or to confirm the existence of an interest
- Ensure the interests of patients are paramount and that use or management of any public funds ensures value for money;
- Check each payslip as soon as possible following receipt to ensure that the amount paid is correct, with any queries raised with the line manager. If the

employee believes that they have been overpaid, they must declare it without delay. Where employees do not understand their payslip, they should contact the Payroll department.

Employees, contractors and board members must not:

- Abuse their official position for personal gain or in showing favouritism;
- Accept inappropriate gifts, hospitality or bribes;
- Misuse or make available confidential information;
- Misuse public funding; fraudulently use public funding for personal gain or for the offer of bribes.

This document should be read in conjunction with other related documents/policies including those that cover:

- F14 Salary Overpayments & Underpayments (Local Management Procedure);
- All Wales Code of Conduct (Business) for NHS Staff;
- F03 Local Anti - Fraud, Bribery and Corruption Policy;
- Register of Employees Interests;
- Commercial Sponsorship - Ethical
- Standard for the NHS.

7. Putting the Principles into Practice

7.1 Social Networking Sites

7.1.1 The Health Board is making increased use of social networks to engage with patients, service users, staff and other stakeholders to deliver key messages.

7.1.2 Employees must remember that expressing views or commenting on content on the Internet in relation to the Health Board cannot be divorced from their working life.

7.1.3 Unguarded comments in relation to an employee's work, working environment, colleagues, patients, carers, visitors, suppliers and contractors etc. can bring the organisation into disrepute and may invite legal action against both the employee and their employer.

7.1.4 Ultimately employees are responsible for what is published online and there can be consequences if policies are broken. If an employee is considering publishing something that makes them think twice, the guidance below applies. Where doubt remains, the employee should contact the Corporate Communications Team to discuss the matter.

7.1.5 Additional examples of situations where you are identifiable as a staff

member include commenting on our official social media accounts or partner- related matters within a public forum.

7.1.6 Whilst employees are encouraged to use social media to reflect positively on and engage with the work of the Health Board and partners, it is important to maintain a coherent online presence through official social media channels.

7.1.7 Therefore, employees and board members are not permitted to communicate externally or on social media accounts, on behalf of the Health Board without having gained approval from the Corporate Communications Team, with the intention of representing official views of wards, Directorates, Divisions, Service/Hospital Sites or Departments/Specialties.

7.1.8 To set up a social media business account, a business case must be prepared, outlining how this activity will benefit the programme or business area compared to the costs in time and the resources of doing so.

7.1.9 The purpose of policies and guidelines is not just to help protect the organisation, but also to protect employees' interests, and to advise of the potential consequences of interactions online and any content that might be posted.

Guidance: <http://howis.wales.nhs.uk/sitesplus/861/page/67285>

Facebook: [Betsi Cadwaladr University Health Board](#)

Twitter: [@bcuhb](#)

Digital Media Officer, Communications Department (Carlton Court, St Asaph):
bcuhbpressdesk@wales.nhs.uk

7.2 Acceptance of Gifts or Hospitality

7.2.1 Gifts

A gift is an item of personal value, given by a third party e.g. a patient, donor or a supplier. The definition includes prizes in draws and raffles at sponsored events/conferences.

It is an offence to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with BCUHB

Such gifts should be refused and if they have already been received, they should be returned clearly advising why they cannot be accepted.

Any acceptance of a gift needs to be justified and the context in which the offer has

been made.

This Standards of Behaviour Policy excludes gifts between members of staff, for example birthday presents or leaving gifts.

7.22 Gifts from Service Users or their relatives

Gifts up to the value of £25 may be accepted from service users and relatives as a mark of their appreciation e.g. for the care that has been provided. This can include gift vouchers/ cards. A common sense approach should be applied to the valuing of gifts using an actual amount if known, or an estimate that any reasonable person would make as to its value.

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

Where a gift is offered that is likely to be over £25 in value it should be politely declined. In some cases the gift may have already been made and it may be difficult to return it, or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of Charitable Funds e.g. used as a prize in a raffle.

A Gifts and Hospitality Form should be completed when gifts of up to £25 are accepted.

Personal gifts of cash from service users or their relatives is not acceptable. These may only be accepted as a donation to the Ayr Lys Charity and recorded as such. The Board Secretary can provide advice regarding the mechanism for appropriately receipting such items in accordance with the Institute of Fundraising Code.

7.23 Gifts from Suppliers, Contractors and Commercial Organisations

Low cost, branded or promotional gifts may be accepted where they are under the value of the common industry standard of £6 in total (selected with reference to existing industry guidance issued by the ABPI) and do not need to be declared. Any gifts outside this definition from suppliers, contractors and other commercial organisations doing business or likely to do business with BCUHB above this value, should be politely but firmly declined.

Whilst it is not necessary to declare gifts of low intrinsic value, staff are required to declare other gifts that they are offered, but not accepted to allow BCUHB to monitor when such organisations are inappropriately offering gifts or potential inducements.

7.24 Gifts from Dignitaries/Overseas Organisations

There may be occasions when visits are made by dignitaries or overseas organisations who consider it 'culturally custom and practice' to exchange gifts. In such cases, employees should seek guidance from the Committee Secretary and declare these gifts on a Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2). A decision will then jointly be made as to the most appropriate way to manage the gift. This will depend on the nature of the 'gift culture' and may include decisions to 'keep and display in public', 'donate to an internal user group', 'auction for charity', etc.

7.3 Bequests/Legacies/Wills

Employees are not permitted to accept bequests left to them by a deceased patient who became known to them through providing care or treatment as part of their Health Board employment. Accepting a gift of this nature, particularly where a patient is considered vulnerable, could leave the staff member open to serious accusations of financial abuse, fraud (by abuse of position) or misconduct. If an employee is made aware that they may be a beneficiary in a patient's will, they must declare this. All cases of this nature must be escalated to the Board Secretary and subsequently reported to the Audit Committee.

7.4 Hospitality

Employees should ensure that they declare all offers of hospitality with an estimated value exceeding £25, whether accepted or declined. Hospitality is defined as the provision of beverages, meals, travel, entertainment, or entry to an event, conference or function, regardless of whether provided during or outside normal working hours. Declarations of hospitality must be made via the electronic system which can be accessed via the following link:
<http://howis.wales.nhs.uk/sitesplus/861/page/41930>. All declarations of hospitality will be reviewed by the Office of the Board Secretary.

7.5 Unacceptable Hospitality

Unacceptable hospitality includes the following examples as general guidance:

- a holiday abroad;
- hotel accommodation;
- use of a company flat;
- attendance at a function or event restricted to staff which is not for the purposes of training or organisational development.

In case of doubt, advice should be sought from the Board Secretary/Local Counter Fraud Specialist and employees should report any case where an offer of

hospitality is pressed which might be open to objection.

7.6 Acceptable Hospitality

7.6.1 Hospitality must be secondary to the purpose of a meeting. The level of hospitality offered must be appropriate and not out of proportion to the occasion; and the costs involved must not exceed the level which the recipients would normally adopt when paying for themselves, or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it appropriate for them to attend the meeting. These types of hospitality must be approved by a Director/Assistant Director and recorded on the gifts and hospitality register in advance of acceptance.

7.6.2 Other hospitality may be accepted where it furthers the aims of the Health Board, provided it is normal and reasonable in the circumstances, for example lunches in the course of working visits. Where the value is estimated to be over £25, a declaration should be made.

7.6.3 Other hospitality may be accepted, for instance where:

- A member of staff is invited to a Society or Institute dinner or function;
- There is a genuine need to impart information, or represent the Health Board in stakeholder community events;
- An event is clearly part of the life of the Stakeholder community or where the organisation should be seen to be represented;
- A function or event is hosted for both Staff and Non Staff, which adds benefit and value to the Health Board or the wider NHS;
- A function or event is hosted externally for staff only for the purposes of training or organisational development.

7.7 Hospitality in the Context of Partnership Arrangements with the Pharmaceutical Industry

7.7.1 Pharmaceutical industry and allied commercial sector representatives organising meetings are permitted to provide appropriate hospitality and/or meet any reasonable actual costs, which may have been incurred. If none is required, there is no obligation or right to provide any such hospitality, or indeed any benefit of equivalent value. See MM08: Code of Practice for BCUHB Staff with Pharmaceutical Companies

<http://howis.wales.nhs.uk/sitesplus/documents/861/MM08%20-%20code%20of%20practice%20for%20BCUHB%20staff%20with%20Pharmaceutical%20companies.pdf>

7.7.2 The Pharmaceutical Industry is expected to adhere to the Association of the British Pharmaceutical Industry (ABPI) Code of Practice for the Pharmaceutical Industry, which clearly specifies what is and what is not acceptable.

<http://www.pmcpa.org.uk/thecode/Pages/default.aspx>

8. Declaration of Interests

8.1 All employees should declare, to the best of their knowledge, if they, or a close relative, or associate, have a controlling or financial interest in a business, which could impact on the activities of the Health Board. All such interests should be declared on starting employment, (by way of the job application form), and then by completing a declaration form upon starting in post, annually and on acquisition of the interest. All employees shall be under a contractual obligation to declare such interests, irrespective of banding on a mandatory annual basis until the interest(s) cease to exist. Declarations should be made on the electronic declaration form via the following link: - <http://howis.wales.nhs.uk/sitesplus/861/page/41930>. The declaration of interests register is reported to the Audit Committee periodically. Before publication, employees' personal identifiable information will be redacted in line with information governance requirements (apart from Board Members, for whom the information is deemed to be in the public domain). Declarations of interest are reviewed by the relevant Directorate Governance Lead, details of which are displayed on the declarations of interest intranet page. Governance Leads are responsible for escalating any concerns to the relevant line manager.

8.2 Employees must declare all private interests which could potentially result in personal gain as a consequence of their position within the Health Board.

8.3 If any employee has a financial/commercial interest in an organisation they must not refer a patient for treatment or investigation to that body.

8.4 The NHS Wales Shared Services Partnership Procurement Team will automatically issue a separate declaration of interest form with every request to waive Standing Financial Instructions.

8.5 All Health Board employees have a duty of care to establish and actively maintain clear personal relationship boundaries with patients, their families and their carers in accordance with their employment contract and/or guidance from professional regulators (e.g. GMC/NMC).

8.6 Mandatory annual declarations of interests are required from Board members, all senior employees (band 8c or equivalent and above), all Consultants and also other employees of any pay band deemed to have 'LHB Officer' status due to undertaking roles where there is potential for a conflict of interest (as determined by a Director). Annual declarations must be submitted even if a nil return (nothing to declare).

8.7 Staff should be aware that the Health Board Management Process will seek advice from the Counter Fraud Team if and when required.

9. Preferential Treatment in Private Transactions

Individual employees must not seek or accept preferential rates or benefits in kind for private transactions carried out with which they have, or may have, official dealings on behalf of the Health Board (this does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised employees interests, on behalf of all employees - for example, NHS employee benefits schemes).

10. Contracts

Employees in contact with suppliers and contractors, particularly if authorised to approve purchase orders or place contracts for goods, materials or services, shall adhere to accepted professional standards, the NHS Wales Shared Services Partnership Procurement Policy and the Standing Orders and Standing Financial Instructions of the Health Board. <http://www.wales.nhs.uk/sitesplus/861/page/87709>

All staff are required to comply with procurement rules and regulations in respect of systems or information which involves the collection or storage of personal data and must abide by Information Governance, Data Protection Impact Assessment and Cyber Security Requirements.

11. Favouritism in Awarding Contracts

11.1 Fair and open competition between prospective contractors or suppliers for contracts is a requirement of the Standing Orders and of European Union (EU) Directives on Public Purchasing for Works and Supplies. This means that:-

- No private, public or voluntary organisation or company which may bid for Health Board business should be given any advantage over its competitors, such as advance notice of the requirements. This applies to all potential contractors, whether or not there is a relationship between them and the Health Board, such as a long-running series of previous contracts;
- Each new contract should be awarded solely on merit, taking into account the requirements of the Health Board and the ability of the contractors to fulfil them.

11.2 Senior managers should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity.

11.3 Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that employees who are known

to have a relevant interest play no part in the selection.

12. Warnings to Potential Contractors

The Health Board will ensure that all invitations to potential contractors to tender for business includes a notice warning those submitting tenders of the consequences of engaging in any corrupt practices involving employees of public bodies.

13. Outside Employment (paid, unpaid or self-employed)

13.1 Employees can undertake other employment provided this does not conflict in any way with their duties as an employee of the organisation. In particular, if employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to carry out their duties as an employee of the Health Board. Employees must also ensure this does not place them in a position where their judgement or actions might be influenced by considerations arising from their other employment.

13.2 Employees who engage in employment (including self-employment) outside BCUHB which may conflict with their contract of employment with the organisation must notify their Line Manager of the circumstances [and declare this annually via the electronic staff declaration form](#)

13.3 Employees have a responsibility to ensure that the line manager is made aware of any hours worked in order that the Health Board fulfils its statutory requirement of the Working Time Regulations 1998.

13.4 An employee absent because of sickness is regarded as unfit to work and should not undertake any paid or unpaid work, in any capacity, during a period of sickness absence from the organisation, unless it is deemed jointly by the manager and the Occupational Health & Well-being Department to be therapeutically beneficial to their recovery. Express written permission must be granted by the manager in advance in all such cases.

13.5 An employee found to be undertaking other work during sickness absence, without the prior written consent of the manager, may be considered in breach of contract and will be subject to disciplinary action which may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal. Such action will only be taken following advice from the Workforce & Organisational Development Department. WP6 – Code of Conduct (Disciplinary Rules and Standards of Behaviour) can be accessed via the Workforce Policies and Key Documents here: <http://howis.wales.nhs.uk/sitesplus/861/document/42179>

14. Private Practice for Medical Staff

14.1 This policy sets standards for all BCUHB employees and other healthcare professionals about their conduct in relation to private practice and other forms of outside employment. The scope of this policy also incorporates any form of outside employment, self-employment or consultancy for employees or Board members, and therefore requires declarations of interest to be made (with line manager oversight) as soon as the interest materialises.

14.2 This policy also:

- ensures that clear standards are in place for managing the relationship between NHS work and private practice;
- covers private work both within and outside NHS facilities;
- offers guidance to individual private practitioners concerning their responsibilities;
- offers guidance to BCUHB employees concerning their role in supporting private patients without disadvantaging NHS patients.

14.3 In particular for medical staff, the amendment to the consultant contract in Wales clarifies the relationship between NHS work, private work and fee-paying work in that it sets out that a NHS consultant's first responsibility is to the NHS.

Participation in private medical services or fee-paying services should not result in detriment to NHS patients or services or diminish the public resources available for the NHS. Essentially, consultants should not schedule private work or fee-paying work at the same time as NHS activities, unless there has been a prior agreement with BCUHB. The Policy can be accessed via the link below:

<http://howis.wales.nhs.uk/sitesplus/861/document/435157>

15. Rewards for initiative

15.1 Potential intellectual property rights (IPR) should be identified, as and when they arise, in order to protect and exploit them properly, thereby ensuring that the Health Board receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by its employees in the course of their duties. Most intellectual property is protected by statute; e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. Senior managers should build appropriate specifications and provisions into the contractual arrangements which they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases. Advice will be provided via the Research & Development (R&D) Department.

- 15.2** With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and an Executive Director should agree a suitable reward for individual circumstances as appropriate. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.
- 15.3** In the case of collaborative research and evaluative exercises with manufacturers, senior managers should see that the Health Board obtains a fair reward for the input its employees provide. If such an exercise involves additional work for an employee outside that paid for by the Health Board under their contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

16. Commercial Sponsorship for Attendance at Courses and Conferences

- 16.1** Some health related companies provide commercial sponsorship to the NHS, including sponsoring equipment, employees and training events. In accordance with the All Wales Code of Conduct (Business) for NHS staff, all employees must consider fully the implications of a proposed sponsorship deal before entering into any arrangement. Only very senior managers with the necessary authority can sign up to, or enter into, any advertising contract or agreement with a company or its representatives. Employees must not allow unauthorised advertising on Health Board premises or documentation.
- 16.2** Acceptance by employees of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where attendance would further the aims of the Health Board and where the employee seeks permission in advance from his/her line manager in line with the Study Leave Policy. The line manager must be satisfied that acceptance will not compromise purchasing decisions in any way. In addition to completing the Study Leave form, you should also seek final approval from your relevant Director or Assistant Director and complete the electronic hospitality declaration form.
- 16.3** On occasions when senior managers consider it necessary for employees advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), the Health Board should normally meet the costs of such a visit so as to avoid compromising the integrity of subsequent purchasing decisions. For such visits prior agreement will be

sought from the Executive Director of Finance. Arrangements whereby the firm meets all/part of the cost of such a visit must be approved by the Executive Director of Finance who will consider the implications for the integrity of subsequent purchasing decisions.

17. Commercial Sponsorship - "Linked Deals"

- 17.1** Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post or equipment for the Health Board. The Health Board will not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the Health Board. Where such sponsorship is accepted, the Executive Director of Finance shall ensure appropriate monitoring arrangements are established to ensure that purchasing decisions are not, in fact being influenced by the sponsorship agreement.
- 17.2** Under no circumstances should Health Board managers agree to "linked deals", whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

18. Postgraduate Education

Any sponsorship/hospitality related to Postgraduate Education will be coordinated and managed by the relevant Postgraduate Centre Manager.

19. Research & Development

All research sponsored by commercial companies, including those sponsored by the pharmaceutical industry, must go through the Health Board's internal Research and Development approval process and will also require an assessment by the Local Research Ethics Committee.

20. Endowment (Charitable) Funds

- 20.1** Monies paid into charitable funds from commercial companies must only be accepted as donations or for sponsorship. Where sponsorship is received it should only be used to fund expenditure which is in line with the terms of the fund use.
- 20.2** Where sponsorship is received this should be recorded on the Gifts and Hospitality Register in accordance with the approved procedure.
- 20.3** Funding for research from commercial companies must not be paid into endowment funds and no commercial research projects should be implemented

using endowment fund monies. All such research projects should be implemented as Research and Development projects.

21. Equality

The Health Board is committed to ensuring that, as far as practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individual groups. An equality impact assessment screening exercise has been carried out to establish whether there is any possible or actual impact this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment (attached) found that there was no material impact on the protected characteristic groups mentioned above.

The Health Board is fully committed to ensuring that all employees are appraised of their obligations under the policy and that additional support and/or reasonable adjustments is available as required – for example, accessing the policy in a different format or support with completing an online declaration. This should be raised with a line manager in the first instance and escalated to the OBS as required.

Employees absent from work for a prolonged period, whether due to a disability or otherwise, are not expected to make a declaration and would not be penalised for failing to make such a declaration

22. Welsh Language

22.1 The Welsh Language (Wales) Measure 2011 has given the Welsh language official status in Wales by introducing Welsh Language Standards for organisations. The duties deriving from the standards mean that the Health Board and all of its employees should not treat the Welsh language less favourably than the English language, together with promoting and facilitating the use of the Welsh language.

22.2 In the conduct of public business, the Health Board's aim is to provide an 'active offer', meaning services should be provided in Welsh without the service user having to ask for it. Enabling our patients and the public to receive high-quality, language appropriate care is paramount to the way we provide and plan our services, as well as encouraging other users and providers to use and promote the Welsh language in the health sector.

22.3 The Health Board has a clear vision - everyone who comes into contact with its

services should be treated with dignity and respect by receiving a safe and responsive service that is accessible in their language of choice. The Health Board will ensure that equality, diversity and human rights will be mainstreamed when developing new policies through Equality Impact Assessments and will:

- Assess the impact of any new and revised policies on groups with 'protected characteristics' as defined under the Equality Act 2010;
- Facilitate and promote equity and the preservation of human rights wherever possible;
- Advance equality of opportunity and human rights wherever possible;
- Ensure that when new policies are implemented they comply with the Strategic
- Equality and Human Rights Plan.

23. Review, Audit and Monitoring

The Board Secretary will monitor the policy and formally review it every 3 years, or sooner, subject to legislative changes.

Internal Audit will conduct periodic audits of the declaration of interests and gifts & hospitality system, and report to the Audit Committee.

In addition, monitoring will be undertaken as follows:

Area	Frequency
Monitoring of gifts and hospitality monthly	Quarterly
Monitoring of DOI compliance	Monthly
Reporting compliance via Executives	
Audit committee reporting – copies of registers and DOI compliance quarterly	Bi-annually

24. Distribution

The Policy will be available via the Health Board's Intranet site. Where employees do not have access to the Intranet their line manager must ensure that they have access to a copy of this document and are able to complete the necessary electronic declarations where appropriate.

25. References

- Health Board Standing Orders
- Bribery Act 2010
- Commercial Sponsorship - Ethical Standards for the NHS, Department of Health
- Code of Conduct and Accountability, Welsh Assembly Government, 2003
- DGM (93)84: Standards of Business Conduct for NHS Staff
- DGM(95)5: Detailed Guidance on Implementing a Code of Conduct and Accountability Finance Guidance Note F35: Guidance on Standards of Conduct for LHB Staff
- General Medical Council Good Medical Practice guidance – financial and commercial arrangements and conflicts of interest, 2013
- NHS Code of Conduct for Boards – Welsh Government Governance e-manual
- Nursing & Midwifery Council gifts and gratuities guidance, September 2013 and The Code: Standards of conduct, performance & ethics for nurses & midwives
- WHC (2005) 016 The NHS & Sponsorship by the Pharmaceutical Industry
- Association of British Pharmaceutical Industry (ABPI) Code of Practice for the Pharmaceutical Industry 2016
- WHC(2006) 090 The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006
- WP6 BCU Code of Conduct (Disciplinary Rules & Standards of Behaviour)

Appendix 1 – Personal Checklist for Declarations of Interests, Gifts & Hospitality

1. Make sure you understand the requirements contained within the Policy. The onus of responsibility for declaring interests, gifts & hospitality is on the employee.
2. Make sure you are not in a position where your private interests and NHS duties may conflict.
3. Declare to your employer any relevant outside interests. If in doubt ask yourself:-
 - a. Could my personal interests be detrimental to the Health Board or to patients' interests in any way?
 - b. Do I have access to information which could influence purchasing decisions made by the Health Board?
 - c. Am I or could I be in a position where I (or my family/friend) could gain from the connection between my private interests and my employment?
 - d. Do I have any other reason to think I may be risking a conflict of interest?

If you remain unsure, discuss it with your manager or the Board Secretary.

4. Mandatory annual declarations of interests: These are required from Bard members, all senior employees (band 8c or equivalent and above), all Consultants and also other employees of any pay band deemed to have 'LHB Officer' status due to undertaking roles where there is potential for a conflict of interest (as determined by a Director). Annual declarations must be submitted even if a nil return (nothing to declare). Additionally posts within some departments at Band 7 and above will be required to submit an annual declaration of interest where it is considered that they may be in a position to influence purchasing and/or foster relationships with external organisations.
5. Always obtain your employer's permission before accepting any commercial sponsorship, gifts or hospitality. Permission needs to be granted as Director/Assistant Director Level.
6. Seek permission from your line manager or seek advice from the Board Secretary before accepting outside work, particularly if there is a possibility of it adversely affecting your NHS duties.

7. If your work is in any way involved with buying goods or services you must adhere to the ethical code of the Chartered Institute of Purchasing and Supply. Contact the
8. Head of Procurement if you require further details. You must not:
 - a. Accept gifts, inducements or inappropriate hospitality unless of low or intrinsic estimated value (£25 or less).
 - b. Use your past or present official position to obtain preferential rates for private deals.
 - c. Show favouritism in awarding contracts or making grants, or in any other dealings with suppliers or potential suppliers.
 - d. Make available or misuse "commercial in confidence" information.

Employees failing to comply with the guidelines could be subject to disciplinary action under the Health Board's Disciplinary Policy and potential legal action.



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Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A (Screening – Forms 1-4) and
B (Key Findings and Actions – Form 5)

<u>For:</u>	OBS02: STANDARDS OF BUSINESS CONDUCT POLICY
<u>Date form completed:</u>	07/03/2022



KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "...all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A

Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Standards of Business Conduct Policy (OBS02)
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The purpose of the policy is to set out the organisation's expectations in relation to the standards of conduct expected of all employees in their role. The policy builds upon the provisions included in Heath Board's Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations are made.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Responsibility for the development and review of the policy rests with Board Secretary and will be ratified by the Audit Committee.
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	<ul style="list-style-type: none"> • The Codes of Conduct and Accountability for NHS Boards & Code of Conduct for NHS Managers. • Standing Orders relating to declarations of interest and offers of gifts & hospitality. • WP6 –Code of Conduct (Disciplinary Rules and Standards of Behaviour Policy). • F03 Local Anti-Fraud, Bribery and Corruption Policy. • F14 Salary Overpayments & Underpayments Local Management Procedure. • MD14 - Private Practice Policy • Other codes of conduct, including those adopted by specific professional groups (GMC, NMC, HCPC etc.) • RD03 - Policy for Intellectual Property.

Part A

Form 1: Preparation

Please answer all questions

		<ul style="list-style-type: none"> • MM08, Code of Practice for BCUHB Staff with Pharmaceutical Companies (also providing guidance for General Practitioners and other Independent Health Contractors). • NHS Wales SSP Procurement Services – Suppliers Policy • Documentation relating to individual's appointment as employees (employment contract) or volunteers to the Health Board
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	<p>All BCUHB Employees, Contractors (including Interims), Agency Workers, Students and Volunteers.</p> <p>BCULHB Audit Committee</p> <p>BCULHB Counter Fraud Team</p> <p>BCULHB Board Members</p>
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	The effectiveness of the Standards of Business Conduct Policy will be dependent upon good communication, awareness and the co-operation of all individuals within the Health Board. In addition, robust operational management processes will need to be in place to ensure effective reporting and information flows.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The aim of this policy is to guide all employees in the work they do and the decisions and choices they have to make, and to reassure the public that these important decisions are being made against a background of professional standards and accountability. The content and directions within the policy is largely dictated by legislation (Bribery Act 2010), relevant national guidance and principles (Nolan Principles of Public Life). The policy has been developed in accordance with the above.

Part A

Form 1: Preparation

Please answer all questions

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Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)	Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?"	How will you reduce or remove any negative Impacts that you have identified?
<p><i>for further direction on how to complete this section please click here training vid p13-18</i></p> <p>Guidance for Completion</p> <p><i>In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered ‘Yes’, you need to indicate if the potential impact will be positive or negative. Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.</i></p> <p><i>The information that helps to inform the assessment should be listed in this column. Please provide evidence for all answers.</i></p> <p>Hint/tip: do not say: “not applicable”, “no impact” or “regardless of...”. If you have identified ‘no impact’ please explain clearly how you came to this decision.</p>			

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

<p>NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.</p> <p>For the definitions of each characteristic please click here</p>						
	Yes	No	(+ve)	(-ve)		
Age		*			<p>This policy will apply to all BCUHB Staff, Contractors, Agency Workers, Volunteers and Service Users.</p> <p>This demographic impacted is generally Adults. However, it is acknowledged that BCUHB do employ Apprentices and students (young adults). There may be instances whereby a referral is required in to the Counter Fraud Service and it is recognised that there may be additional considerations for investigations/interviews involving young people. This is addressed via the Counter Fraud Policy (the March 2022 revision includes a section for young adults / Appropriate Adult representation will be included as per the requirements of the Police and Criminal Evidence Act 1984 (PACE) Codes of Practice).</p>	<p>Whilst the assessment is that there is 'no impact', it is noted that the CF policy has been reviewed and specific provision has been made for investigations/interviews involving young people.</p>
Disability	*		*		<p>The policy will provide for the management of declarations of interest and gifts & hospitality. The process for recording such interests and declarations is via an electronic system. It is recognised that there may be those with an impairment</p>	<p>The March 2022 review of the policy will expand upon the 'Equality' section to specify that reasonable</p>

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

				<p>(for example, a visual impairment) who may find that they are unable to make the required electronic declaration without further assistance (such as a screen reader).</p> <p>Employees absent from work for a prolonged period, whether due to a disability or otherwise, are not expected to make a declaration and would not be penalised for failing to make such a declaration.</p>	<p>adjustments should be made wherein an employee requires additional support to make said electronic declaration.</p> <p>The policy will provide that the document is available in other formats on request.</p>
Gender Reassignment		*		<p>The assessment is that there is no negative impact on this group.</p>	<p>No negative impact identified.</p>
Pregnancy and maternity		*		<p>The assessment is that there is no negative impact on this group. Employees returning to work post maternity leave should receive a 'return to work' interview and induction to ensure they are familiar with any employment/contractual obligations, such as the requirement to make a declaration. This includes any policy development/revisions.</p> <p>Employees currently on maternity leave are not expected to make a declaration.</p>	<p>No negative impact identified.</p>

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Race		*			The assessment is that there is no negative impact on race or ethnicity. However, there may be language barriers where English/Welsh is not the individual's first language. There is insufficient data to indicate whether the document should be available in a language other than English/welsh as standard. This will need to be addressed on a case by case basis.	The policy will state that information is available in other languages subject to request.
Religion, belief and non-belief		*			The assessment is that there is no negative impact on this group.	Not applicable
Sex		*			The assessment is that there is no negative impact on this group.	Not Applicable
Sexual orientation		*			The assessment is that there is no negative impact on this group.	Not Applicable
Marriage and civil Partnership (Marital status)		*			The assessment is that there is no negative impact on this group.	Not Applicable
Socio Economic Disadvantage	*			*	The assessment is that there is no negative impact on this group. However, whilst receiving gifts and/or hospitality could be considered more beneficial to those with a lower household income or those experiencing financial difficulties, there can be no exceptions as to the requirement to uphold professional standards and	Not Applicable

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					compliance with applicable legislation. The policy will apply as standard to all pay grades, including volunteers.	
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Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: <http://howis.wales.nhs.uk/sitesplus/861/page/42166> and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker <https://humanrightstracker.com>.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2* *Right to life*
- *Article 3* *Prohibition of inhuman or degrading treatment*
- *Article 5* *Right to liberty and security*
- *Article 8* *Right to respect for family & private life*
- *Article 9* *Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

[UN Convention on the Rights of the Child](#)

[UN Convention on the rights of people with disabilities.](#)

[UN Convention on the Elimination of All Forms of Discrimination against Women](#)

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
	*			Right to respect for family & private life	In the interests of transparency and good governance, the Health Board will routinely publish Board members declarations on its website. This would include both direct and indirect interests (for example, any spousal interests). The Gifts & Hospitality register of all declarations will also be received at the Audit Committee as per its cycle of business. Any publications/reports will be in accordance with data protection (DP) requirements. For example, where an employee has made a declaration that includes a patient's or member of the public's identifiable information, this would be anonymised.	Not Applicable. Whilst it is recognised that there may be instances where private information is declared by an employee, the information will be managed/published in accordance with DP principles and the common law of confidentiality (access to the system database restricted to OBS SMT and data anonymised as appropriate prior to reporting and/or publication).

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	*		*		The policy will be sent for translation post final approval.	Not Applicable
Treating the Welsh language no less favourably than the English language		*			As per above.	Not Applicable

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

<p>What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p>Engagement and consultation undertaken with Internal audit, counter fraud, exec team and independent members</p>
<p>Have any themes emerged? Describe them here.</p>	<p>This policy has been extant for a number of years and no new themes have emerged. The key area remains that the requirements of the policy and the contractual obligations of all employees should be accessible and adequately communicated. This is addressed via operational management procedures within the OBS – regular comms, policy available on the intranet etc.</p>
<p>If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?</p>	<p>N/A</p>

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- <http://howis.wales.nhs.uk/sitesplus/861/page/44085>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) <i>for further direction on how to complete this section please click here training vid p13-18</i>	Standards of Business Conduct Policy
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2. Brief Aims and Objectives: (Copy from Form 1)	The purpose of the policy is to set out the organisation's expectations in relation to the standards of conduct expected of all employees in their role. The policy builds upon the provisions included in Heath Board's Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations are made.
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From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? Guidance: This is as indicated on form 2 and 3	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/> *
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/> *

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?</p> <p>High significance may mean:</p> <ul style="list-style-type: none"> - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. <p>GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
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Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p>5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?</p>	<p>Yes <input type="checkbox"/></p>	<p><input checked="" type="checkbox"/></p>
<p>6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>How is it being monitored?</p>	<p>OBS SMT Audit Committee</p>	
<p>Who is responsible?</p>	<p>Statutory Compliance, Governance & Policy Manager</p>	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	What information is being used?	System generated reports of number of declarations. Where any common themes arise, for example difficulties in using the system, these would be discussed at the OBS SMT.
	When will the EqIA be reviewed?	In line with the policy review cycle or sooner if required

7. Where will your policy or proposal be forwarded for approval?	Audit Committee
--	-----------------

8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity Senior sign off prior to committee approval:	Name	Title/Role
	Bethan Wassell	Statutory Compliance, Governance & Policy Manager
	Molly Marcu	Interim Board Secretary

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	Not Applicable		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	The March 2022 review of the policy will expand upon the 'Equality' section to specify that the Health Board is fully committed to ensuring that all employees are appraised of their obligations under the policy and that additional support and/or reasonable adjustments is available as required – for		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
	Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.		
	example, accessing the policy in a different format or support with completing an online declaration. This should be raised with a line manager in the first instance and escalated to the OBS as required.		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	No negative impact identified		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	As per above, expansion on the Equality section of the policy.	Interim Board Secretary / Statutory Compliance, Governance & Policy Manager	Prior to final approval (March 2022)



Cyfarfod a dyddiad: Meeting and date:	Audit Committee 15th March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Annual Internal Audit Plan 2022/23 Internal Audit Charter Internal Audit Progress Report 1 st December 2021 to 28 th February 2022						
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton – Board Secretary						
Awdur yr Adroddiad Report Author:	Dave Harries – Head of Internal Audit Nicola Jones – Deputy Head of Internal Audit						
Craffu blaenorol: Prior Scrutiny:	The annual plan and charter has been considered by the Board and Interim Deputy Board Secretary and subsequently presented to the Executive Team. The progress report has been considered and approved by the Board Secretary.						
Atodiadau Appendices:	Appendix 1: Annual Internal Audit Plan 2022/23 and Internal Audit Charter Appendix 2: Progress report Appendix 3: Limited assurance report: Standards of Business Conduct Appendix 4: Limited Assurance report: Integrated Service Boards Governance						
Argymhelliad / Recommendation:							
The Audit Committee is asked to:							
<ul style="list-style-type: none"> Approve the Annual Internal Audit Plan for 2022/23; and Receive the progress report. 							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	<input checked="" type="checkbox"/>	Ar gyfer Trafodaeth For Discussion	<input type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input checked="" type="checkbox"/>	Er gwybodaeth For Information	<input type="checkbox"/>
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 Internal Audit Plan is produced in accordance with the requirements as set out within the Public Sector Internal Audit Standards: Standard 2010 – Planning.							

The progress report is produced in accordance with the requirements as set out within the Public Sector internal Audit Standards: Standard 2060 – Reporting to Senior Management and the Board.
Cefndir / Background:
<p>The internal audit plan for 2022/23 details the risk based planned reviews for 2022/23 following review of Board and Committee papers; Board Assurance Framework; Corporate Risk Register; risk based meetings with Independent Members and Executive Directors; and reviews deferred from 2021/22.</p> <p>The progress report summarises six assurance reviews finalised since the last Committee meeting in December 2021, with the recorded assurance as follows:</p> <ul style="list-style-type: none"> • Substantial assurance (green) – none; • Reasonable assurance (yellow) – Two; • Limited assurance (amber) – Two; and • Assurance not applicable (grey) – Two. <p>The report also details:</p> <ul style="list-style-type: none"> • Reviews issued at draft reporting stage and work in progress; • Key Performance Indicator measures.
Asesu a Dadansoddi / Assessment & Analysis
Goblygiadau Strategol / Strategy Implications
The Internal Audit plan for 2021/22 was approved by the Audit Committee in March 2021.
Opsiynau a ystyriwyd / Options considered
N/A
Goblygiadau Ariannol / Financial Implications
The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.
Dadansoddiad Risk / 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.
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
<p>The audit plan for 2022/23 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan.</p> <p>The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – <i>Section 4.5 Reviewing internal audit assignment reports.</i></p>
Asesiad Effaith / Impact Assessment
<p>The Internal Audit report provides third line assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.</p> <p>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.</p>

Betsi Cadwaladr University Local Health Board

Audit Committee Internal Audit Progress Report

1st December 2021 to 28th February
2022

NWSSP Audit and Assurance Services

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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.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

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
<p>Targeted intervention</p> <p>Review completed December 2021 with Executive approval January 2022</p>	Reasonable	-	3	-	<p>The Chair's Assurance Report to the Board is brief and does not provide, in our view, sufficient narrative to ensure the delegated powers are being fulfilled, e.g. reporting of project/escalated risks from the Evidence Group, establishment of sub-groups. Attendance at Steering Group meetings requires renewed impetus as we noted two meetings that were not quorate [which is of concern, recognising this is a Board established Group].</p> <p>Governance arrangements for the project are as expected, however opportunities exist to ensure ToR and associated housekeeping arrangements are complied with at all times.</p> <p>Overall, the Health Board has progressed the requirements placed upon it by Welsh Government well, fully implementing five of the seven stipulated actions. It also formally reported that, due to time being a limiting factor, it was unable to fully engage with all relevant stakeholders in the design of the matrices.</p> <p>However, we identified one action that, in our opinion, requires urgent focus [that is also reflected in correspondence with</p>

Title	Assurance Level	High	Medium	Low	Key Messages
					<p>Welsh Government] relating to the production of the financial framework; as the Health Board is eight months into this project, it is of paramount importance to ensure there is a process to capture return on investment.</p> <p>Evidence was in place to support all, except one, attributes. Mental Health and CAMHS management must ensure evidence is submitted to support implementation.</p>
<p>Learning Lessons Review completed December 2021 with Executive approval February 2022</p>	Reasonable	1	1	-	<p>The review identified variation in the learning of lessons and how these are shared across the Health Board. Whilst there was evidence to demonstrate learning and completion of actions had been shared within local governance structures, it was not clear how the learning from specific incidents had been shared more widely across the Health Board. We understand a Lessons Learned library is under development, which will be a repository for reports and learning and will be available to all staff.</p> <p>Our sample test review noted that although local variations reflected on the standard and design of the documentation, in all cases an incident closure form was completed, or a complaint letter sent. Following investigation either no learning was identified and care provided was deemed appropriate, or the findings and actions have been captured and either reported through governance structures, or were due to be reported. For the sample we reviewed, actions had been completed or plans in place to implement the actions and dissemination of lessons learned.</p> <p>There is regular reporting on lessons learned to the Patient Safety and Quality</p>

Title	Assurance Level	High	Medium	Low	Key Messages
					Group via Divisional AAA reports. The Patient Safety Report provides themes and trend data, however there is a lack of clear reporting to the Committee on the outcomes or effectiveness of lessons learned, to provide assurance that learning is making a difference across the Health Board.
Standards of Business Conduct Review completed January 2022 with Executive approval March 2022	Limited	3	2	-	<p>Compliance with Declarations of Interest is generally low across the Health Board. As of 27th January 2022, compliance of DOIs for staff listed as band 8c and above was 29%. This is based on 297 staff, out of 990, who submitted DOIs.</p> <p>Data from the ESR system is used for the DOI system however this has not been updated regularly (August 2021 being the last update at the time of the review), resulting in new staff not included on the database which will affect the compliance figures.</p> <p>There was no evidence that the majority of gifts declared were in line with the requirements of the policy to donate the gifts to the Health Board's charity. There was also a lack of information provided on the hospitality declarations to determine whether these were approved in line with the policy. The level of declarations, for both gifts and hospitality, appear low in number when compared to the number of staff employed by the Health Board.</p> <p>There has also been a lack of oversight of compliance with declarations, with no regular reporting /escalation in place.</p>
Integrated Service Boards Governance	Limited	1	-	-	The role, remit, and responsibilities of each Integrated Service Board is outlined in respective Terms of Reference. However,

Title	Assurance Level	High	Medium	Low	Key Messages
Review completed January 2022 with Executive approval March 2022					<p>they are not consistent across all three areas.</p> <p>Whilst the Integrated Service Boards have established robust Terms of Reference and escalation mechanisms with the Regional Leadership Group and Regional Partnership Board, we were unable to confirm that the ISBs complied with the Health Board governance framework as we found no evidence of Health Board Executive level oversight or regular assurance reporting to Health Board Committee for scrutiny.</p> <p>Standing Orders, Standing Financial Instructions and Scheme of Delegation are all key documents in ensuring the achievement of good standards of governance. However, we are unable to confirm whether responsible officers are operating within their delegated authority in their participation at Integrated Service Boards as it is not clearly defined.</p>
Follow up - Progress against Healthcare Inspectorate Wales (HIW) recommendations : Mental Health and Learning Disabilities Review completed December 2021 with Executive approval January 2022	Not applicable	-	-	-	<p>We reviewed the evidence provided supporting the reported closure of each specific HIW recommendation covered by this review.</p> <p>Twenty-eight actions have evidence to confirm implementation.</p> <p>One action relating to record keeping arrangements remains outstanding (not implemented) and requires management attention.</p> <p>Five actions relating to Care and Treatment Plan audits, staff training, and recruitment are partially implemented, with further work required to complete these.</p>
Temporary Hospitals: Follow up of KPMG	Not applicable	-	-	-	We reviewed the evidence for the closure of each KPMG recommendation. The review identified that:

Title	Assurance Level	High	Medium	Low	Key Messages
<p>recommendations</p> <p>Review completed October 2021 with Executive approval November 2021</p>					<ul style="list-style-type: none"> • Three of the eight recommendations are considered as implemented in respect of the actions agreed by the Health Board with Welsh Government. • Five of the eight recommendations are considered to be partially implemented. In respect of one of these the agreed action is an audit (R3) which is currently in progress, whilst for the other four (Recs 1,2,7 & 8) progress has been made and is understood to be concluded in the near future.

Work in Progress Summary

3. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	<p>Overdue management response.</p> <p>Draft report issued for management response and Executive approval. Response was due 23rd February 2022. This has been escalated to the Board Secretary and the Interim Director of Regional Delivery is now taking this forward. We are advised there are a number of considerations that need to be taken into account and have agreed that a response can be provided by 11th March 2022 in order to update the Audit Committee.</p>	2 nd February 2022
HASCAS/Ockenden	Briefing paper issued for Executive approval. Response due 2 nd March 2022.	16 th February 2022
Decommission of Ysbyty Enfys Temporary Hospitals	Discussion draft issued for management comment. Draft report to be issued for management response and Executive approval on 1 st March 2022.	18 th February 2022 (discussion draft)

Review	Status	Date draft report issued
Employment of medical locum doctors	Discussion draft issued for management comment. Draft report to be issued for management response and Executive approval on 2 nd March 2022.	22 nd February 2022 (discussion draft)
Cluster working	Discussion draft issued for management comment. Draft report to be issued for management response and Executive approval on 8 th March 2022.	28 th February 2022 (discussion draft)

Fieldwork

4. The following reviews are currently in progress:

- Risk Management – fieldwork has commenced.
- Budgetary Control and Financial Reporting - fieldwork is underway and information to support testing has been provided.
- Clinical Audit – fieldwork is complete and report is being drafted.
- Business Continuity Plans – fieldwork is nearing completion.
- On-call arrangements – fieldwork is nearing completion.
- Waste Management – fieldwork is underway and information to support testing has been provided.
- Capital Funded Systems – fieldwork is underway and information to support testing has been provided.
- Voluntary Early Release Scheme – fieldwork has commenced.

Briefs have been issued and are awaiting Executive approval for the following reviews:

- Impact Assessments.
- Roster Management.

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 undertaken in this reporting period. A review of actions completed during 2021/22 will be undertaken in March / April 2022 with progress reported to the Audit Committee in June 2022.

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.

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. Within the plan for 2021/22 there is a review scheduled around major capital schemes funded by Welsh Government, through which the Health Board includes the cost for audit. We have been advised by our colleagues in the Specialist Services Unit of Audit & Assurance that no review will be undertaken on the North Denbighshire scheme this year, as no progress has been made with the Scheme.
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 50% to 43%. This is based on fourteen final reports. We forecast that should all remaining reviews be completed, in the timeline set by the Committee, the Health Board will only achieve 70% against this KPI. This is lower than expected despite the revised reporting arrangements. The status of the internal audit plan continues to be provided to the Executive Team on a monthly basis.

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	43%	80%	v>20%	10%<v<20%	v<10%

Indicator	Status	Actual	Target	Red	Amber	Green
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	Review in progress.	
Governance structure	Q4	Deferred.	-
Targeted Intervention	Q3	Final report issued.	Reasonable
Transformation of services	Q3/Q4	Deferred.	-
Impact Assessments	Q3	Brief awaiting Executive approval.	
Standards of Business Conduct: Declarations	Q2	Final report issued.	Limited
Integrated Service Boards (ISB)	Q2/Q3	Final report issued.	Limited
Budgetary Control & Financial Reporting, including COVID-19 financial governance	Q4	Review in progress.	
Procurement: Contract Management & Single Tender Waivers	Q1	Final report issued.	Reasonable
Value Based Healthcare	Q3	Deferred.	-
Learning Lessons	Q1/Q2	Final report issued.	Reasonable
HASCAS & Ockenden external reports – Recommendation progress and reporting (Recs 14 & 15)	Q1/Q4	Final briefing paper issued.	Assurance Not Applicable
HASCAS & Ockenden – Workforce	Q4	Draft briefing paper issued	Assurance Not Applicable
Clinical Audit	Q2/Q3	Review in progress.	
Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	Q1	Draft report issued.	Limited
Network and Information Systems Regulations 2018 (NIS Regulations)	Q4	Review in progress	
Digital Strategy	Q3	Deferred.	-

Planned output	Outline timing	Status	Assurance
Cluster working - Governance	Q2/Q3	Draft report issued.	Reasonable
Unscheduled Care	Q3	Deferred.	-
Business Continuity Plans	Q2/Q3	Review in progress.	
Secondary Care Division – Ysbyty Glan Clwyd	Q2	Final report issued.	Assurance Not Applicable
Maternity Cross-Border Arrangements	Q1/Q2	Final report issued.	Reasonable
Recruitment – Employment of medical locum doctors	Q3	Draft report issued.	Reasonable
Roster management	Q4	Brief awaiting Executive approval.	
Establishment Control – Leaver Management	Q1/Q2	Final report issued.	Limited
Upholding Professional Standards in Wales	Q1	Final report issued.	Reasonable
On-Call arrangements	Q3	Review in progress.	
Statutory Compliance: Asbestos Management	Q1	Final report issued.	Reasonable
Waste Management	Q3	Review in progress.	
Preparedness for Climate Change/ Decarbonisation	Q4	Deferred.	-
Capital Funded Systems	Q4	Review in progress.	
Integrated Audit and Assurance Plans	TBC	Deferred due to no major capital scheme progressing.	-
Carry over: Temporary Hospitals – Follow-up of KPMG recommendations	Q1/Q4	Final report issued.	Assurance Not Applicable
Carry over: Follow up of previous Healthcare Inspectorate Wales reports	Q1	Final report issued.	Assurance Not Applicable
Contingency: Security Invoice Review	Q1	Final report issued.	Assurance Not Applicable
Contingency: Decommissioning of Ysbyty Enfys temporary hospitals	Q3	Draft report issued.	Assurance Not Applicable
Voluntary Early Release Scheme	Q4	Review in progress.	

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

Annual Internal Audit Plan: Draft Internal Audit Charter March 2022

Betsi Cadwaladr University Health Board

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1. Introduction

This document sets out the Internal Audit Plan for 2022/23 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

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

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

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

Accordingly, this document sets out the risk-based approach and the Plan for 2022/23. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, WHSSC and EASC on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant Health Boards and Trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

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

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

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

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

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

We will ensure that the plan remains fit for purpose by recommending

changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

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

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

- 1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance and Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
- 2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
- 3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
- 4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.
- 5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), WHSSC and EASC.
- 6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

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

2.3 Link to the Health Board systems of assurance

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

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and the Quality, Safety and Experience Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board Executives and Independent members to discuss current areas of risk and related assurance needs. Meetings have been held, and planning information shared, with the Health Board's Executive team, the Chair of the Audit Committee and the Chair of the Board.

The draft Plan has been provided to the Health Board's Executive Management team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and Corporate Risk Register.

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2022/23

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

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

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

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

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

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

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

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance

to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the ongoing impact of and recovery from the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

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

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

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

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

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital & Estates work delivered as a part of the agreed plan. The work to be included for 2022/23 is still being agreed but it will result in an additional charge. This will be reported to the Audit Committee for agreement when the plan is presented as final.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2022/23 and:

- approve the Internal Audit Plan for 2022/23;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Dave Harries CMIIA QiCA

Head of Internal Audit – Betsi Cadwaladr University Local Health Board
Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2022/2023

Planned output / Ref number	BAF/ CRR	Outline Scope	Executive/ Director Lead	Outline timing
Speak out Safely (BCU-2223-01)	BAF21-11	Following the launch of Speak Out Safely (SOS) in April 2021, we will review its use by staff to raise concerns and the process operating once a concern is raised. Building on the implementation of SOS, we will take the opportunity to review the Health Board's compliance with the Public Interest Disclosure Act (1998).	Director of Workforce & OD	Q1
Board Assurance Framework (BAF) (BCU-2223-02)		We will review the compilation and reporting of the BAF for completeness in line with evaluating against HM Treasury – Assurance Frameworks (2012) and Good Governance Institute: Building a Framework for Board/Governing Body Assurance (2014).	Board Secretary	Q3
Risk Management (BCU-2223-03)		We will review the continued implementation of the Risk Management Strategy across the Health Board.	Medical Director	Q4
Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website (BCU-2223-04)		I sicrhau bod dogfennau ar y we yn cydymffurfio â'r Safonau/To ensure documents on the Health Board Website comply with the Standards.	Director of Public Health / Director of Partnership, Engagement and Communications	Q1
Effective Governance: Ysbyty Gwynedd and Ysbyty Wrexham Maelor		We will undertake a benchmark governance review at both sites to ensure governance in situ, pre organisational change, is effective.	Deputy Chief Executive & Director of Integrated Clinical Delivery	Q1

Planned output / Ref number	BAF/ CRR	Outline Scope	Executive/ Director Lead	Outline timing
(BCU-2223-05)				
Effective Governance: Committee and Executive Management Group arrangements		We will review the implementation and operation of the revised Committee arrangements and ensure the Executive Management Groups are compliant with their Terms of Reference.	Board Secretary & Lead Director	Q2
(BCU-2223-06)				
Effective Governance: Operating Model including accountability arrangements and Delegated Limits		We will review the implementation and effectiveness of the revised governance structure across the Health Board.	Deputy Chief Executive & Director of Integrated Clinical Delivery	Q4
(BCU-2223-07)				
Targeted Intervention – Strategic Support funding		We will review the documented plan on the use of the strategic funding from Welsh Government and identify the benefits and outcomes from this investment, including evidence reported to the Health Board.	Deputy Chief Executive & Director of Integrated Clinical Delivery	Q4
(BCU-2223-08)				
Transformation of services (Deferred from 2021/22)		We will review improvement groups and the Programme Management Office (PMO) as well as the overarching transformation of services and seek to answer "Are there effective programme, project and improvement arrangements to support transformation?".	Director Transformation and Planning	Q2
(BCU-2223-09)				
Board and Committee reporting – Adequacy and quality of papers		We will review the process for the request of and submission of papers for Committees, including the timelines for preparation, Executive approval and whether the	Board Secretary	Q1

Planned output / Ref number	BAF/ CRR	Outline Scope	Executive/ Director Lead	Outline timing
to support decision making (BCU-2223-10)		Standing Orders were met for the publication of Papers. We will also review the process for the completion of business cases through to submission for Board/Committee approval.		
Chair's Action (BCU-2223-11)		We will review the submission of Chairs Action in accordance with Standing Orders. We will also seek to benchmark the volume and value with other NHS Wales organisations.	Board Secretary	Q1
Voluntary Early release Scheme (VERS) (BCU-2223-12)		We will review the submission and approval for applications submitted through to Health Board and Welsh Government approval (where relevant).	Director of Workforce & OD	Q1
Financial Management, Reporting and Budgetary Control (BCU-2223-13)		To review key financial controls and compliance in accordance with Finance policies/procedures.	Director of Finance	Q4
Charitable Funds (BCU-2223-14)		We will review the controls in place across the Health Board in accordance with Charity Commission guidance including <i>CC8 – Internal financial controls for charities and Charity governance, finance and resilience: 15 questions trustees should ask.</i>	Director of Finance / Director of Partnership, Engagement and Communications	Q1
Delivery of Health Board savings (BCU-2223-15)		We will review the planned savings, profiling of savings and progress made coupled with following the movement of the saving from the budget.	Director of Finance	Q3
Management of utilities		Following the increase in utility costs we will document the process adopted for the management and approval of utility expenditure. Using	Director of Finance	Q1

Planned output / Ref number	BAF/ CRR	Outline Scope	Executive/ Director Lead	Outline timing
(BCU-2223-16)		Estates and Facilities Performance Management System (EFPMS) data, we will interrogate the Health Board consumption using data analytics and benchmark the Health Board with other NHS Wales organisations.		
Mental Health & Learning Disabilities Division (BCU-2223-17)	BAF21-05:08	We will undertake a wide-ranging review of the Division, including but not limited to: Culture Learning lessons Compliance with policies	Director of Public Health	Q3
Value Based Healthcare (Deferred from 2021/22) (BCU-2223-18)	BAF21-15	We will review what steps the Health Board has taken in progressing Value Based Healthcare.	Director of Transformation, Strategic Planning and Commissioning	Q3
Contracted patient activity – Quality & Safety arrangements (BCU-2223-19)		For contracted activity, we will review the process and assurance in situ concerning quality and safety.	Director of Therapies & Health Sciences	Q4
Data analysis – Concerns/ Complaints/ Incidents/ Never Events/ HIW reports/ Risk register/ Medication errors/ Regulation 28s (BCU-2223-20)		The Health Board is data rich and we will undertake a review of key sources of data to triangulate information from which we will report possible areas of risk which are not currently subject to independent or operational scrutiny.	Director of Nursing & Midwifery Services	Q2
Follow-up - Audit Wales: Continuing Healthcare Arrangements		We will follow-up implementation of the eight agreed recommendations in the Audit Wales report: <i>Continuing Healthcare</i>	Director Transformation and Planning & Director of Public Health	Q3

Planned output / Ref number	BAF/CRR	Outline Scope	Executive/ Director Lead	Outline timing
report issued in November 2020 (BCU-2223-21)		<i>Arrangements – Betsi Cadwaladr University Health Board</i> , published November 2020.		
Digital Strategy (<i>Deferred from 2021/22</i>) (BCU-2223-22)	BAF20-18	We will review progress against the timelines set out in the plan to understand if the Health Board is achieving its expected goals and whether the Digital Strategy is aligned and supports the delivery of corporate plans.	Chief Digital Information Officer	Q2
Welsh IG Toolkit for Health Boards and Trusts (BCU-2223-23)	CRR20-06	We will review the completion and evidence underpinning the 2021/22 submission of the toolkit.	Chief Digital Information Officer	Q2
Recruitment Improvement Review – Pre-Employment verification and appointment process (BCU-2223-24)	BAF21-18	We will review the implementation of the Recruitment Improvement Review that will include end to end sampling (incorporating pre-employment checks and internal Health Board staff appointment checks).	Director of Workforce & OD	Q3
People & OD Strategy: Operational delivery architecture (BCU-2223-25)	BAF21-18	Working with colleagues in Workforce & OD, we will review the delivery architecture adopted by Health Communities, Regionally Managed Services and Service Support Functions.	Director of Workforce & OD	Q3
Performance management and accountability arrangements (BCU-2223-26)		We will review the process in place to ensure the delivery of expected performance is adequately scrutinised and evidence of improvement steps taken, where required.	Director of Finance	Q3
Unscheduled care: Urgent Primary Care	BAF21-01	We will review whether the reported benefits, approved by the Board, have been	Deputy Chief Executive & Director of	Q2

Planned output / Ref number	BAF/ CRR	Outline Scope	Executive/ Director Lead	Outline timing
Centres – Business Case outcomes achieved (BCU-2223-27)		realised and that the Centres are delivering a return on investment made. We will also review how patients access the service.	Integrated Clinical Delivery	
Public Health – Smoke Free sites (BCU-2223-28)	BAF21-02	We will review Policy and procedure in place to ensure the Health Board complies with the requirements laid out in Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 that came into force on 1 March 2021.	Director of Public Health	Q4
Unscheduled care: GP Out of Hours (BCU-2223-29)	BAF21-04	We will review access to the service across the Health Board coupled with scrutinising available data to ensure delivery is in accordance with relevant performance measures/standards.	Deputy Chief Executive & Director of Integrated Clinical Delivery	Q2
Follow-up of Audit Wales report: Effectiveness of Counter-Fraud Arrangements – Betsi Cadwaladr University Health Board (BCU-2223-30)		We will review progress made by the Health Board towards implementing the <i>Effectiveness of Counter-Fraud Arrangements – Betsi Cadwaladr University Health Board</i> published by Audit Wales in September 2020.	Director of Finance	Q2
Planned Care delivery		We will review progress made in developing the business case for the Regional Treatment Centres and steps taken to address the backlog across a small number of specialties. We will review, where applicable, the delivery of plans and underpinning	Deputy Chief Executive & Director of Integrated Clinical Delivery	Q2

Planned output / Ref number	BAF/ CRR	Outline Scope	Executive/ Director Lead	Outline timing
(BCU-2223-31)		evidence and triangulate to Board/Committee reports.		
Statutory Compliance: Fire Safety (BCU-2223-32)	CRR20-04	We will review the Health Board's compliance with the Welsh Health Technical Memorandum (WHTM) 05-01: Firecode - Managing healthcare fire safety, including Chapter 12 Reporting and Audit; WHTM 05-02: Firecode - Fire safety in the design of healthcare premises, ensuring Fire Officers are consulted and have input.	Director of Finance	Q4
Preparedness for Climate Change/ Decarbonisation (BCU-2223-33)		To determine the adequacy of management arrangements to ensure compliance with the Welsh Government decarbonisation strategy.	Director of Finance	Q4

Please note: Capital audits agreed with our specialist Capital & Estates Team and the national audits undertaken at DHCW, NWSSP, WHSSC and EASC will be added later.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2022/23
Audit plan 2022/23 agreed/in draft by 30 April	R	100%
Audit opinion 2021/22 delivered by 31 May	R	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	R	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	R	80%
Report turnaround management response to draft report [20 working days minimum]	R	80%
Report turnaround draft response to final reporting [10 days]	R	80%

Appendix C: Internal Audit Charter

1 Introduction

- 1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.
- 1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:
- Board means the Board of Betsi Cadwaladr University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
 - Senior Management means the Chief Executive as being the designated Accountable Officer for Betsi Cadwaladr University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.
- 1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

- 2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Betsi Cadwaladr University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.
- 2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.
- 2.3 The organisation's risk management, internal control and governance arrangements comprise:

-
- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
 - the appropriate assessment and management of risk, and the related system of assurance;
 - the arrangements to monitor performance and secure value for money in the use of resources;
 - the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
 - compliance with applicable laws and regulations; and
 - compliance with the behavioural and ethical standards set out for the organisation.

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

3 Independence and Objectivity

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

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

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

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- 3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.
 - 3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited
 - 3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.
 - 3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

- 4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.
- 4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.
- 4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.
- 4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.
- 4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

private meetings with the Head of Internal Audit.

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

5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.
- 5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.
- 5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.
- 5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.
- 5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the NHS Digital Health and Care Wales, Wales Shared Services Partnership, WHSSC and EASC.
- 5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- 5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

- 6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.
- 6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

- 7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:
 - reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
 - reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
 - reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
 - reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
 - reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
 - reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
 - monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

- ensuring effective co-ordination, as appropriate, with external auditors; and
 - reviewing the Annual Governance Statement prepared by senior management.
- 7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.
- 7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

- 8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

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

- 8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.
- 8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

assurance needs of the organisation will be met as required by the Standards and facilitate:

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

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

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

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

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

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

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

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

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
 - a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
 - b) Disclose any qualification to that opinion, together with the reasons for the qualification;
 - c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
 - d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
 - e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
 - f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;

- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Board Secretary 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Board Secretary and Chair of the Audit Committee.
- If non-compliance continues, the Board Secretary and the Chair of the Audit Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
 - Specific
 - Measurable
 - Achievable
 - Relevant / Realistic
 - Timely.

-
- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
 - The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.
- 9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision may be made for a follow-up review within the same financial year. Issue and clearance of follow-up reports shall be as for other assignments referred to above.
- 9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

- 10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.
- 10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.
- 10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

- 11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.
- 11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.
- 11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

- 12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.
- 12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.
- 12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

- 13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.
- 13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

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

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
February 2022



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Standards of Business Conduct Final Internal Audit Report

March 2022

Betsi Cadwaladr University Health Board



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
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University Health Board



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Executive sign-off:	Board Secretary
Distribution:	Interim Deputy Board Secretary
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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

Acknowledgement

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

To provide assurance to the Health Board that processes are in place to comply with Standing Orders (Order 8): Values and Standards of Behaviour.



Overview

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

- The current compliance rate for completion of Declarations of Interest (DOI) across the Health Board is 29% for Band 8c or above.
- The staff data uploaded to the system from ESR which captures the staff required to submit a DOI has not been updated regularly.
- Monitoring and reporting arrangements are not adequate to ensure reliability of the data and compliance with the Policy.

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

Report Classification

			Trend
Limited	More significant matters require attention.		 2018/19
	Moderate impact on residual risk exposure until resolved.		

Assurance summary¹

Assurance objectives	Assurance
1 Identify staff who are required to submit a declaration of interest	Reasonable
2 Identify compliance rates in respect of return of declarations of interest	Limited
3 Review the Gifts and Hospitality Register including a sample of support documents	Limited
4 Monitor and Review Reporting Arrangements	Limited

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	The Standards of Business Conduct Policy requires review and updating.	1	Operation	Medium
2	Staff data on the DOI system is not updated regularly.	2	Operation	High
3	Compliance rates for Declarations of Interest are low across the Health Board.	2	Operation	High
4	Gifts and Hospitality declarations do not provide sufficient information to demonstrate compliance with the policy.	3	Operation	Medium
5	Monitoring and reporting arrangements require review.	4	Design	High

1. Introduction

1.1 A review on Standards of Business Conduct has been completed in line with the 2021/22 Internal Audit Plan. This review has sought to provide the Health Board with assurance that processes are in place to comply with Standing Orders Section 8: Values and Standards of Behaviour. This section provides the over-arching framework and details requirements for Board Members and all Health Board officers to:

- Declare interests;
- How to deal with gifts and hospitality; and
- Registering gifts and hospitality.

The Health Board has a Standards of Business Conduct Policy that sets out the standards of conduct expected of all employees in their role. This incorporates guidance and requirements in respect of:

- other employment;
- disclosure of interests; and
- gifts and hospitality.

The Health Board operates an electronic system for registering Declarations of Interest and Gifts and Hospitality. This captures and records declarations, and is used for reporting to the Health Board

1.2 The risk considered in the review were:

- guidance for staff regarding declaration of interest, gifts and hospitality are not clear and easily available for staff resulting in a lack of submissions.
- all mandatory declarations of interest are not submitted and reviewed on an annual basis leading to inappropriate decisions being made.
- insufficient documentation supporting the declarations of gifts as well as hospitality resulting in a risk of bribery and corruption.

1.3 The overall objective was to review compliance with guidance as issued through the Office of the Board Secretary.

The scope of the review included the following:

- a review of the arrangements in place to identify those staff that are required to submit a declaration of interest (DOI) on an annual basis (Senior Staff/LHB Officers and other Staff undertaking roles where there is potential for conflict, as determined by Directors), including staff/structure changes;
- a review of the electronic register to identify compliance rates in respect of the return of DOIs for Senior staff / LHB Officers (as above);
- a review of the gifts and hospitality register, including a review of documentation available to support a sample of submissions; and
- monitoring and reporting arrangements.

2. Detailed Audit Findings

Objective 1: Identification of staff who are required to submit a declaration of interest.

- 2.1 The Standards of Business Conduct (SOBC) Policy, which is available via the Health Board intranet site, was published in 2015 and was due for review in August 2021. We are advised this is the extant policy. The policy states that *"All employees should declare, to the best of their knowledge, if they, or a close relative, or associate, have a controlling or financial interest in a business, which could impact on the activities of the Health Board"*.
- 2.2 The policy clearly states the process involved for declaring any gifts or hospitality received. It outlines the characteristics of what gifts and hospitality should be declared making it easy for the user to understand. The policy states that any declaration will be reviewed and monitored by the Office of the Board Secretary.
- 2.3 In addition, the policy also outlines the need for annual declarations for Board Members and Senior Employees (8c and above). It outlines that some Band 7-8b staff may be required to submit declarations of interest (DOI) but does not confirm what roles or departments this refers to, and how this will be monitored. A previous internal audit review on Standards of Business Conduct (2017-18) recommended that the Office of the Board Secretary consults with the Finance director to identify all areas/departments which can influence / entering contractual arrangements and consider broadening the mandatory requirement for annual declarations of interest below that of existing Band 8c range of posts. We are advised that these posts are decided by department heads / directors however there is lack of guidance for this within the policy.
- 2.4 The policy was easily available on the Health Boards intranet site by using either the search function or via the 'Working for us' tab. The webpage also allows users to easily access to declaration forms, which can be used to submit declarations, gifts and hospitality.
- 2.5 Staff are reminded of the policy via the Health Board bulletin, with the latest reminder being sent in September 2021. A reminder is also included in pay slips on a quarterly basis.

Conclusion:

- 2.6 There is a comprehensive policy in place, however this is overdue for review and requires further clarification relating to the roles that require a declaration of interest. In comparison to other Health Board policies, the Health Board SOBC policy is well structured and clear.

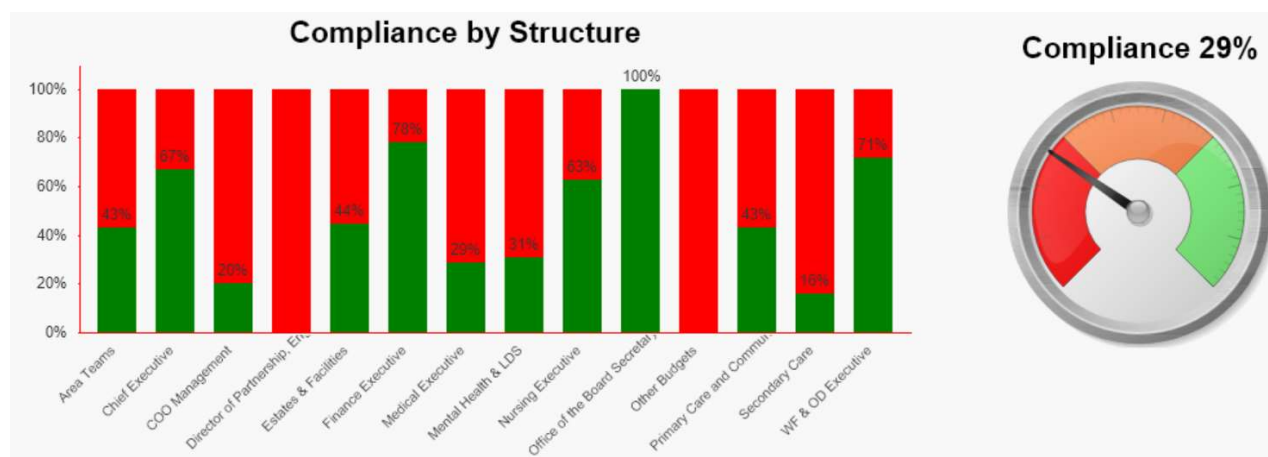
Objective 2: Review of electronic register to identify compliance rates in respect of Declarations of Interest for senior staff

- 2.7 The Standards of Business Conduct Policy, section 8.6 states *"Mandatory annual declarations of interests are required from Board members, all senior employees (band 8c or equivalent and above), all Consultants and also other employees of*

any pay band deemed to have 'LHB Officer' status due to undertaking roles where there is potential for a conflict of interest (as determined by a Director)."

- 2.8 There is an electronic DOI system in place, which allows staff to enter details of any declarations (including nil response), which is then updated on the system. The system uses Electronic Staff Record (ESR) data to list those staff required to have a DOI in place. These are identified using the grade (8c or above) or salary equivalent (i.e., pro-rata). This information can be viewed via a QlikView dashboard, which provides a summary of compliance and the details of staff who have submitted declarations, and those who have not yet submitted them.
- 2.9 A review of the data identified some recently recruited staff were not included in the lists. We are advised that the data was last downloaded from ESR in August 2021 and had not been updated due to an error on the system. We are advised that this has since been resolved with an update on 21 January 2022. A review of the information confirms that those staff we identified as missing are now included in the system.
- 2.10 We reviewed the DOI register to establish compliance rates across the Health Board. As of 27th January 2022, compliance of DOIs for staff listed as band 8c and above was 29%. This is based on 297 staff, out of 990, who submitted DOIs. Figure 1 below sets out compliance by structure and Table 1 sets out compliance by grade.

Figure 1: DOI compliance for bands 8c and above by structure (27th January 2022)



The following areas have below 50% compliance:

- Area Teams (43%)
- COO Management (20%)
- Director of Partnerships, Engagement and Communication (0%)
- Estates & Facilities (44%)
- Medical Executive (29%)
- Mental Health & Learning Disabilities (31%)
- Primary Care and Community (43%)

- Secondary Care (16%)

2.11 Table 1: Data on compliance for bands 8c and above by grade

Pay Grade	Total number of staff	Declarations Received	% Compliance
<i>Associate Specialist</i>	47	3	6%
<i>Band 8c</i>	142	78	54%
<i>Band 8d</i>	63	30	47%
<i>Band 9</i>	33	15	45%
<i>Consultant</i>	590	133	22%
<i>Dentist Scale A</i>	23	1	4%
<i>Dentist Scale B</i>	9	0	0%
<i>Dentist Scale C</i>	11	9	92%
<i>Other - Band 8c or above</i>	92	21	22%
<i>Specialty Dr</i>	150	3	2%
<i>Very Senior Manager / Director / Board</i>	17	8	47%

- 2.12 It should be noted that the system identifies between the number of declarations submitted and the number of staff who have submitted declarations. Compliance figures exclude where more than one declaration has been submitted by the same member of staff.
- 2.13 We reviewed the system to establish if DOIs had been completed for Board Members and Executives for 2021/22. On viewing the data in the system, we identified twelve individuals who had either not submitted declarations (ten) or who were not on the DOI system (two). We have since clarified with the Office of the Board Secretary that six of the individuals identified above have completed the declarations (three since the exceptions were identified), however where these were completed earlier in the year this is not reflected on the system.
- 2.14 Whilst compliance figures above are low it should be noted that the accuracy and reliability of the data cannot be assured as although declarations had been completed these were still showing on the system as 'declaration not received'. We are advised that the Office of the Board Secretary will be undertaking manual checks to ensure those declarations required at senior level are completed and an exception report will be run on a regular basis to identify any anomalies.

Table 2: Independent, Executive and Board Member Declarations

	Number of staff	Declarations completed	Declarations not completed
Board Members and Executives	11	9	2
Independent Members (including Associate Members)	10	6	4

- 2.15 We also compared the details of the DOIs submitted for Independent Members in 2019/20 to 2020/21 to confirm if there were any declarations that had not been declared for the latter. We did not identify any issues.

Conclusion:

- 2.16 Compliance with DOIs is generally low across the Health Board, resulting in non-compliance with Standing Orders. This requires action by the Health Board to address the low compliance and ensure declarations for the financial year (2022/23) are monitored regularly to ensure compliance from the start of the financial year.

Objective 3: Review of Gifts and Hospitality Register including a review of documentation available

- 2.17 The Standards of Business Conduct Policy states *"Employees are not permitted to accept any gift worth over £25. Where a gift is offered by e.g., patients or their relatives, with an estimated value over £25, it should be politely declined and declared via the electronic system"*.
- 2.18 We reviewed the Gifts register for 2021-22. At the time of testing there were 25 submissions. These are listed by area below:

Table 3: Register of Gifts submitted by Area

Area	Number of gifts declared
Area – West	8
Mental Health & LD	1
Area – Central	7
Corporate – Therapies & Health Sciences	1
Area – East	3
Board	1
Corporate – Medical Director	1
Corporate – WOD – HR & Performance	1
Secondary Care	1
Pharmacy West	1

We selected 13 for review, however only seven of these were valued above the £25 threshold; six were not required to be declared (however we recognise this demonstrates good practice having been declared).

Of the seven which were valued over £25, the reasons for accepting were as follows:

Table 4: Summary of reasons recorded for accepting the gift

Reason	Not to cause offence to offeree	Accepted on Behalf of the ward	As an educational grant	As a donation for Awyr Las
Number of Gifts	4	1	1	1

- 2.19 Section 7.2.2 of the Policy states *"In some cases a gift estimated to be worth over £25 may have been delivered in the employee's absence and may be difficult to return or it may be felt that the bearer may be offended by a refusal. Under such*

circumstances the gift can be accepted and, where possible, the bearer advised that it will be utilised for the benefit of the Awyr Las charity e.g., used as a prize in a raffle. A Gifts declaration form explaining the action taken must be completed."

Based on the seven gifts that were accepted, only one followed the policy requirements to donate to the Awyr Las charity. In respect of the four which were accepted to not cause offence there was no evidence of any recommendation for these gifts to be donated to the Charity.

2.20 We reviewed the Hospitality register for 2021-22. At the time of testing there were nine submissions in total, with seven of them over the threshold value of £25. All seven declarations which were over £25 were reviewed.

2.21 We reviewed the information submitted for each of the seven hospitality declarations and noted overall there was a lack of information provided in the submission. Of the seven sampled:

- Two out of the seven had been approved by the Deputy Board Secretary, with five recording status as 'submitted'.
- Three out of seven had the required director approval
- Two provided a date of when the hospitality occurred. These had / not been approved by the Director in advance of the acceptance of the hospitality.

The lack of dates meant we were unable to verify whether approval was given prior to the event taking place, which is a key requirement of the SOBC policy 7.6.1 *"These types of hospitality must be approved by a Director/Assistant Director and recorded on the gifts and hospitality register in advance of acceptance."*

Conclusion:

2.22 There was no evidence that the majority of gifts declared were in line with the requirements of the policy to donate the gifts to the Health Board's charity. There was also a lack of information provided on the hospitality declarations to determine whether these were approved in line with the policy. A number of these had also not been approved, although we recognise that this has been due to absence in the Office of the Board Secretary team.

The level of declarations, for both gifts and hospitality, appear low in number when compared to the number of staff employed by the Health Board.

Objective 4: Review the Monitoring and Reporting Arrangements

2.23 In order to comply with the standing orders, it would be expected that regular reviews would be carried out on DOIs as well as Hospitality register to ensure compliance with the policy.

2.24 We are advised that compliance is usually monitored by the Office of the Board Secretary on a quarterly basis, however due to sickness in the team there has not been capacity to undertake this. We are advised that this will be monitored monthly going forward to ensure increased compliance.

- 2.25 There are Governance Leads within the Health Board who have access to the DOI system for their individual divisions to allow local monitoring. The policy includes the following *"Declarations of interest are reviewed by the relevant Directorate Governance Lead, details of which are displayed on the declarations of interest intranet page. Governance Leads are responsible for escalating any concerns to the relevant line manager"*. The Office of the Board Secretary sends reminders to individuals that are significantly out of date, and emails confirming this have been provided.
- 2.26 The Audit Committee are provided with an annual report on Gifts, Hospitality and Declarations of Interest. The last report was provided in September 2021. The report details the declarations of directors / independent members (pertaining to the Related Party Disclosure for the Accounts) and provides a list of gifts and hospitality. It does not include any data on the overall compliance with DOI completion across the Health Board, and therefore no assurance on this area is given to members.

Conclusion:

- 2.27 We recognise that there has been a gap in monitoring the compliance with DOIs due to sickness within the team. The governance leads within all areas should be reviewing this information regularly to ensure that there is compliance with the policy within their areas / departments.

Monitoring and reporting arrangements require review to ensure that DOI, gift and hospitality information is reviewed regularly to ensure compliance with the Policy and Standing Orders. Reporting to the Audit Committee could also be enhanced to provide assurance that compliance is on track or areas where compliance is low are taking appropriate action.

Appendix A: Management Action Plan

Matter Arising 1: Standards of Business Conduct Policy (Operation)	Impact
<p>The Standards of Business Conduct Policy was published in 2015 and was due for review in August 2021. The requirements of the policy are generally clear and provide sufficient detail to staff on the process to submit declarations of interest, gifts and hospitality. We would suggest the following amendments be considered when the policy is being reviewed:</p> <p><u>Clarity on roles where a DOI is required</u> Currently the policy states <i>"Additionally posts within some departments at Band 7 to 8B which may be in a position to influence purchasing and foster relationships with external organisations are also required to complete an annual declaration."</i> Despite this there is not sufficient guidance on what types of roles may require a declaration and the process / responsibility for monitoring this.</p> <p><u>Governance Leads responsibilities</u> Whilst the policy states that Governance Leads review the declarations of interest and are responsible for escalating concerns, further detail could be provided in the policy outlining the expected monitoring (i.e., monthly) and the escalation route for non-compliance.</p> <p><u>Monitoring and reporting arrangements</u> Further information on reporting arrangements should be included, reflecting any agreed changes to the monitoring and reporting process (as recommended in finding 5 below).</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Staff are not clear on responsibilities for identifying posts below 8c that require a declaration. • Responsibilities for monitoring are not clear, resulting in lack of compliance with the policy.
Recommendations	Priority
<p>1.1 The Standards of Business Conduct policy is reviewed and updated where required, including further information:</p> <ul style="list-style-type: none"> • Those roles below band 8c that require a declaration of interest • Responsibilities of Governance Leads to ensure compliance within their areas 	<p>Medium</p>

- Monitoring and reporting arrangements

Agreed Management Action		Target Date	Responsible Officer
1.1	Agreed, the policy has been updated with a view to incorporating best practice identified from the All-Wales Standards of business conduct Policy as well as the requirement for all staff to submit a declaration of interest annually.	31/05/2022	Interim Board Secretary

Matter Arising 2: Declarations of Interest system (Operation)		Impact
<p>The declarations of interest system uses data extracted from the Electronic Staff Record (ESR) system to capture all Health Board Staff. This data can then be filtered to review those staff who require DOIs and then provides data on whether a declaration has been received or not (and includes a link to the declaration).</p> <p>This data has not been updated regularly, which has meant that staff lists have not been up to date. We are unable to confirm that all staff meeting the criteria have submitted the required declaration.</p> <p>We also identified some staff where a declaration has been received but the system still records them as 'Declaration not received'. This was identified when reviewing a small sample of staff, which suggests that there may be further issues with the data reported.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Out of date information is used to review compliance with DOI submission Inaccurate records of DOIs will impact on the compliance rate
Recommendations		Priority
<p>2.1 The Office of the Board Secretary should seek confirmation from Finance that this information has been updated on a regular basis, to ensure compliance can be accurately monitored.</p> <p>2.2 Exception reporting should be produced and reviewed regularly to highlight any issues with the data and the impact on compliance rates.</p>		High
Agreed Management Action	Target Date	Responsible Officer

<p>2.1 Agreed, however a new system is being put in place with effect from April 2022, which will be managed directly by the Office of the Board Secretary, and monthly updates from ESR will be incorporated onto the MES Declare system to ensure its accuracy and completeness.</p>	31/05/2022	Interim Board Secretary
<p>2.2 Exception reports will be generated on a monthly basis on the new system, and automated alerts instigated on overdue submissions of staff with declarations over 6 weeks late.</p>	30/06/2022	Interim Board Secretary

Matter Arising 3: Declarations of Interest Compliance (Operation)	Impact
<p>The compliance rates for Declarations of Interest are currently 29% across the Health Board, noting finding 2 above, this may not be accurate.</p> <p>We reviewed the system to establish if DOIs had been completed for Board Members and Executives. On viewing the data in the system, we identified twelve individuals who had either not submitted declarations (ten) or who were not on the DOI system (two). We are therefore unable to confirm whether twelve out of the 21 Board Members / Executives / Independent members have submitted a declaration of interest for 2021/22.</p> <p>There are Governance Leads within areas who are responsible for this (as stated in the Standards of Business Conduct Policy, section 8.1 . <i>"Declarations of interest are reviewed by the relevant Directorate Governance Lead, details of which are displayed on the declarations of interest intranet page. Governance Leads are responsible for escalating any concerns to the relevant line manager"</i>. As the compliance rates across the Health Board are low, it is implied that there is a lack of overall monitoring at local level.</p> <p>The Office of the Board Secretary do not currently provide any data or confirm compliance with Governance leads. Whilst it is the Governance Leads responsibility to monitor this information, the Office of the Board Secretary should confirm this is being undertaken regularly to ensure greater compliance for the next financial year (2022/23). We are advised that going forward information on declaration of interest compliance will be reviewed by the Executive Directors Group and consideration is being given to automatic reminders to staff who have not yet completed one.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> Non-compliance with the Standards of Business Conduct Policy and Health Board Standing Orders
Recommendations	Priority
<p>3.1 Governance leads to be reminded of their responsibility to review DOIs regularly and escalate non-compliance where required.</p> <p>3.2 The Office of the Board Secretary to progress the options for reminding staff of declarations due via automatic emails.</p>	High

Agreed Management Action	Target Date	Responsible Officer
3.1 Governance Leads will be issued monthly reports highlighting their teams' compliance with DOI submissions, which will form part of their monthly governance meetings, and escalated to the appropriate Execs Delivery Group on a bi-monthly basis.	30/04/2022	Interim Board Secretary
3.1 An automated approach to DOI management is being pursued via the MES Declare system, with the aim of ensuring that this is in place from the 1 st of April 2022. This will also be supported by a communications plan and a refreshed FAQ page	30/04/2022	Interim Board Secretary
3.2 As part of the planned communications plan, staff will be reminded of their obligations to disclose gifts and hospitality offered and received (onto the MES Declare system) under the Standards of Business Conduct Policy. This will also feed into the assurance monitoring by governance leads, which will include pursuing unauthorised declarations and escalate non-compliance of staff for known Gifts and Hospitality received, but which they have not declared.	30/06/2022	Interim Board Secretary

Matter Arising 4: Gifts and Hospitality requirements (Operation)		Impact
<p>When reviewing the Gifts and Hospitality registers, it was clear to see that there was a lack of declarations meeting the requirements set out by the Standards of Business Conduct.</p> <p>The majority of the gifts declared were not donated to the Health Board charity, as per the policy.</p> <p>The declarations of hospitality did not include sufficient detail to determine whether the policy was followed. There has also not been regular review of hospitality submissions to ensure the policy has been adhered to.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Gifts and Hospitality being incorrectly accepted
Recommendations		Priority
<p>4.1 The guidance regarding the process of accepting / declaring gifts as well as Hospitality should be circulated / highlighted to staff on a regular basis, ensuring all staff are made aware of the policy as well as what they should do when accepting either gifts or hospitality. Those who oversee governance for gifts and hospitality should be encouraged to remind Directors / Assistant Directors of their role in approving hospitality prior to acceptance.</p>		Medium
Agreed Management Action	Target Date	Responsible Officer

<p>4.1 Agreed, a communications plan will be put in place to publicise the importance of disclosure of gifts and hospitality as part of the process of raising awareness on the requirements of the Standards of business Conduct Policy.</p> <p>(Consideration is also being given in relation to making the process of accepting / declaring gifts as well as Hospitality and the submission of an annual declaration of interests (even a Zero return), to be recorded as part of employees' Annual appraisal process.</p> <p>The level of compliance can then be monitored from the systems where the Annual Assessment or PADR is recorded. The feasibility of this approach is being considered.)</p>	30/06/2022	Interim Board Secretary
---	------------	-------------------------






Matter Arising 5: Monitoring and reporting arrangements (Design)		Impact
<p>We are advised that there has not been regular monitoring and review of the declarations of interest, gifts and hospitality system due to absence within the Office of the Board Secretary Team.</p> <p>The Audit Committee are provided with an annual report on Gifts, Hospitality and Declarations of Interest. The last report was provided in September 2021. The report details the declarations of directors / independent members and provides a list of gifts and hospitality. It does not include any data on the overall compliance with DOI completion across the Health Board, and therefore no assurance on this area is given to members.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Lack of oversight of compliance with declarations, resulting in low compliance across the Health Board.
Recommendations		Priority
<p>5.1 The Office of the Board Secretary to consider the monitoring arrangements in place for declarations, gifts and hospitality to ensure these are reviewed on a regular basis.</p> <p>5.2 Reporting to the Audit Committee to be updated to include current compliance rates for DOIs. Consideration should be given to more regular reporting if compliance rates are generally low.</p>		High
Agreed Management Action	Target Date	Responsible Officer

<p>5.1 DOI monitoring will take place monthly with scope incorporating:</p> <ul style="list-style-type: none">• The completeness of the disclosures for decision makers• Quality assurance checks on submissions• Significantly out of date disclosures requiring escalation• Monthly update of ESR starters and leavers data• DOI disclosures requiring follow-up action• Gifts and hospitality declaration monitoring <p>Where appropriate, Governance Leads will also be assigned the same responsibilities for DOI reports to be monitored by the Office of the Board Secretary on a bi-monthly basis, with compliance rates to be reported to Audit Committee on a quarterly basis, by the Office of Board Secretary.</p> <p>The annual report on gifts and hospitality will be submitted to the Audit Committee in order to evidence compliance.</p>	31/05/2022	Interim Board Secretary
---	------------	-------------------------

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	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.

Prioritisation of Recommendations

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

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

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



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Integrated Service Boards Governance

Final Internal Audit Report

March 2022

Betsi Cadwaladr University Health Board



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GIG
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University Health Board



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Review reference:	BCU-2122-007
Report status:	Final
Fieldwork commencement:	11 th November 2021
Fieldwork completion:	7 th January 2022
Discussion Draft/Debrief meeting:	7 th January 2022
Draft report issued:	13 th January 2022
Management response received:	1 st March 2022
Final report issued:	2 nd March 2022
Auditors:	Principal Auditor, Deputy Head of Internal Audit, Head of Internal Audit
Executive sign-off:	Executive Director Transformation, Strategic Planning, and Commissioning
Distribution:	Area Directors Board Secretary Interim Deputy Board Secretary
Committee:	Audit Committee



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

Acknowledgement

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

Disclaimer notice - please note

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Executive Summary

Purpose

The purpose of this review was to establish the role, function, and governance arrangements for Integrated Service Boards (ISBs).

Overview

We have issued limited assurance on this area.

The matters requiring management attention include:

- ISB Terms of Reference were not consistent across Areas.
- No evidence of Health Board Executive level scrutiny or oversight of ISBs.
- Health Board Committees do not receive updates from ISBs.
- Delegated authority regarding ISB participation is not stated in Health Board Standing Order and Financial Instructions or Scheme of Delegation.

Other recommendations / advisory points are within the detail of the report.

Report Classification

Limited



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Trend

N/A

Assurance summary¹

Assurance objectives

Assurance

1	Role of Integrated Service Boards	Reasonable
2	Governance and reporting arrangements	Limited
3	ISB remit and delegated authority	Limited

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

Key Matters Arising

	Assurance Objective	Control Design or Operation	Recommendation Priority
ISB Governance Arrangements	1	Operation	High

1. Introduction

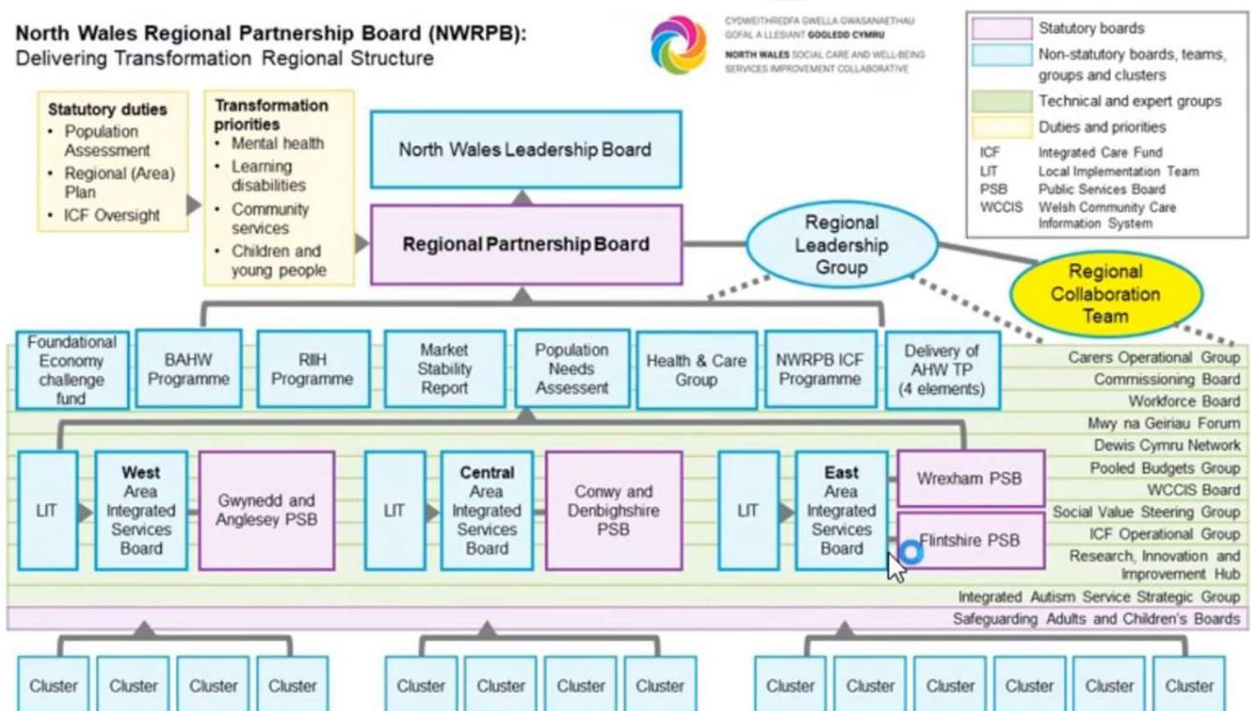
- 1.1 Good corporate governance is an integral part of any organisation and is particularly pertinent where organisations are working collaboratively together.
- 1.2 The Well-being of Future Generations (Wales) Act 2015 (the “Act”) set about establishing a legally binding common purpose for specified public bodies in Wales to improve the current and future social, economic, environmental, and cultural well-being of Wales.
- 1.3 The Act outlines seven well-being goals that all specified public bodies must work to achieve and emphasizes the need to work together and to consider sustainable development and the long-term implications of decisions made.
- 1.4 The overall objective of the review was to establish the robustness of governance arrangements in place within the Health Board supporting Integrated Service Boards and to determine adherence with relevant policies and legislation.
- 1.5 This review focuses on the Health Board’s governance arrangements over its participation to Integrated Service Boards and any assurance will apply to the Health Board only.
- 1.6 The agreed scope of review included the following areas:
 - Role of Integrated Service Boards.
 - Governance arrangements of Integrated Service Boards within the Health Board.
 - Policy and legislative compliance.
 - Compliance with Health Board Standing Orders and Financial Instructions.
 - Decision making and communication within the Health Board.
 - Reporting, management, and administration.
- 1.7 The following risks were identified at the outset of the review:
 - Lack of sound governance arrangements in place.
 - Failure to adhere to policy or legislative requirements.
 - Integrated Service Boards decisions and actions are not communicated to the Health Board.
 - Lack of transparency.
 - Health Board ISB members are operating outside their remit and/or Standing Financial Instructions.
 - Roles and responsibilities are not clearly defined.
 - Adverse financial implications.

2. Detailed Audit Findings

Objective 1: Role of Integrated Service Boards (ISBs)

- 2.1 The purpose of this review was to determine the role, function, and remit of the Integrated Service Boards (ISBs) that BCUHB are members of, and to establish how the ISBs governance arrangements align with that of the Health Board.
- 2.2 The following structure chart extract from the North Wales Regional Partnership Board Terms of Reference shows ISBs as non-statutory boards.

Regional Partnership Board structure chart



- 2.3 The Health Board are members of three separate Integrated Service Boards – West, Central, and East. Their placement on the chart alongside Public Service Boards (PSBs) led us to initially query whether they were functioning as sub-groups of the PSBs. This is pertinent as the remit, function, and limitations of PSB sub-groups are explicitly stated in SPSF3 – Statutory Guidance on the Wellbeing of Future Generations (Wales) Act 2015.
- 2.4 The BCUHB Area Directors confirmed that ISBs were not sub-groups of their respective PSBs, but rather a sub-group of the Health Board and Local Authority Leadership Group accountable to the Regional Partnership Board. Furthermore, they advised that the ISBs essentially function as non-statutory cross-organisation working groups and forum to meet with partner organisations to discuss prioritisation and strategy on issues within the remit of their Terms of Reference.
- 2.5 According to the Terms of Reference, the ISBs purpose is to provide strategic leadership to the development of the model of Health and Wellbeing Services

within their respective areas, working together with partner organisations to contribute to Welsh Governments "A Healthier Wales" strategy and to develop and oversee the delivery of integrated services.

2.6 The following table shows the main functions and specific responsibilities of each ISB by Area. The information was taken directly from each ISBs respective Terms of Reference:

West	Central	East
Deliver the developments and changes to the service commissioned by the Gwynedd and Anglesey Public Services Board in accordance with local plans to recover from the pandemic, giving particular attention to community resilience plans.	Strategic shaping of local priorities, services and service delivery models for the local population.	Determining the strategic response for meeting population health and social care need where a collaborative approach is required.
Consider and react to key operational and strategic challenges and the risks which could arise.	Allocation and redeployment of "resources" (in the broadest sense) and oversight and agreement of areas for pooled budgets.	Allocation and redeployment of resources in order to meet strategic and operational imperatives.
Govern any combined funds arrangements which could exist.	Agree the allocation and co-ordination of Grant monies relevant to the ISB.	Provide leadership for the transformation of Community Services, Children's services, Learning Development and Mental Health.
Monitor any frameworks or strategies which may be agreed regionally which would guide the area's direction.	Raising awareness of broader grants and the impact of these within the ISB organisations.	Agree the allocation and deployment of Grant monies requiring a partnership response / agreement.
Provide reports and give assurance of progress to the Regional Recovery Board and the Gwynedd and Anglesey Public Services Board.	To act as the Programme Board for ICF and Primary Care monies; assessing the effectiveness of delivery and evaluation reports.	To act as the Programme Board for ICF and Primary Care monies; assessing the effectiveness of delivery and evaluation reports.
Revisit the data gathered for the Population Needs Assessment. In addition, consider the latest priorities of the Well-being Plan. This will enhance the group's understanding of the existing needs of our communities and the effect of the pandemic.	To agree a joint performance dashboard for Health and Wellbeing within the Area and to receive regular performance and quality reports.	To act as the Programme Board for ICF, Transformation and Primary Care Funding as others as agreed, providing necessary responses into the Regional Partnership Board, Welsh Government and others as required.

Monitor the progress of service transformation programmes, giving attention to how they respond and align with the local recovery plans. The group will also consider the sustainability of transition programmes after March 2021.	Integrated workforce design, capacity, and development.	
Co-ordinate the responses and recovery plans of the partner organisations in order to avoid duplicating work and make the best use of our resources.	Area level delivery of the unscheduled care Agenda.	
Ensure that the process of assessing the effect on equality is used should changes be introduced to our services or policy.	Review of asset management /co-ordination and joint utilisation.	
	Integrated ICT Strategy.	
	Integrated engagement and communication strategy.	

Conclusion:

- 2.7 The role, remit, and responsibilities of each Integrated Service Board is outlined in respective Terms of Reference. However, they are not consistent across all three areas.

Objective 2: Governance and Reporting Arrangements

- 2.8 Each of the three area Integrated Service Boards are supported by comprehensive Terms of Reference. Terms of Reference are reviewed annually and include details of specific purpose and responsibilities, membership, accountability and reporting arrangements, frequency of meetings, and conditions for quorum.
- 2.9 We found that the ISB Terms of Reference were not consistent across the Areas. Whilst we recognise that a standardised Terms of Reference may not be appropriate, management may wish to consider this.
- 2.10 The West ISB Terms of Reference states that: *"The Group will be accountable to the Public Services Board in relation to delivering any specific work commissioned. The group will instruct the Public Services Board regarding any future direction in the health and care field."* From a lay perspective it could be difficult to distinguish from this whether the West ISB is functioning as a sub-group of the Anglesey and Gwynedd PSB. If it is intended as a sub-group of the PSB, the role and remit of the ISB must comply with the conditions

stated in SPSF3 – Statutory Guidance on the Wellbeing of Future Generations (Wales) Act 2015.

- 2.11 We reviewed a sample of minutes from each ISB and found many of the topics and issues discussed were consistent and recurring across areas. The focus of the meeting minutes reviewed were on updates regarding COVID, transformational schemes, ICF funding and exit strategy, and winter planning. We confirmed that matters arising in the three area Integrated Service Boards were escalated to the North Wales Regional Partnership Board via the Regional Leadership Group. However, we were unable to find any evidence that ISB minutes, discussions, or actions, were fed back to the Health Board Executive or Board Committees.
- 2.12 We reviewed all 2021/22 financial year (April 2021 to time of review-December 2021) minutes and papers for the bi-monthly Health Board Strategy, Partnership and Population Health Committee (SPPH) thereafter the Partnerships, People and Population Health Committee (PPPH) and found the following:
- An update from the Regional Partnership Board was presented in each of the five SPPH / PPPH Committees reviewed.
 - Area Integrated Service Boards were included in the 2021/22 SPPH Cycle of Business (presented April 2021) however no updates were recorded in subsequent meetings.
 - The *"Public Service Board – Conwy and Denbighshire and Area Integrated Service Board"* report outlining the role of the Central Area ISB was presented at the first (October 2021) PPPH Committee.
 - We found no evidence that ISB minutes or issues or significance had been submitted to either SPPH or PPPH Committees for scrutiny, or that the ISBs were held to account regarding delivery.
 - We noted that Integrated Service Boards had again been included in the draft PPPH Cycle of Business (October 2021).

Conclusion:

- 2.13 Whilst the Integrated Service Boards have established robust Terms of Reference and escalation mechanisms with the Regional Leadership Group and Regional Partnership Board, we were unable to confirm that the ISBs complied with the Health Board governance framework as we found no evidence of Health Board Executive level oversight or regular assurance reporting to Health Board Committee for scrutiny.

Objective 3: ISB Remit and Delegated Authority

- 2.14 We reviewed Health Board Standing Orders, Standing Financial Instructions and Scheme of Delegation and found no provision of delegated authority for Integrated Service Boards.
- 2.15 Further, we have been unable to identify or confirm that the Health Board has formally delegated responsibility for ISBs within its governance structure.

Conclusion:

- 2.16 Standing Orders, Standing Financial Instructions and Scheme of Delegation are all key documents in ensuring the achievement of good standards of governance. However, we are unable to confirm whether responsible officers are operating within their delegated authority in their participation at Integrated Service Boards as it is not clearly defined.

Appendix A: Management Action Plan

Matter Arising 1 – ISB Governance Arrangements (Operation)		Impact	
We reviewed Integrated Service Boards governance arrangements and noted the following limitations: <ul style="list-style-type: none">• ISB Terms of Reference were not consistent across Areas.• We found no evidence of Health Board Executive level scrutiny or oversight of ISBs to ensure the objectives and actions of the ISB aligned with Health Board objectives.• Health Board Committees do not receive updates from ISBs.• Delegated authority regarding ISB participation is not stated in Health Board Standing Order and Financial Instructions or Scheme of Delegation.		Lack of consistency and accountability. ISB objectives may conflict with Health Board objectives. Lack of oversight and scrutiny.	
Recommendation		Priority	
The Health Board ensures Integrated Service Board governance arrangements are aligned with its own governance and planning frameworks, and is subject to regular review and scrutiny.		High	
Agreed Management Action		Target date	Responsible Officer
This action will be addressed as part of the review of the key documents supporting the embedding of the new Operating Model. These documents are the Scheme of Reserved Delegation development, the Performance and Accountability Framework, as well as the risk management policy		30/06/2022	Board Secretary

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	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.

Prioritisation of Recommendations

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

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

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Cyfarfod a dyddiad: Meeting and date:	Audit Committee 15th March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	<ul style="list-style-type: none"> • Audit Wales programme update • Commissioning Older People's Care Home Placements • Quality Governance Arrangements 						
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary, on behalf of the executive team						
Awdur yr Adroddiad Report Author:	Andrew Doughton, Simon Monkhouse, Fflur Jones and Dave Thomas						
Craffu blaenorol: Prior Scrutiny:	All final Audit Wales reports on Betsi Cadwaladr University Health Board have passed through a clearance process with the lead Executive Director.						
Atodiadau Appendices:							
Argymhelliad / Recommendation:							
<p>The Audit Committee is requested to:</p> <ul style="list-style-type: none"> • Receive and discuss the local audit reports and audit committee update. 							
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:							
<p>The update provides an overview of progress of the external audit programme</p> <p>The performance audit reviews provide assurance and opinion on the effectiveness of arrangements in key areas as are described within the reports.</p>							
Asesiad / Assessment & Analysis							
Goblygiadau Strategol / Strategy Implications							
Opsiynau a ystyriwyd / Options considered							

Goblygiadau Ariannol / Financial Implications

The Care Home Commissioning review focusses on services that combined public sector expenditure totals some £170 million across the region. The report highlights challenges around the complex fee structures across sectors and that this can cause tension amongst partners. The report also highlights that the pooled fund arrangements do not provide value for money.

Dadansoddiad Risk / Risk Analysis

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Asesiad Effaith / Impact Assessment

.

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: March 2022

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 2022-23.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2021-22 Financial Statements.	<p>Audit Planning and Interim Testing work are now underway and will be continuing into April 2022, with the audit of the financial statements taking place in May/June 2022.</p> <p>Presentation of audit reports and audited accounts to Audit Committee scheduled for 13 June 2022.</p> <p>Submission of the audited Excel accounts pro-forma and associated returns to the Welsh Government by 15 June 2022.</p>
Opinion on Financial Statements	<p>It is anticipated that the opinion will be issued during mid-June 2022.</p>
Audit of the 2021-22 Funds Held on Trust Accounts	<p>The audit will take place during November 2022 and December 2022. Our audit report will be issued in December 2022.</p>

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.

Exhibit 2 – Work completed

Area of work	Audit Committee
Quality Governance	March 2022

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead Gill Harris	This review is examining the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges. Therefore, reporting has been moved to later in 2021.	Drafting report
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.	This review was replaced by work on Test, Track and Protect. The review is now recommencing. Data analysis currently being completed.

Exhibit 4 – Planned work not yet started

Topic	Focus of the work	Current status
<p>Follow-up outpatients</p> <p>Executive Lead Gill Harris</p>	<p>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.</p>	<p>Commencing March 2022</p>

Good Practice events and products

- 4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.
- 5 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available [here](#). Details of future events are available on the [GPX website](#).

NHS-related national studies and related products

- 6 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.
- 7 **Exhibit 5** provides information on the NHS-related or relevant national studies published in the last 12 months.

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

Title	Publication date
<u>Joint working between Emergency Services</u>	January 2022
<u>Care Home Commissioning for Older People</u>	December 2021
<u>Picture of Healthcare</u>	October 2021
<u>Taking care of the carers</u>	October 2021
<u>Rollout of the Covid-19 vaccination programme in Wales</u>	June 2021
<u>Cwm Taf Morgannwg Joint Review follow up</u>	May 2021



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Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

Review of Quality Governance Arrangements – Betsi Cadwaladr University Health Board

Audit year: 2019

Date issued: March 2022

Document reference: 2471A2021-22

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

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

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Summary report

About this report

- 1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.
- 2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.
- 3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.
- 4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.
- 5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. Our review did not include assessment of specific ongoing quality concerns or complaints. This report summarises the findings from our work at Betsi Cadwaladr University Health Board (the Health Board) carried out between May and August 2021. To test the 'floor to board' perspective, we examined the

arrangements for general surgical services, this included conducting a survey of operational staff working across general surgery. The survey findings are shown at **Appendix 2**.

- 6 As part of our audit approach, we have worked closely with Healthcare Inspectorate Wales (HIW) to ensure relevant information is shared and to prevent any duplication of activity. In accordance with COVID legislative requirements and guidance at the time of fieldwork, all audit work was undertaken remotely.

Key messages

- 7 Overall, we found that the **Health Board is taking steps to improve quality governance by redeveloping its Quality Improvement Strategy and plans, reviewing its governance processes and systems, and investing in and reorganising resources that support it. There is good Board and committee level scrutiny of quality information and reports. However, there are opportunities for improvement, such as ensuring the new quality priorities reflect quality and harm risks relating to current significant service pressures, establishing multidisciplinary mortality reviews, improving organisation-wide learning and addressing inconsistencies in resources for quality improvement activities.**
- 8 The Health Board is taking a proactive approach to refreshing its Quality Improvement Strategy and supporting quality framework and is seeking to manage quality risks operationally. It is investing in quality improvement and embedding its culture and behaviours through its Stronger Together programme. Corporate and operational quality and safety governance arrangements are being strengthened, for example through the Health Boards new integrated governance framework. The Health Board has adequate corporate and operational resources to support quality governance, which it is reorganising and strengthening to ensure consistency across the organisation and avoid silo working and duplication. The Board receives a good level of information to scrutinise harm from COVID-19 and the Health Board is taking steps to improve quality dashboards. The Quality, Safety and Experience Committee is well served with quality information, and this is resulting in a stronger focus on improvement.
- 9 However, there are opportunities for improvement. The Health Board's new Quality Improvement Strategy needs clear outcomes that can be monitored, and new quality priorities will need to reflect COVID-19 recovery plans. Whilst risk management arrangements are improving, we found variation in risk management resource and training at an operational level. We also found that the Health Board needs to better deploy its resources for quality improvement activities such as clinical audit and mortality reviews and ensure it demonstrates learning and impact from these activities. A relatively high proportion of Health Board staff responding to the NHS Wales staff survey said they had experienced bullying, harassment or abuse. Given less than half of the respondents felt the organisation takes effective action when it did occur, the Health Board needs better systems for managing,

addressing, and learning from these concerns. To reduce the risk of quality and safety issues being missed the Health Board needs to provide staff with guidance on using its new 'triple A' template, which highlights critical issues (Alert), summarises activity (Assurance) and outlines significant achievements (Achievements), especially setting out how much detail is expected and how to agree which issues should be escalated. Whilst the Health Board is taking steps to improve its quality and patient safety dashboards, further work is needed, and operational data analytics support needs to be reviewed. The measures in the integrated quality and performance report aligns with the NHS delivery framework, but there are no locally agreed quality measures or wider measures of performance such as for community services. The Health Board's also needs a stronger focus on outcomes, local measures, and the quality of wider of services that the Health Board delivers and commissions.

- 10 Noting the work which is already underway within the Health Board to strengthen quality governance arrangements, the improvement requirements highlighted in this report should be used to further focus that work, and to ensure that when concerns arise in specific areas, as they have within mental health and vascular services, the Health Board has the necessary arrangements to quickly identify and respond to them and to prevent similar issues occurring in future.

Recommendations

- 11 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations	
Quality and patient safety priorities	
R1	We found that the Health Board did not formally review its quality improvement priorities in light of the consequences of COVID-19. The Health Board should ensure its new Quality Improvement Strategy sets out how the Health Board will manage and mitigate the potential harms associated with the COVID-19 pandemic.

Recommendations

Risk management training

- R2 We found that not all operational staff are trained to record clinical and non-clinical risks and compile risk registers. The Health Board should ensure staff have adequate levels of risk management training so that they can confidently contribute to the risk identification and escalation process.
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Quality improvement support

- R3 The Health Board's Quality Improvement Hub (BCUQI) has developed a quality improvement database to allow staff to share, adopt and learn from existing quality improvement projects. However, we found that the database is not well used. The Health Board should promote and encourage routine use of the database by setting targets for participation, by keeping the level of engagement under regular review and by taking action if engagement is too low.
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Clinical Audit

- R4 The Health Board has restarted clinical audits after most activity was paused during the pandemic. The Health Board should look to use its programme of clinical audit work to focus on the risk of harm as a result of the pandemic. For example, to better understand the consequences of long waits or exacerbation of chronic conditions. The audits could be targeted at high-risk specialities.
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Mortality reviews

- R5 We found that mortality reviews are not reported to the QSE Committee in a timely manner. The Health Board should ensure the QSE committee receives a quarterly mortality review report, which highlights learning and what action has been taken.
- R6 We found that, generally, mortality reviews are medically led, but there is an appetite for multidisciplinary mortality reviews. The Health Board should look to establish a system where a multidisciplinary mix of staff are routinely involved in mortality reviews.

Recommendations

Sharing learning and good practice

- R7 The Health Board recognises that it does not yet have a process to systematically share learning across the organisation. The Health Board should use the new integrated governance framework and the Quality Improvement Hub (BCUQI) as tools to support organisational learning and sharing good practice across the organisation.
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Values and behaviours

- R8 Only 37.9% of Health Board staff responding to the NHS staff survey agreed or strongly agreed that the organisation takes effective action when bullying harassment or abuse occurred. The Health Board should review its systems for managing, addressing, and learning from the concerns of staff in relation to bullying, harassment, or abuse.
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Complaint handling

- R9 We found that operational teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis. The Health Board should review levels of complaints handling training across the organisation. If this shows shortfalls, the programme of training should be expanded.
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Flows of information and assurance

- R10 Less than half (42%) of respondents responding to our survey agreed or strongly agreed that they receive regular updates on patient feedback for their work area. Whilst patient feedback is shared with wards monthly, the Health Board needs to ensure all ward staff are aware of this feedback and that it is easily accessible to staff.
- R11 The Health Board introduced a new reporting format (triple A) to improve the flow of quality assurance. But we found some variation in the levels of detail provided in the reports. To reduce the risk of quality and safety issues being missed or not correctly escalated the Health Board should provide staff with guidance on using the new template, especially setting out how much detail is expected and how to agree which issues are escalated.

Recommendations

Quality and patient safety performance measures

- R12 We found that whilst the measures in the integrated performance report aligns with the NHS delivery framework, there are no locally agreed quality measures or wider measures such as for community services. Through the new Quality Improvement Strategy, the Health Board should review current quality measures with a view to developing measures that reflects the services it provides and commissions across primary, community and secondary care.

Detailed report

Organisational strategy for quality and patient safety

- 12 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.
- 13 We found that **the Health Board is building its strategic approach to quality improvement and is managing quality risks corporately and operationally. But there are opportunities for improvement such as ensuring the new Quality Improvement Strategy has measurable outcomes, reduces the occurrence of concerns and incidents and responds to the increased direct and indirect of harm as a result of the pandemic.**

Quality and patient safety priorities

- 14 **The Health Board is taking a proactive approach to refreshing its Quality Improvement Strategy and supporting quality framework. However, there are opportunities to ensure the new strategy has clear outcomes that can be monitored.**
- 15 In 2017, the Board agreed a three-year quality and improvement strategy, which ended in March 2020. The strategy remains extant whilst the Health Board develops a new strategy. It sets out five quality improvement priorities, these are to:
- **Reduce mortality** – reduce avoidable deaths.
 - **Reduce harm** – continuously seek out and reduce patient harm.
 - **Improve reliability of care** – achieve the highest level of reliability for clinical care.
 - **Deliver what matters most** – work in partnership with patients, carers, and families to meet all their needs and better their lives.
 - **Deliver integrated care** – deliver innovative and integrated care close to home which supports and improves health, wellbeing, and independent living.
- 16 Work on the new Quality Improvement Strategy was paused to allow staff to respond to the COVID-19 pandemic. It was restarted in April 2021 but there have been further delays. The Health Board is expecting to finalise the new strategy by summer 2022. Although the strategy has been delayed, the Health Board has continued to review and refine its quality assurance and governance processes. The Health Board is reviewing, developing, and aligning key plans and frameworks which will support the new Quality Improvement Strategy. The following plans will be ready for approval at the same time as the strategy:
- Patient Safety Plan
 - Patient and Carer Experience Plan
 - Clinical Effectiveness Plan

- Quality Assurance Framework

- 17 In March 2020, Internal Audit issued a limited assurance report on the 2017-20 Quality Improvement Strategy. It highlighted several issues such as a lack of an implementation plan, lack of regular progress reporting and no formal launch. The review made two high priority recommendations. These related to ensuring clear monitoring and reporting arrangements for the next Quality Improvement Strategy and ensuring the data on ward welcome/quality boards are kept up to date. The Health Board has looked to strengthen its approach in developing its new strategy. The strategy will be accompanied by an implementation plan, delivered through divisional annual quality plans and the Health Board's new integrated governance arrangements (see paragraph 67) will provide oversight of the strategy's implementation. The new strategy is being developed with good internal stakeholder engagement, including operational staff and involvement from the Quality Safety and Experience (QSE) Committee which is helping to shape priorities and outcomes. The Health Board's 2021-22 Annual Plan sets out a vision to deliver 'high quality services, which deliver safe, compassionate and effective care' but it does not detail quality improvement priorities. However, since the Annual Plan was approved by the Board in July 2021, the Health Board has developed interim quality priorities and associated actions for 2021-22, these were approved by the QSE Committee in November 2021.
- 18 At the height of the pandemic, the Health Board did not formally review its existing quality priorities to reflect challenges posed by COVID-19. But operationally the general surgery services and acute division strengthened existing priorities to focus on infection prevention and control, maintain urgent surgical care, clinical prioritisation, and service recovery. There are significant challenges and service pressures ahead. As a result, the quality improvement priorities in the new strategy will need to reflect the context of resetting and recovering services and the consequences of delayed access across primary, community and acute services (**Recommendation 1**). There are also a range of well-documented quality concerns in specific areas such as mental health and vascular services, as well as increasing concerns relating to urology services. The strategic quality priorities will need to ensure that these issues are learnt from to prevent similar issues occurring in future.
- 19 Operationally, the three acute divisions¹ and associated general surgery services have quality and safety priorities and plans to deliver them, but we found inconsistencies. The priorities for two of the three acute divisions (Ysbyty Gwynedd and Wrexham Maelor) do not align with those in the previous Quality Improvement Strategy. This is mirrored in the general surgery services. Generally, quality priorities for the acute divisions and general surgery services are reviewed annually, but we found inconsistent methods for identifying them. These ranged from adopting the corporate quality and safety priorities to reviewing national

¹ Ysbyty Glan Clwyd, Ysbyty Gwynedd and Wrexham Maelor Hospital.

standards and Welsh Government targets. Staff gave several reasons for the differences, which included unclear corporate priorities whilst the new strategy is developed and that services have some autonomy to set their own priorities. Whilst we accept the actions to deliver the priorities will be tailored to individual service areas, there should be a direct link to the corporately agreed priorities. The Health Board's intention to develop an overarching implementation plan for the new quality strategy with supporting divisional delivery plans should provide a mechanism to achieve this.

Risk management

- 20 **The Health Board is seeking to operationally manage quality risks and these link into divisional quality group meetings, but there are inconsistencies in the level of operational resources to support risk management and a need for further staff training.**
- 21 The Health Board is improving its risk management systems and in October 2020 launched its updated risk management strategy and policy. The policy appropriately covers both clinical and non-clinical risks and describes a low-risk appetite for patient and staff safety and quality and patient outcomes. The Health Board's Risk Management Group oversees risk management arrangements, specifically monitoring directorate level risks and the Corporate Risk Register (CRR) prior to scrutiny by the Audit Committee. The Health Board manages its risks through the Datix system, and the process is well documented in its risk management strategy. The new risk management process is still bedding in, we observed members of the QSE Committee seeking clarification on the format and management process for both the CRR and BAF.
- 22 In our 2020 Structured Assessment we reported that the Health Board introduced specific arrangements for managing COVID-19 risks supported by additional training for those leading command and control and workstreams. COVID-19 risks are now incorporated into and managed through the BAF and CRR.
- 23 Operationally, risks are reviewed by the secondary care management team, acute divisions and at a service level, for example at quality and patient safety meetings. We found that operational resources for risk management varies. For example, all acute divisions and most general surgery services have designated risk management leads (all except Ysbyty Gwynedd general surgery service). But only the leads at Ysbyty Gwynedd Acute Division and Wrexham Maelor General Surgery Service have protected time to fulfil their role. The risk management team's six members of staff provide support and training for operational staff although the team's capacity was reduced because of the need to respond to the pandemic. We also found inconsistencies in the levels of corporate support received and a need to ensure adequate support and training in risk management (**Recommendation 2**). Those we spoke to recognised and welcomed the improvements to risk management, but also felt further work was needed, this included further staff training in identifying risk.

Organisational culture and quality improvement

- 24 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.
- 25 We found that **the Health Board is investing in quality improvement and is seeking to embed a positive culture and behaviours through its Stronger Together programme. But the Health Board needs to deploy its resources more effectively and ensure it demonstrates learning and impact from its activities.**

Quality improvement

The Health Board is driving a good approach to strengthen quality improvement but needs to maximise the value from clinical audit and mortality reviews.

Resources to support quality improvement

- 26 The Health Board is reviewing its quality improvement resources as part of a wider programme of change. The Health Board realised that the existing system of having three quality improvement teams (Nursing Quality Improvement Team, Medical Quality Improvement Team and Service Improvement Team) was not working effectively or being used as intended, in addition the teams were collectively holding a high number of vacancies (14.8 WTE). As such, the Health Board is currently establishing a Transformation and Improvement Team. Led by the Director of Transformation and Change, this team will centralise quality improvement, service improvement and project management office functions. The new team will incorporate the previous quality improvement functions, ensuring resources are strategically targeted.
- 27 Improvement in Practice is the national quality improvement training programme for NHS staff in Wales, it replaced Improving Quality Together (IQT) in January 2020. The goal of the programme is to develop quality improvement capability within NHS Wales using a common language for quality improvement. The Health Board delivers this programme locally and training is run throughout the year. Clinical staff deliver the programme, but during the pandemic they have found it difficult to be released from their clinical duties, although the training is now delivered virtually. Considering the size of the organisation, very few Health Board staff have completed this training, in total, 124 staff have completed the silver Improving Quality Together training and to date, 147 staff have completed the Improvement in Practice training.

- 28 The Health Board's Quality Improvement Hub ([BCUQI](#)) is a network to support staff with quality improvement through access to training, information and resources. Staff can also support Health Board Quality Improvement by sharing good practice and learning. To support training, BCUQI has developed a quality improvement database. The database allows staff to share, adopt and learn from existing quality improvement projects. However, the Health Board reported that the database is not well used, this being a consequence of having different improvement teams across the organisation and no central overview (**Recommendation 3**). This does not mean the Health Board does not take part in quality improvement projects, for example it runs a successful ward accreditation scheme and matrons conduct regular audits to identify ward-based issues and learning.

Clinical Audit

- 29 Clinical audit is an important way of providing assurance about the quality and safety of services. The Executive Medical Director is the executive lead for clinical audit and effectiveness. The Health Board has a clinical audit policy which is currently being reviewed, it was last reviewed in January 2020. The clinical audit plan for 2021-22 was approved by the Audit Committee in June 2021. The plan, which covers national (tier 1), corporate (tier 2), and local audits (tier 3), was also approved by the QSE Committee in July 2021. Whilst the plan has been approved, it remains a 'live' plan with some discussion about whether some tier 3 audits should be upgraded to tier 2 during the year. Most clinical audit activity was paused during the pandemic, with 2020-21 activity being carried forward into the clinical audit plan for 2021-22. Operationally, we found all acute divisions and general surgery services have clinical audit programmes, which cover tier 1-3 audits. The Health Board reported that audit activity is restarting gradually. As such, there is an opportunity for the Health Board to develop clinical audit work focusing on the risk of direct or indirect harm as a result of the pandemic (**Recommendation 4**).
- 30 The Health Board's Clinical Effectiveness Department supports operational staff to design and deliver audits relevant to their practice. It also offers training, for example a clinical audit e-learning module has been running for the past year and the team holds virtual cafes to support staff. The team employs 6.8 WTE staff but at the time of our review the team held two vacancies; for the Head of Clinical Effectiveness, which is being covered on an interim basis, and for a Clinical Effectiveness Facilitator. We also understand that the lead for clinical audit is retiring. This may present a further risk to the effective delivery of the clinical audit plan.
- 31 The Health Board recognises that the clinical effectiveness resource is not big enough to adequately support clinical audit and as a result the support offered by the team is variable. For national audits the team will project manage the audit and submit data when requested. But there is limited support for corporate and local audits, which generally includes data processing, some analysis and designing proformas. The level of support offered is agreed by the Head of Clinical

Effectiveness on a case-by-case basis. The Health Board is reviewing this resource and developing proposals to maximise existing resources within the quality and clinical effectiveness departments.

- 32 The Clinical Effectiveness Department keeps a database of clinical audits. To improve the process, the Health Board is implementing a recently purchased clinical audit management and tracking system. The system will allow the Health Board to capture tier 1-3 audit findings and monitor actions and compliance with clinical guidance for example guidance from the National Institute for Health and Care Excellence (NICE). The new clinical audit management system will make it easier to identify learning which can be triangulated with other sources of quality assurance. Progress against the clinical audit plan is reported quarterly to the QSE Committee and annually to the joint QSE and Audit Committee.
- 33 Aside from Glan Clwyd general surgery service, the acute divisions and general surgery services have systems for tracking clinical audits. Currently, these paper-based systems track programme delivery and actions to address findings. But there is a lack of consistency about which system is used, that being the divisional/service system, corporate system, or both. The new clinical audit management system will streamline and standardise this process at an operational and corporate level.
- 34 Generally, findings, learning and good practice from clinical audits is shared and discussed. For example, assurances flow to the QSE Committee through its Clinical Effectiveness sub-group and clinical effectiveness groups held by the acute divisions and Secondary Care Executive Team. Findings are discussed at site and service level for example through matron and managers meetings. However, services are facing operational pressures which can affect quality and outcomes. The Health Board should therefore strengthen how it uses clinical audit intelligence for assurance purposes.

Mortality reviews

- 35 Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. The Health Board is taking steps to improve mortality reviews. In October 2021, it appointed a Clinical Mortality Lead to lead on improving systems and processes and on clearing the Health Board's backlog of stage 2 mortality reviews.
- 36 Mortality reviews are a regular feature on the QSE Committee agenda, but reporting is not timely. In 2020-21, the committee only received mortality review reports covering the period between January and June 2020. It also received a separate report detailing COVID-19 mortality rates between March 2020 and February 2021. So far, in 2021-22, the committee has only received the 2020 mortality review annual report, covering January to December 2020. Whilst the pandemic has disrupted mortality reviews, the Health Board should be returning to routine and regular reporting. For continued assurance, the committee should

receive mortality review reports every quarter, which highlight learning and actions taken as a result (**Recommendation 5**).

- 37 Operationally, all three acute divisions and general surgery services have a programme of mortality review meetings. The findings are discussed at the clinical effectiveness groups, which are mirrored at divisional, secondary care and QSE Committee sub-group levels. During the pandemic, whilst the general surgery services sustained mortality review meetings, not all acute divisions did. Review meetings have since been reinstated. Generally, the review meetings are medically led but from our interviews there is an appetite for these to be multidisciplinary reviews (**Recommendation 6**).
- 38 Good practice and learning from mortality reviews is shared via several routes. For example, through the medical directors' weekly email, departmental briefings, quality, and safety meetings and at clinical conferences. But the Health Board recognises that it does not yet have a process to systematically share learning across sites (**Recommendation 7**). This is not unique to mortality reviews. Those we interviewed felt that more learning could be gleaned from mortality reviews, feeling that because the Health Board has a backlog of stage 2 mortality reviews, caused by COVID-19, there is an emphasis on 'getting them done' and less focus on understanding the learning. Notwithstanding the issues with timeliness of mortality reporting mentioned earlier, the Health Board is starting to improve its mortality review reporting in respect of learning and improvement actions, which can be shared through clinical effectiveness groups. Themes highlighted in the 2020 annual report included missing second signatures on do not attempt cardiopulmonary resuscitation paperwork and the condition of case notes.

Values and behaviour

- 39 **The Health Board is using its 'Stronger Together' organisational approach to improve values and behaviour, but there are opportunities for improvement.**
- 40 The Health Board is embarking on a major organisational development programme called Stronger Together, which focuses on improving quality, productivity, and engagement. Central to the programme is improving the organisation's culture by ensuring the right behaviours, structures and processes are in place. The 'discovery phase' of Stronger Together, which included staff engagement, lasted three months, ending in October 2021.
- 41 Our work revealed a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns. Of the staff who completed our survey², 77% agreed or strongly agreed that the organisation encourages staff to

² We invited operational staff working across general surgery services to take part in our online attitude survey about quality and patient safety arrangements. The Health Board publicised the survey on our behalf. Although the findings are unlikely to be representative of the views of all staff across general surgery services, we have used

report errors, near misses or incidents. Just over half (55%) of respondents agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation. Two thirds of respondents (65%) agreed or strongly agreed that the organisation acts to ensure that errors, near misses or incidents do not happen again.

- 42 Staff are encouraged to report incidents, and at the time of our review the Health Board had just established a new serious incident's panel. The panel, which is jointly chaired by the Executive Director of Nursing and the Executive Medical Director, is convened within 24 hours of a serious incident and a rapid review is held with the team concerned. Overall, the rapid review is a supportive process to aid learning, which operational staff were positive about. But this process only works well when a culture of open, honest discussion is encouraged. Only a third (32%) of staff responding to our survey agreed or strongly agreed that communication between senior management and staff is effective. Learning from complaints and incidents is disseminated in several ways such as at putting things right, mortality meetings and ward managers meetings. But as highlighted earlier, whilst the Health Board shares learning locally, it does not yet have a systematic way of effectively sharing learning across sites and services.
- 43 Staff responding to the recent NHS Wales staff survey³ reported their experiences of bullying, harassment, or abuse by a line manager (12%) or member of the public (16%) or a colleague (21%) over the past year. Given the proportion of respondents saying they had experienced this behaviour we would expect the Health Board to take action when it happened. But fewer than half (37.9%) agreed or strongly agreed that the organisation takes effective action when it did occur (**Recommendation 8**), indicating the need to strengthen focus on this important area.
- 44 All staff have access to the Datix system to report incidents and near misses. Acute division staff receive training on how to use the system to report concerns and near misses. However, training has been affected by COVID-19 and the work needed to prepare for the new all Wales Datix system which went live in July 2021. This has affected the Datix team's capacity to train although virtual training and support is available.
- 45 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. In July 2021, the Health Board's mandatory training compliance was 83.39%, which is near the 85% target and one of the highest compliance rates in Wales. Whilst the compliance rate is positive, only 32% of general surgery staff responding to our survey agreed or strongly agreed that they have enough time at

them to illustrate particular issues. 164 members of general surgery staff responded to our survey.

³ The NHS Wales staff survey ran for three weeks in November 2020 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 18%.

work to complete any statutory and mandatory training. Although operational teams allot time for staff to complete training, teams should ensure adequate time is allowed.

- 46 Personal Appraisal and Development Reviews (PADR) is a two-way discussion which helps staff understand what is expected of them in their role and become more engaged and take responsibility of their own performance and development. The Health Board PADR rates have dipped slightly since the pandemic. In July 2021, the Health Board achieved 69.4% against a target of 85%. The Health Board plans to improve compliance rates through communications and tailoring support for areas with especially low compliance rates.

Listening and learning from feedback

- 47 **The Health Board has a good approach to listening and learning from feedback, which it is seeking to strengthen further. However, the Health Board needs to ensure learning is consistently triangulated, shared, acted on and embedded, and that staff are informed of feedback.**

Patient Experience

- 48 The Health Board's Patient and User Experience Strategy (2019-22), which sets out how it collects and uses patient and user feedback is under review. The redeveloped strategy, called the Patient and Carer Experience Strategic Plan, will support the new Quality Improvement Strategy. The Health Board expects the new plan will be finalised by summer 2022.
- 49 The Quality Safety and Experience Committee (QSE) receives a quarterly Patient and Carer Experience report, which covers complaints performance, ombudsman cases and an update on patient feedback. This report identifies lessons learned, emerging themes and remedial actions taken. The committee also receives an assurance report from its Patient and Carer Experience sub-group, which is presented in the Health Board's 'triple A' report format. The Executive Team's weekly quality bulletin also includes high-level details about complaints, serious incidents and never events.
- 50 The Health Board's Patient Experience Team has 17.8 WTE members of staff and supports services to capture feedback. The Health Board also has a Patient Advice and Liaison Support Service (PALS) which facilitates patient and carer feedback with a view to early resolution. There are three PALS officers for each locality. PALS officers meet as a team to share learning and experience but also meet with the wider Patient Experience Team, so they are not working in isolation. To further enhance the patient experience resource and build expertise throughout the organisation, the Health Board is recruiting 100 patient experience champions. The champions will be a team of multidisciplinary staff volunteers based in each clinical team. The initiative will increase ward level visibility and ownership of patient experience activities. Currently, the Patient Experience Team reports to the acute

divisions, who report directly to the QSE Committee's Patient and Carer Experience sub-group on patient experience matters. This means reporting by-passes both the secondary care management structure and the Executive Team. This will be improved greatly as the Health Board's new governance structure starts to embed (see paragraph 67).

- 51 The Health Board has good resources for managing complaints and concerns in accordance with the Putting Things Right process. There are 29 WTE staff in the complaints handling team. In May 2021, the Health Board introduced a new complaint handling process, which has a greater focus on early resolution. The central complaints team receives and logs complaints before forwarding to the relevant ward or service for resolution. The PALS officers are central to the new process. When we interviewed staff, the new complaints process had only been in place for two weeks. We found that staff were supportive of the new process and were adjusting to its use. However, there were concerns raised that the process was time consuming for lead nurses. Generally divisional teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis (**Recommendation 9**). The majority (70%) of general surgery staff responding to our survey agreed that the Health Board acts on concerns raised by patients. In September 2021, 65.93% of complaints were responded to within 30 days, this is below the Welsh Government target of 75%. But the number of early resolutions has increased since the new complaints handling process was introduced.
- 52 The Patient Experience Strategy sets an annual target to capture 20% of patient/care/user experience. Understandably, COVID-19 caused a significant drop in patient feedback and the target had not been measured for 12 months, however prior to the pandemic the target was not being met. In July 2021, the Health Board successfully implemented phase one of the new CIVICA Once for Wales Patient Feedback System. The new system aims to support real-time patient and service user feedback, making it easier for the Health Board to reach its target.
- 53 Operational teams seek patient and staff feedback in several ways, such as on-site comments cards, postal and online patient satisfaction surveys and patients speaking directly with matrons. In April 2020, the Health Board stopped using 'happy or not' customer feedback kiosks to aid infection prevention and control, but tablet computers continue to support digital feedback. As well as working closely with the complaints team, PALS officers hold engagement events across community and acute wards to give patients and carers the opportunity to discuss their concerns. These events called Care to Share continued during the pandemic but were less frequent, held virtually and targeted areas where there were concerns. Whilst patient feedback is shared with wards monthly, our survey of general surgery staff indicates that more needs to be done to disseminate patient experience information given less than half (42%) of respondents agreed or strongly agreed that they receive regular updates on patient feedback for their work area (**Recommendation 10**).

Listening to staff

- 54 The Health Board is committed to listening to staff so it can learn from their experiences and concern. But less than half (45%) of staff responding to our survey agreed that the organisation acts on the concerns raised by staff.
- 55 The Health Board reviewed its raising concerns process and in April 2021, launched its Speak Out Safely process. The new process offers staff several avenues to raise concerns in confidence. For example, staff can speak to a Speak Out Safely guardian or champion, anonymously raise concerns through a platform called Work in Confidence and approach their managers and trade union representatives. Work is still ongoing to fully implement the policy, for example two Speak out Safely Guardians have recently been recruited and the Health Board is planning to recruit locally based speak out safely champions.

Patient stories

- 56 The Health Board is taking steps to improve the reach of patient stories. Whilst the QSE Committee has received stories at most meetings since March 2019, the Board has only recently started to receive them (September 2021). The Health Board also has plans for stories to feature at executive team meetings.
- 57 The Health Board is also improving the way patient stories are told and organised. Since May 2021, QSE Committee members listen to the story beforehand and an accompanying paper outlines the emerging themes, learning points and suggested service improvements which members discuss. This is a more productive use of committee time. The Health Board is planning to make these recordings available to the public from early 2022. Currently, patient stories are chosen at random, but the Health Board is developing a 12-month schedule and has ambitions to align stories to themes from complaints and incidents. As most patient stories will be digital the Health Board is investing in digital storytelling equipment and training staff to use it. There are also plans to develop a library of stories to use for training purposes.

Patient Safety Walkabouts

- 58 As with other health bodies, executive and independent member safety walkabouts had to be stopped during the pandemic. Prior to this, walkabouts were ad-hoc in nature and feedback was not collated in a structured way. Staff we spoke to felt that that aside from the Chair, Chief Executive Officer and Executive Director of Nursing, Board members were not visible. Positively, the Health Board has recognised these weaknesses and in July 2021 launched its new Quality and Safety Walkabouts. A standard operating procedure provides clarity on the process, sets out expected frequency, ensures coverage across service areas and templates standardise how feedback is captured and reported. Any actions noted during walkabouts are recorded and monitored through Datix. The Patient Safety and Quality Group received its first quarterly patient safety walkabout report in

October 2021. Between July and September 2021, eight walkabouts had taken place capturing 14 improvement actions. The walkabouts covered a range of services and hospitals including outpatients at Gwynedd Hospital, pharmacy at Glan Clwyd Hospital and the Stanley Eye Unit at Abergel Hospital. This should go some way to improve Board member visibility and further triangulate learning.

Governance structures and processes

- 59 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, and effective services.
- 60 We found that **there is good ongoing work to strengthen corporate and operational quality and safety governance arrangements and whilst the Health Board has a good level of resources to support quality governance it is taking action to ensure resources are used effectively.**

Organisational design to support effective governance

- 61 **Ongoing changes to quality governance arrangements are designed to support integrated and collective accountability for quality arrangements.**
- 62 The Health Board has a complicated organisational structure with multiple tiers, which can make lines of accountability difficult to understand, especially at an operational level. To test the 'floor to board' perspective, this review examined the arrangements for general surgical services, as such **Exhibit 2** shows the current organisational structure for acute services. The Health Board has a similarly complex structure for primary and community services. However, since our fieldwork the Health Board has developed and is currently implementing a new operating model (see paragraph 66).

Exhibit 2: current organisational structure for acute services

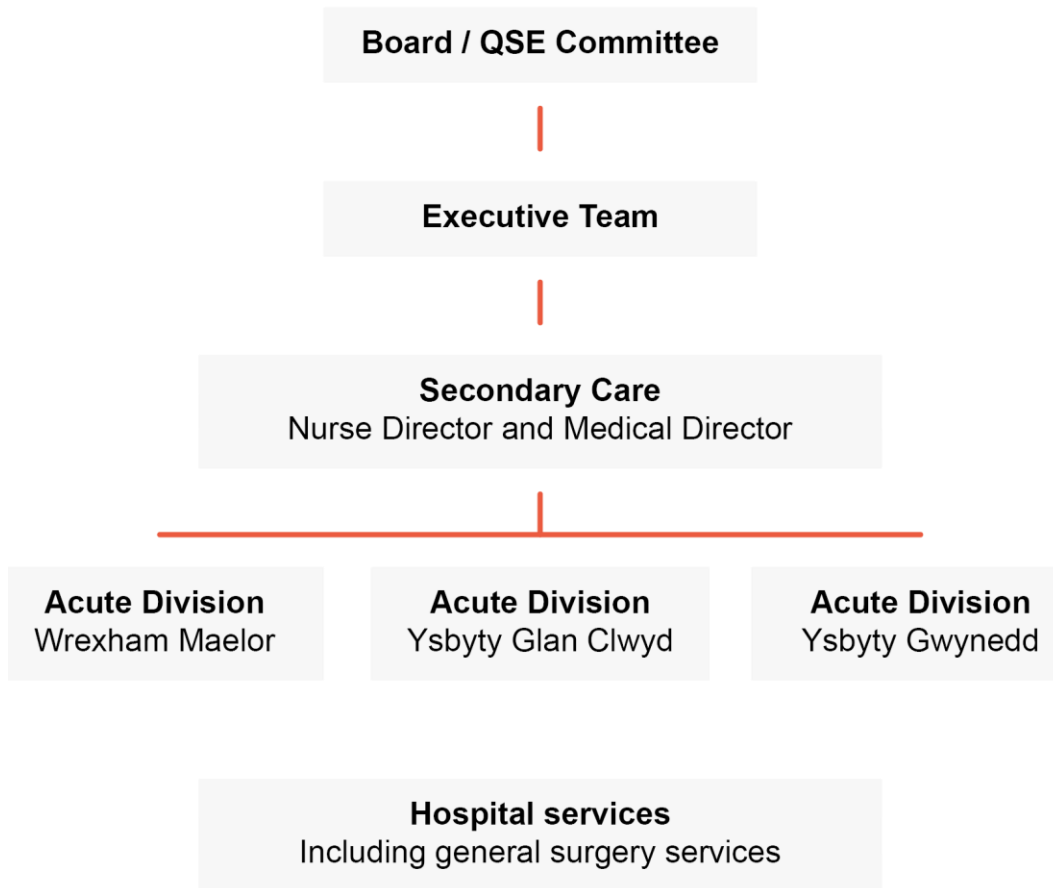


Exhibit source: Audit Wales analysis of Health Board organisational structure

- 63 The Executive Director of Nursing and Midwifery is the named lead for quality and patient safety. But day to day responsibility is shared with the Executive Medical Director and the Director of Therapies and Health Sciences. Below the executive team, sits the secondary care structure, which has a Nurse Director and a Medical Director. Hospital site and community 'Area', responsibility for quality and patient safety mirrors the corporate arrangement. Lead site or service nurses and medical directors or clinical leads take joint ownership for quality and patient safety. Feedback from the services suggests this arrangement works well.
- 64 The QSE Committee has begun to improve its quality governance structure to improve assurance systems. In August 2020, the committee approved the establishment of four new sub-groups:
- Patient Safety and Quality
 - Clinical Effectiveness
 - Patient and Carer Experience

- Strategic Occupational Health and Safety

- 65 Each of the sub-groups has a terms-of-reference and have been meeting since October 2020, although some meetings were cancelled because of COVID-19. In April 2021, we observed a Quality and Patient Safety group meeting. It was clear that the group was still establishing, for example, some of the groups reporting into the sub-group had only met once or twice. Some of the sub-group's administration was not well organised for example the action log was partially complete, which meant the 5-minute item took 40 minutes. The monthly meeting has a very heavy agenda. It receives assurance reports from its sub-groups these include infection prevention and control, personal protective equipment and safer medicines sub-groups. It also receives reports from the secondary care tier, the three acute divisions, women's services and mental health and learning disabilities. The Health Board reported that the QSE Committee sub-groups have since started to settle. Moving forward, the four sub-groups will formally report to the new Executive Delivery Group for Quality as part of the new integrated governance framework.
- 66 In addition to the ongoing service pressures caused by the pandemic, the Health Board is going through a period of change. It recognises that its current structure is too complicated making oversight and information flow difficult. As such, Stronger Together, the Health Board's organisational development programme, has developed a new operating model. The new model moves towards integrated health communities and some pan-North Wales regional services. The Health Board is currently implementing the new structures and is aiming to have a shadow form operating from 1 April 2022.
- 67 The Health Board is also beginning to implement its new integrated governance framework, which was approved in July 2021. One of the aims of the new framework is to allow a clearer focus on floor to Board oversight of service quality. The new structure will involve establishing three executive delivery groups, one of which is focused on quality improvement. Reporting into the executive delivery groups will be 10 tactical delivery groups, four of which relate to quality and patient safety, these are: patient safety, patient experience, clinical effectiveness and infection prevention and control groups. To aid clear lines of reporting the tactical delivery groups will be mirrored at an operational level. These will replace and standardise the current divisional and service level quality and safety and clinical effectiveness meetings and improve lines of sight. A similar governance review is underway for divisional teams. As of February 2022, the new executive delivery groups had held or were about to hold their first meetings.
- 68 To aid the flow of assurances the QSE Committee also approved the 'triple A' reporting model, which filters assurances from operational teams up to the QSE Committee. But some interviewees felt that guidance was needed when introducing the template, as there can be some variation in the level of detail provided (**Recommendation 11**). Without guidance there is the risk that quality and safety issues are missed or not escalated correctly. The Health Board needs assurance that the right information is filtering up.

Resources and expertise to support quality governance

- 69 **The Health Board has a good level of corporate and operational resources to support quality governance, but there are inconsistencies in levels of resource across the organisation, and concerns that existing resources are not being used to their full potential. The Health Board is taking action to address these concerns.**
- 70 Corporately, the Acting Associate Director of Assurance manages three heads of service covering quality assurance, patient experience and patient safety. Together the team provide a good level of support for quality governance and patient safety and experience. Across the organisation approximately 130 staff support quality assurance. Staff are generally based within specific service areas, with some being a corporate resource and others local resources. The Health Board has recognised that existing arrangements can result in silo working and duplication and is reviewing its resources and how they are organised. The Health Board is in the process of implementing a business partner model in which staff would be part of a corporate team but still be based in their localities. The aim of this model is to drive consistency, make it easier to share good practice and learning and reduce duplication and silo working. There is also a wider review of divisional governance structures underway which will further clarify roles and structures.
- 71 All three acute sites have quality governance lead nurses, who are members of the corporate patient safety team and work across clinical teams. They are supported by a team of eight to ten staff. However, the perception of this support varies across the organisation. For example, in our data collection survey⁴, all three acute divisions said they had a dedicated quality and patient safety lead, but only Ysbyty Glan Clwyd Acute Division said the lead was part of the corporate team. For general surgery, only Ysbyty Gwynedd said they did not have a dedicated quality lead. This variation suggests that the resource is not well organised or recognised, causing inequities across the organisation, as well as affecting the ability for teams to consistently manage quality improvement and provide the assurances required to the Board and its committees. Overall, the Health Board has a good level of quality governance capacity, but it needs to ensure the review it has undertaken results in these resources being used to best effect.

⁴ We asked the Health Board to complete data collection surveys which captured information about corporate resources to support quality and patient safety and quality governance arrangements for the acute divisions and general surgery services.

Arrangements for monitoring and reporting

- 72 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.
- 73 We found that **the Health Board is adapting and improving its quality monitoring and reporting, recognising the challenge of COVID-19 and wider quality risks.**

Information for scrutiny and assurance

- 74 **The Board receives a good level of information to scrutinise harm from COVID-19. The Health Board is taking steps to improve quality dashboards, but further work is needed to ensure a more consistent approach is adopted across the organisation and to strengthen operational data analytical capacity.**
- 75 The Health Board has made a commitment to assessing harm from COVID-19 built around the four quadrants of harm model⁵ and has ensured information is reported widely. The Board, QSE Committee and Executive Team receive a COVID-19 update report at each meeting. The report covers the prevalence and impact of the virus, overall risks and issues and an update on the test trace and protect and vaccination programmes. Recent update reports outline the work being done to better understand long-Covid such as data modelling and developing long-Covid patient pathways. The Quality and Performance report also details how COVID-19 is impacting on key performance measures. In addition, the Board receives exception reports for example on how COVID-19 is affecting primary care services. The Health Board has established a team to review nosocomial COVID-19 cases. Like others, the Health Board continues work to establish how best to assess wider harm from COVID-19.
- 76 The Health Board holds a wealth of data on its 'IRIS' business intelligence data warehouse. But without the correct expertise it is difficult to extract and make use of this information. Whilst there is some corporate informatics support and a small Quality Data Analytics Team (four members of staff), operational staff we interviewed expressed their frustration at the lack of data analytics support.
- 77 The lack of data analytics support has meant that divisions and service areas have developed their own quality and patient safety dashboards. This means there is inconsistency across the organisation, making it difficult for teams to compare between service areas. The Health Board has recently introduced a new quality dashboard, which houses 15 metrics and can be sorted by ward, speciality, and

⁵ NHS Wales COVID-19 Operating Framework: quarter 1 2020 to 2021 sets out the four types of harm cause by COVID-19, these being: harm from COVID itself, harm from overwhelmed NHS and social care system, harm from reduction in non-COVID activity and harm from wider societal actions /lockdown.

site. Whilst the dashboard needs further development, this is a positive start. The new Quality Improvement Strategy will look to address further improvement.

- 78 Not all the divisions and general surgery services have developed quality and patients' safety dashboards. Where they have, the dashboards are discussed at monthly divisional quality and patients' safety meetings and the Acute Division Management Team meetings. Of the three acute divisions, only Glan Clwyd does not discuss a dashboard at its quality and patient safety meeting. And for general surgery only Wrexham Maelor holds a dedicated quality and patient safety meeting, where their dashboard is reviewed. The Quality Data Analytics Team has been tasked with standardising operational quality dashboards. And as the new integrated governance framework embeds the Health Board should see improved levels of consistency of reporting across operational teams.

Coverage of quality and patient safety matters

- 79 **The Quality, Safety and Experience Committee is well served with quality information, and this is resulting in a stronger focus on improvement. But there needs to be a stronger focus on outcomes, local measures, and the quality of services that the Health Board commissions from other organisations.**
- 80 The Health Board's Quality and Performance report focuses on the NHS delivery framework and its measures are aligned to the quadruple aims within A Healthier Wales. The Board receives the report at each meeting. For assurance purposes the measures are divided amongst the committees, with the QSE Committee scrutinising quality measures. The report has a clear format, grouping measures and narrative by theme and showing performance trends. The narrative highlights key performance risks and actions to address them. While this report aligns with the NHS delivery framework measures, there are no locally agreed quality measures for acute or community services (**Recommendation 12**).
- 81 The QSE Committee has a large remit and routinely receives quality and patient safety assurance reports. Routine reports received by the QSE Committee include:
- Patient Safety report - provides quarterly information on aspects such as patient safety incidents, litigation, and patient safety alerts.
 - Serious incident report – provides information and analysis on serious incidents and never events over a two-month period.
 - Patient and Carer Experience report – covers complaints, ombudsman cases and patient and user feedback.
- 82 The committee also receives detailed reports on specific current issues such as COVID-19 outbreaks, vascular surgery, urology services and mental health. However, generally there is a greater focus on secondary care services than on community and primary care and the committee does not receive any assurance on the quality of services the Health Board commissions from other organisations.

- 83 The Health Board is in the process of improving its performance reports. We reviewed recent quality and patient safety assurance reports and the improvements are clear, such as an emphasis on learning and highlighting themes. This is a positive start, but the Health Board accepts there is more to do, such as developing patient-related outcome and experience measures (PROMS and PREMS).

Appendix 1

Management response to audit recommendations

Recommendation	Management response	Completion date	Responsible officer
Quality and patient safety priorities R1 We found that the Health Board did not formally review its quality improvement priorities in light of the consequences of COVID-19. The Health Board should ensure its new Quality Improvement Strategy sets out how the Health Board will manage and mitigate the potential harms associated with the COVID-19 pandemic.	We accept the priorities were not formally reviewed although we did seek to prioritise the mitigation of the four harms from COVID as part of our organisational strategy. We will ensure the new Quality Strategy under development reflects this recommendation. We have set interim quality priorities while the strategy is being developed which are based on the key quality risks and concerns that have been identified.	September 2022	Associate Director of Quality
Risk management training	The Health Board has updated its Risk Management Strategy and training has been made available. The Risk	Completed – ongoing	Director of Governance

Recommendation	Management response	Completion date	Responsible officer
<p>R2 We found that not all operational staff are trained to record clinical and non-clinical risks and compile risk registers. The Health Board should ensure staff have adequate levels of risk management training so that they can confidently contribute to the risk identification and escalation process.</p>	<p>Management Group has refreshed terms of reference and a new executive lead has been appointed (the Executive Medical Director). The Health Board is also working to implement the new Once for Wales Risk Register module as part of the Datix Cymru system and is likely to be the pilot site.</p>	<p>training offer and monitoring via Risk Management Group</p>	
<p>Quality improvement support</p> <p>R3 The Health Board's Quality Improvement Hub (BCUQI) has developed a quality improvement database to allow staff to share, adopt and learn from existing quality improvement projects. However, we found that the database is not well used. The Health Board should</p>	<p>The Health Board has created a new Transformation and Improvement Directorate bringing together the different teams involved in quality improvement, service improvement, transformation and programme management. This will replace the BCUQI Hub. The team will develop a fundamentally different approach to sharing improvement opportunity and which will be overseen by the Executive Delivery Group for Transformation.</p>	<p>Completed – new Transformation and Improvement Directorate in place.</p>	<p>Director of Transformation and Improvement</p>

Recommendation	Management response	Completion date	Responsible officer
<p>promote and encourage routine use of the database by setting targets for participation, by keeping the level of engagement under regular review and by taking action if engagement is too low.</p>			
<p>Clinical Audit</p> <p>R4 The Health Board has restarted clinical audits after most activity was paused during the pandemic. The Health Board should look to use its programme of clinical audit work to focus on the risk of harm as a result of the pandemic. For example, to better understand the consequences of long waits or exacerbation of chronic conditions. The audits could be targeted at high-risk specialities.</p>	<p>The Health Board will develop a quality and risk informed programme of clinical audit. The Quality Department and Clinical Effectiveness Department are working to develop proposals on closer collaboration and a new clinical audit system is in the process of roll-out.</p>	<p>June 2022</p>	<p>Head of Clinical Effectiveness</p>

Recommendation	Management response	Completion date	Responsible officer
Mortality reviews R5 We found that mortality reviews are not reported to the QSE Committee in a timely manner. The Health Board should ensure the QSE committee receives a quarterly mortality review report, which highlights learning and what action has been taken.	The Health Board will introduce reporting on mortality reviews to the QSE Committee either through a dedicated report or the Patient Safety Report.	30 June 2022	Associate Director of Quality & Associate Medical Director of Mortality Review
Mortality reviews R6 We found that, generally, mortality reviews are medically led, but there is an appetite for multidisciplinary mortality reviews. The Health Board should look to establish a system where a multidisciplinary mix of staff	The Health Board has appointed a new Associate Medical Director for Mortality Review to provide strategic leadership and is in the process of embedding the new Learning from Deaths Framework. The Reducing Avoidable Mortality Group has been reformed and the Health Board is working with the national work stream for	30 September 2022	Associate Medical Director of Mortality Review

Recommendation	Management response	Completion date	Responsible officer
are routinely involved in mortality reviews.	the new Mortality Module of Datix Cymru. The overall new system will enhance multi-professional involvement.		
Sharing learning and good practice R7 The Health Board recognises that it does not yet have a process to systematically share learning across the organisation. The Health Board should use the new integrated governance framework and the Quality Improvement Hub (BCUQI) as tools to support organisational learning and sharing good practice across the organisation.	The Health Board will implement a learning library through its new Intranet, BetsiNet rather than the external BCUQI Hub web site which will become part of the new Transformation and Improvement Service. In addition, the revised Incident Policy and Complaints Policy will set out new approaches to sharing learning systematically including Learning Events and a Learning Bulletin. The Safety Alert process is also to be revised. These actions form part of the mitigation actions for the risk on the Board Assurance Framework.	30 September 2022	Associate Director of Quality
Values and behaviours	The Health Board has adopted the all-Wales Respect and Resolution Policy. The Health Board has launched a new	Completed – and continued	Associate Director of HR

Recommendation	Management response	Completion date	Responsible officer
<p>R8 Only 37.9% of Health Board staff responding to the NHS staff survey agreed or strongly agreed that the organisation takes effective action when bullying harassment or abuse occurred. The Health Board should review its systems for managing, addressing, and learning from the concerns of staff in relation to bullying, harassment, or abuse.</p>	<p>Speak out Safely Policy and framework including the appointment of Speak out Safely Guardians, a Multi-Disciplinary Team to oversee concerns and a new secure platform for staff to anonymously raise concerns. Additionally, significant work is underway as part of Stronger Together to explore and improve staff engagement and support.</p>	<p>through the Stronger Together programme</p>	
<p>Complaint handling</p> <p>R9 We found that operational teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis. The Health Board should</p>	<p>The Health Board has refreshed its complaint handling training, and this was re-launched in spring 2022 (following deferment over post-winter pressures). Training will be recorded within the ESR system. In addition, virtual complaint support clinics are held weekly to support staff.</p>	<p>Completed</p>	<p>Associate Director of Quality</p>

Recommendation	Management response	Completion date	Responsible officer
review levels of complaints handling training across the organisation. If this shows shortfalls, the programme of training should be expanded.			
Flows of information and assurance R10 Less than half (42%) of respondents responding to our survey agreed or strongly agreed that they receive regular updates on patient feedback for their work area. Whilst patient feedback is shared with wards monthly, the Health Board needs to ensure all ward staff are aware of this feedback and that it is easily accessible to staff.	The Health Board has implemented the new all-Wales Civica Real Time Feedback System. All services are available in this system with all team/ward managers and above given access to the dashboard. Monthly Reports are also sent to services. Patient and Carer Champions are being recruited with over 100 now in place. To complement this a new framework for collecting and acting on patient feedback is being developed setting out standards and good practice for teams to follow.	30 September 2022	Associate Director of Quality

Recommendation	Management response	Completion date	Responsible officer
<p>Flows of information and assurance</p> <p>R11 The Health Board introduced a new reporting format (triple A) to improve the flow of quality assurance. But we found some variation in the levels of detail provided in the reports. To reduce the risk of quality and safety issues being missed or not correctly escalated the Health Board should provide staff with guidance on using the new template, especially setting out how much detail is expected and how to agree which issues are escalated.</p>	<p>As part of the new Operating Model being developed as part of the Stronger Together programme, a new integrated governance and assurance framework will be developed setting out a new governance framework, and standards and principles for governance across the organisation including reporting, escalation, and accountability.</p>	<p>30 June 2022</p>	<p>Director of Governance</p>

Recommendation	Management response	Completion date	Responsible officer
<p>Quality and patient safety performance measures</p> <p>R12 We found that whilst the measures in the integrated performance report aligns with the NHS delivery framework, there are no locally agreed quality measures or wider measures such as for community services. Through the new Quality Improvement Strategy, the Health Board should review current quality measures with a view to developing measures that reflects the services it provides and commissions across primary, community and secondary care.</p>	<p>A new Quality Highlight Report has been produced for the Board. New quality measures will be included in the new Quality Strategy.</p>	<p>30 September 2022</p>	<p>Associate Director of Quality</p>

Appendix 2

Staff survey findings

Exhibit 4: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Delivering safe and effective care						
1. Care of patients is my organisation's top priority	58	70	21	7	5	162
2. I am satisfied with the quality of care I give to patients	67	57	11	20	7	162
3. There are enough staff within my work area/department to support the delivery of safe and effective care	13	39	30	39	40	163
4. My working environment supports safe and effective care	27	65	30	24	17	163

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Delivering safe and effective care						
5. I receive regular updates on patient feedback for my work area / department	14	54	38	37	14	162
Managing patient and staff concerns						
6. My organisation acts on concerns raised by patients	37	77	25	7	3	162
7. My organisation acts on concerns raised by staff	16	56	41	26	18	159
8. My organisation encourages staff to report errors, near misses or incidents	45	79	25	5	5	161
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	21	68	36	17	7	161

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Managing patient and staff concerns						
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	27	77	33	8	5	160
11. We are given feedback about changes made in response to reported errors, near misses and incidents	19	58	45	26	7	161
12. I would feel confident raising concerns about unsafe clinical practice	32	70	32	15	10	163
13. I am confident that my organisation acts on concerns about unsafe clinical practice	28	67	37	13	11	164
Attitude statements	Number of staff agreeing or disagreeing with statements					

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total respondents
Working in my organisation						
14. Communication between senior management and staff is effective	14	39	38	45	28	164
15. My organisation encourages teamwork	27	70	38	16	11	163
16. I have enough time at work to complete any statutory and mandatory training	9	43	34	43	35	164
17. Induction arrangements for new and temporary staff (e.g. agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care	12	60	46	15	16	163 ⁶

⁶ 14 respondents responded, 'don't know'.



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Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

Commissioning Older People's Care Home Placements – North Wales Councils and Betsi Cadwaladr University Health Board

Audit year: 2020-21

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

Contents

Partners are working individually and collectively to provide care home placements for vulnerable service users, this is made more difficult by complex national processes, resulting in a significant focus on costs, which causes division amongst partners and has the potential to impact adversely on service users and their families. Strengthening accountability and developing a regional strategy and delivery plan has the potential to drive positive change and better partnership working, especially in relation to complex and more specialist care.

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Partners are working together to provide care for vulnerable service users but are carrying significant risks associated with market stability, workforce, and pre-placement agreements, along with a reliance on spot purchasing 6

The Regional Partnership Board's 2018 Market Shaping Statement set out some aspirations for care home commissioning which were added to by the RPB's response to 'A Heathier Wales' in 2019, however, neither of these have driven the development of a clear regional strategy for commissioning care home placements for older people in North Wales or a delivery plan to take forward the aspirations that have been identified 9

Whilst the RPB network brings partners together to 'think regionally', its structures, largely set out by the Welsh Government, are extensive and complex, and lines of accountability need to be strengthened 12

Nationally set fee structures are complex and result in a significant focus on cost which causes division amongst partners and has the potential to impact adversely on service users and their families 14

Partners need to do more to demonstrate they are meeting their statutory responsibilities around the Welsh language, and the Well-being of Future Generations Act, when commissioning care homes provision and making individual placements 17

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Summary report

Background

- 1 The Social Services and Well-being (Wales) Act 2014 (the Act) came into force on 6 April 2016. The Act provides the legal framework for improving the wellbeing of people who need care and support and for transforming social services in Wales.
- 2 Across Wales, the costs of care home commissioning for older people run into several hundreds of millions of pounds each year and many thousands of people are affected.

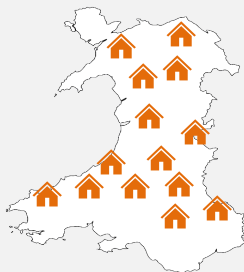
Exhibit 1: key facts about care home commissioning

The exhibit sets out some key facts about adult care home services in North Wales.

4,353

People aged over 65 receiving adult care home services in North Wales from local authorities in 2018-19.

Of these, **1,034** are also receiving nursing services.



2016 data¹ indicates 6,048 care home residential places in North Wales, made up of:

2,636 residential places

1,194 residential Elderly Mentally Ill (EMI) places

1,555 general nursing places

663 EMI nursing places

£74.2 million

North Wales Local Authority spend on nursing and residential placements aged 65 and over in Wales in 2019-20.
(Stats Wales)

£98.8 million

Health Board continuing healthcare and funded nursing care costs in 2019-20.
(Annual Accounts)²

¹ Market Shaping Statement: Care homes for older people in North Wales

² Data sourced from Health Board Annual Accounts. The majority but not all Continuing Healthcare costs relate to care home placements.

- 3 The Act requires councils and health boards to work together to assess the care and support needs of the population in their area. Partners are to identify what services are needed and to use their resources effectively; for example, by establishing and maintaining pooled fund arrangements in relation to the exercise of their care home accommodation functions.
- 4 The Act established Regional Partnership Boards (RPBs) to prioritise the integration of services including for older people with complex needs and long-term conditions, including dementia. In North Wales, the RPB includes the statutory partners – Isle of Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham Councils and Betsi Cadwaladr University Health Board.
- 5 In early 2020, we identified strategic commissioning of care home placements for older people was a risk to both councils and the Health Board for the following reasons:
 - high level of spending on these services;
 - forecast increases in numbers of older people expected to need support;
 - recruitment and retention competition between health, social care providers and parts of the independent sector as well as retail and hospitality employers; and
 - potential untapped benefits of strategic commissioning across North Wales public sector bodies.
- 6 During 2020-21, the COVID-19 pandemic has highlighted the fragility and issues around capacity of the care market and the need to plan strategically on a regional level.

About this report

- 7 This report sets out the findings from the Auditor General's review of care home commissioning arrangements across North Wales. The work has been undertaken as a part of our statutory programme of local audit work at each of the local authorities in North Wales and the Betsi Cadwaladr University Health Board. Reflecting the cross-sector focus of this review we have presented our findings as a single report that includes recommendations for strengthening the pan-North-Wales approach to care home commissioning and associated partnership working. We have used the term care homes to reflect all types of residential and nursing care homes in a generic sense although where we specifically refer to one type we have noted that in the text.

Key messages and overall conclusions

- 8 Care home commissioning requires collaboration between councils, the Health Board, and providers to ensure that service users are accommodated in suitable placements.

- 9 **In overall terms, our review found that partners are working individually and collectively to provide care home placements for vulnerable service users; this is made more difficult by complex national processes, resulting in a significant focus on costs, which causes division amongst partners and has the potential to impact adversely on service users and their families. Strengthening accountability and developing a regional strategy and delivery plan has the potential to drive positive change and better partnership working, especially in relation to complex and more specialist care.**
- 10 Whilst some of the significant issues and challenges for care home commissioning that we identify in this report may be unique to North Wales, many exist because of the frameworks, policy and legislation which are nationally set out. While there is need for regional improvement, there is real opportunity to consider both the extent of these issues in other regions, and how national reform may help provide a platform for sustainable services. We have reported separately to the Welsh Government, recommending action that they should take to improve the framework within which regional partners operate. Private sector care home providers are not audited by the Auditor General per se, but public money paid to such providers is subject to the Auditor General's examination as part of the audit of public bodies. As part of commissioning and procurement activities, the Welsh Government and local authorities should consider how private sector providers can be encouraged further to support public bodies to improve care home provision. The findings that underpin the above conclusions are considered in the following sections.

Partners are working together to provide care for vulnerable service users but are carrying significant risks associated with market stability, workforce, and pre-placement agreements, along with a reliance on spot purchasing

- 11 At an operational level, officers continue to work through and around the complexities of the national funding structure to get the best they can from the care home market. When commissioning care home placements, operational managers work hard to ensure service users receive the best care to meet their needs, but those with budget responsibilities must also balance this against costs.
- 12 Sustainability of the care home market is a key issue for North Wales. There are publicly and privately owned care homes and income is dependent on demand and fee rates. The funding approach is short term in nature and does not address the longer-term financial viability of the market. Nor does it properly anticipate long-term changes in need and how to adapt the market to meet that need.
- 13 In business it is essential that supply and demand are closely aligned, and in North Wales, care home provision does not reflect demand. Managers told us that there is a lack of some specialist provision such as for people with dementia and some

parts of the region have an oversupply of care homes that are not specialist in focus. Where there is an under supply of suitable care homes in an area, a person may be placed some way from their home and local community, or it could result in a delayed discharge from hospital. If a placement was made, this could be in other parts of Wales or sometimes outside Wales altogether. Placement outside of Wales may well be sensible for residents of more easterly counties and at times, a placement away from where the resident lived is the correct decision: for example, to be nearer to relatives or to ensure that the resident can live in a home where the staff are predominantly Welsh speaking. However, this can also lead to relatives having long journeys to visit their relatives.

- 14 The care home market in North Wales also has some vulnerabilities. Some care-home owners are nearing retirement and will want to sell their businesses. Some homes do not currently meet the environmental standards required under the regulations³. Once sold, the new owners may need to comply if the homes are unoccupied at the point of sale. This will affect the marketability of their businesses, and the cost of building work to comply with the standards may not be reflected sufficiently in the fee toolkit methodology. Officers continue to contract with these care homes even though they do not fully meet the environmental standards, as without using them capacity would be too limited.
- 15 Partners, through the Care Home Operational Group, have supported care homes to improve quality standards such as practice development nursing support, monitoring officer support in development processes and improvement action plans and business continuity plans, recruitment and advertising vacancies, environmental health support with food hygiene, health and safety officers and Welsh learning courses for care home staff.
- 16 In addition, partners provide support to help people to stay well, be self-caring and to prevent escalation to managed care. This support includes falls prevention services and community wellbeing programmes.
- 17 Commissioners and providers continue to work together despite the obvious challenges posed by the current complexities of the market. Managers meet regularly with providers, and the Chief Executive of Care Forum Wales which represents providers is now the chair of the RPB. Frustrations are mainly around the process and fee structure, but providers and commissioners continue to work through this imperfect arrangement.
- 18 The social care workforce is another vulnerability and one that has been clearly documented in the North Wales Social Care and Community Health Workforce Strategy 2018-2021, developed by the North Wales Workforce Board (NWWB), which sets out its priorities as:
 - stabilising the workforce – recruitment and retention;

³ The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017

- learning and development – develop a workforce across the sector that has the skills, knowledge, and competencies to deliver high quality personalised services; and
- workforce planning and development in the care home sector.

Whilst the NWWB reports to the RPB and has undertaken work to begin delivery of these priorities, these are not part of a comprehensive regional delivery plan.

- 19 In line with other regions in Wales, the challenges that currently exist include a high turnover of staff, vacancies in both the health and social care sectors, variable pay in identical posts within the Health Board and councils, the impact of BREXIT, qualification requirements and the large sums paid out for agency staff by providers. The NWWB is working on the Foundation Economy Challenge Fund project which is developing a business model for a not-for-profit staffing agency to help tackle the workforce challenges across North Wales around recruitment, retention and training of the region's social care and health workers.
- 20 The Social Care Workforce Development Partnership circulates information on training and recruitment which informs and encourages staff and potential recruits to get involved across North Wales. And Flintshire is working on value-based recruitment to attract people who want to work in the care sector.
- 21 The region is currently in the process of agreeing a new North Wales pre-placement agreement (PPA) and has extended the current version where these are in place, until the new version can be introduced. However, some placements are not covered by a PPA because those providers have decided not to sign the agreement. PPAs cover things like registration requirements, quality monitoring, reference to payment processes and payments after death. Service specifications are also not in place across the region. In working to introduce a new version of the PPA, partners should be aiming to limit and ideally eliminate instances where providers refuse to sign the new PPA. Not having these agreements and specifications in place poses a significant risk to the service users' placement especially where disputes arise.
- 22 Councils and the Health Board commission on a spot purchase basis, generally within a pricing framework. Whilst this means that they only pay for the services they use, it also means that if there are potential financial benefits from block contracts or cost and volume contracts, they are not realised. As a result, service users and partners could be paying more than they should.

The Regional Partnership Board's 2018 Market Shaping Statement set out some aspirations for care home commissioning which were added to by the RPB's response to 'A Heathier Wales' in 2019, however, neither of these have driven the development of a clear regional strategy for commissioning care home placements for older people in North Wales or a delivery plan to take forward the aspirations that have been identified

- 23 The Social Services and Well-being (Wales) Act 2014 'codes and guidance' state that local health boards and councils should, in relation to care homes, agree an appropriate integrated regional market position statement and regional commissioning strategy. These should specify the outcomes required of care homes, including the range of services required. There should also be an agreement on the methods of commissioning (for example, some services may require a block contract, step up, step down intermediate care services, respite care, etc).
- 24 Partners in North Wales hold considerable data locally on their service users, the range of services across the region such as service users in care homes, those receiving domiciliary care support, extra care housing provision and other support services. Whilst the Statement projects potential increased care home placements based on current numbers and population forecasts, it does not provide any data or projections of the impact of preventative services on care home placements.
- 25 In North Wales, partners' preferred model of care home provision for older people differs. The demographics across the region vary considerably, which means that demand and commissioning needs vary. Some councils have retained their in-house care homes whilst others rely on the independent sector for care home placements. Those remaining councils have a mix of in-house and independent provision. Some parts of the region have an oversupply of some types of care home places although others lack capacity in specialist areas such as dementia care. Whilst some partners may prefer larger, newer care homes others prefer smaller care homes, but choice is largely down to what is actually available, or what could be supported in the locality. Most see extra care housing replacing some of the current care home capacity.
- 26 Despite these differences, to comply with the Act, North Wales regional partners developed their Market Shaping Statement – **Care homes for older people in North Wales** (the Statement) in 2018 based on its population assessment. The statement commits to tackling a range of issues including workforce skills, the Welsh language, and the fee methodology. The Market Shaping Statement stated

that: 'There may need to be a rationalisation of provision across North Wales; for example, in some areas there is a shortage of residential care provision and in others there is an over-supply – this will require joined-up strategic development to ensure that home owners are aware of projected future demand and that commissioners and owners work together to develop the workforce to meet the anticipated needs (dementia and complex physical health conditions).' Whilst it set out some of the issues, and aspirations for care, it did not provide a clear regional strategy or delivery plan for care for older people in care homes in the future.

- 27 Of course, a regional strategy does not mean that everything must be done on a regional footing. A regional approach may be appropriate where there is an explicit need for services to be commissioned and delivered consistently or where demand is low for very specialised services. A regional approach may also provide the platform for a North Wales solution and prevent costly and sometimes poor service-user experiences from out of area placements. There may also be opportunities to create economies of scale through regional commissioning and delivery. On the other hand, a sub-regional approach could be achieved where partners want to work together to shape and adapt services to meet local circumstances. A local approach could continue where things work well, but could benefit by alignment with regionally agreed standards, processes, and fee structures. Whilst national policy assumes a regional approach, partners will need to agree how a regional approach can benefit North Wales and what remains best managed locally. In North Wales, partners operate with a mix of regional, sub-regional and local arrangements but the merits and limitations of each have not been formally considered by the RPB.
- 28 Partners will need to be bold if they are to shape the care home market. This starts with an agreed vision, an understanding of the shape of the care market in the future and transparency in how they will deliver the transition, engaging meaningfully with providers.
- 29 Although the Market Shaping Statement committed to publishing a delivery plan to underpin it, this work has not been completed. Whilst the COVID-19 pandemic had major capacity implications for social care and health partners during 2020 and to date, it should be noted that the Statement was approved in 2018. Partners could therefore have been developing a delivery plan during 2018 and 2019 to set out how the important issues it raised would be addressed.
- 30 While the RPB through its response to 'A Healthier Wales', in 2019, talks about the potential changes needed in the volume and type of care home placements needed for older people, it did not capture this in an overall care home commissioning strategy or a delivery plan to explain how it will get from where it is now to where it needs to be.
- 31 We observed the North Wales Commissioning Board meeting on 24 February 2021 as part of this review. At this meeting attendees agreed the Board's priorities for 2020-2022 in respect of planning for the next iteration of the Market Shaping Statement. This gives the RPB an opportunity to update the Statement and

develop a clear strategy and delivery plan, to shape the market and pattern of care home provision especially in relation to the more complex and specialist care, which for some users is currently provided out of region.

As previously reported, the current pooled fund arrangement does not provide value for money or any of the intended benefits associated with the pooled fund model

- 32 As referred to earlier in this report, partners are required under the Act to establish and maintain a pooled fund arrangement to support the delivery of their care home accommodation functions. In 2020, Audit Wales raised concerns about how the six North Wales councils and Health Board had sought to meet these obligations. We concluded that whilst the current pooled fund arrangement meets the minimum technical compliance, as agreed by the Welsh Government, it does not provide value for money. The Auditor General wrote to each North Wales council and the Health Board in September 2020, proposing that they should review the current pooled fund arrangement for residential care for older people, to ensure that transfers of funds between public bodies have a tangible benefit such as better, more integrated commissioning of residential and nursing home care. The Auditor General also wrote to the Welsh Government raising his concerns.
- 33 The RPB was also advised about recommendations made in a separate Welsh Government commissioned report⁴ on pooled budget arrangements for older people's residential care across Wales. All RPB chairs have been asked by the Welsh Government for their improvement plans detailing how they will address the nine recommendations set out in that report, including how they will use the Association of Directors of Social Services Cymru toolkit, which has been available since summer 2019, to support the development of pooled funds. These plans were expected to strengthen pooled fund arrangements and identify the steps which can be taken at an all-Wales level to share learning. To support this approach, the Welsh Government asked the National Commissioning Board to work with RPBs to develop regional commissioning and pooling of resources.
- 34 The RPB chair replied to the Welsh Government on 1 March 2021 setting out partners' reasons for delaying any progress with the pooled fund arrangement until the Welsh Government had considered responses to the White Paper – **Rebalancing Care and Support** because of its potential impact on the role and function of the RPB. The RPB has clearly stated its view that pooled budgets should be based locally and not on a larger regional footprint. It is understood that

⁴ Welsh Government, [Welsh Government Pooled Budgets Evaluation Framework focusing on the use of pooled budgets relating to care home accommodation for people aged over 65](#), June 2020.

the RPB is in ongoing dialogue with the Welsh Government on the best way to implement the Act more broadly, and not just in relation to the use of pooled budgets.

- 35 Whilst the stance of partners on pooled budgets at the regional level up to this point is noted, there has been a recent Ministerial Statement setting out the next steps following the consultation on the White Paper. The Statement sets out an expectation of effective partnership working at all levels, including regionally. It also highlights the benefits of a regional approach in providing care to service users with complex needs. With that as context, the existing recommendation we made to all North Wales RPB partners in respect of pooled budgets remains in place. This stated that RPB partners should review the current pooled budget arrangement for residential care for older people, to ensure that transfers of funds between public bodies have a tangible benefit such as better, more integrated commissioning of residential and nursing home care.

Whilst the RPB network brings partners together to 'think regionally', its structures, largely set out by the Welsh Government, are extensive and complex, and lines of accountability need to be strengthened

- 36 The Act sets out RPB membership; it can comprise a councillor from one council in the region, Directors of Social Services, a Local Health Board member, a council housing and an education representative, a registered social landlord, a member of the public and a carer. Additional members can be co-opted as necessary such as members from the Wales Ambulance Service, Fire Service and Police. With the North Wales RPB comprising six councils and the Health Board, this routinely results in over 30 people attending each meeting.
- 37 The RPB structure has evolved over time; whilst it is subject to local context, much is as set out by the Welsh Government. The North Wales RPB is supported by a Regional Leadership Group and Regional Collaboration Team. Four Transformation Boards covering Learning Disabilities, Community Services and Children and Young People and the Together for Mental Health Board underpin the work of the RPB. There are three Local Implementation Teams, specific to mental health and three Area Integrated Service Boards operating sub regionally, covering Wrexham and Flintshire, Gwynedd and Anglesey, and Conwy and Denbighshire. The establishment of these boards and Local Implementation Teams shows that partners recognise the benefits of sub-regional working and have developed arrangements that cover local differences whilst supporting the regional approach. The RPB is further supported by groups, boards and networks as follows:
- Carers Operational Group
 - Commissioning Board

- Workforce Board
- Mwy na Geiriau Forum
- Dewis Cymru network
- Pooled Budgets Group
- Welsh Community Care Information System Board
- Social Value Steering Group
- Integrated Care Fund Operational Group
- Research Innovation and Improvement Hub
- Integrated Autism Service Strategic Group

Appendix 1 sets out these groups in an organisation chart.

- 38 The establishment of these groups shows that partners come together to address some of the detailed aspects of RPB business. Attendance at these meetings can be considerably time consuming but demonstrates commitment to partnership working across the region. Although this shows that the RPB is maturing in the way it conducts its business, the scale of the RPB structure and operation makes it quite unwieldy and presents challenges for the way it operates.
- 39 The Welsh Government has set out its expectations for integrated services clearly in legislation and supplementary guidance, which includes the role of the RPB in delivering this change. We identified barriers to more regional integration in North Wales as follows:
- organisational difference – priorities, approaches, and accountability;
 - perceived reduction in accountability presented by the additional layer of governance;
 - funding source and additional costs;
 - local control versus regional control;
 - scale and diversity of the region;
 - lack of willingness to share resources; and
 - lack of trust amongst some partners.
- 40 When taking part in RPB meetings, officers, and councillors, may not have delegated authority to commit their own organisation's resources or decide on policy and strategic direction. Whilst RPB members are accountable within their own organisational governance arrangements, there is no evidence to demonstrate decisions are taken back for approval, or that the RPB business is subject to formal scrutiny to hold it to account or challenge its proposals.
- 41 The Regional Leadership Board is briefed by members of the RPB on the activities and proposals made. However, this Board does not have the delegated authority to commit individual councils' resources or decide on policy and strategic direction. In addition, the RPB is not held to account for delivering impact or meeting legislative requirements by partners or the Welsh Government.

Nationally set fee structures are complex and result in a significant focus on cost which causes division amongst partners and has the potential to impact adversely on service users and their families

The fees paid for care home placements fluctuate depending on the service user's own resources, which public body makes the placement and contractual arrangements with providers, and fee rates do not necessarily reflect the complexity of residents' care needs

- 42 The funding arrangements for care homes are complex. At a high level, responsibility for care home fees is straightforward. A person can choose to move to a care home at their own expense if they have the resources to pay. If a person has primary health needs, then the health board is responsible for meeting the full costs. If a person has social care needs, the council is responsible for meeting these costs, but the service user will be assessed to determine how much they should pay towards their care. And if a person has a combination of health and care needs then the council and health board will share the costs. However, the detail that sits behind how this works in practice is complex and confusing.
- 43 For example, if a council contracts for the placement, the maximum amount a service user pays for their care per week varies depending on where they live. For example, a person with over £50,000 capital, living in Anglesey or Gwynedd, receiving the lowest level of care in a care home would pay £586.32 per week if they were placed in Anglesey or Gwynedd. However, if the same person were placed in Conwy, they would pay £611 per week, a difference of £1,283 per year. Alternatively, if placed in Wrexham, they would pay £608.72 per week, a difference of £1,164 per year. Some people may choose to move into a care home outside their area; but if the decision is made because of limited local care home capacity, service users are directly affected financially by market capacity.
- 44 Councils and the Health Board negotiate with providers each year to agree fees for residential care and nursing home placements. Councils pay an enhanced rate in each category for people with mental health problems.
- 45 The fees are calculated using a toolkit originally adapted in 2013 for North Wales. This toolkit is designed to set out the costs that have been considered in the calculation of the care home fees. It provides transparency in the process and should provide a fair fee structure, although some providers do not routinely share their business accounts to support the process. We were told during the review that over a third of providers consider that their costs are not covered by the toolkit

assumptions, so they renegotiate their fees separately with each council. One council told us that a provider in their area had six homes all with different fee rates and around 20% of providers in that area had renegotiated their fees in 2019-20. If a council places one of its residents into the home in a neighbouring council, it will pay the rate set by that council, whether it be higher or lower, not the rate it has agreed with that provider for in-county placements.

- 46 Where councils commission the placement, these should be at the agreed rates or the individually renegotiated weekly rate. Service users will be financially assessed in line with Welsh Government guidance to determine how much they should pay per week towards their care costs, and if they are able to pay the full cost themselves then they will pay the rate agreed by the council. Under the Welsh Government's COVID-19 hardship fund, a £50 per week per resident temporary fee uplift was awarded for council commissioned residential care and in-house residential care provision; this is in addition to the care home fees.
- 47 If a service user chooses a care home where the provider will not accept the prices agreed with the councils, another person, normally a relative or a friend may agree to pay a third-party top up which is the difference between the care home fees and the amount the Council would normally pay. If the third-party ceases to pay the top up amount there are three choices:
- the care home accepts the lower agreed rate;
 - the service user moves to a care home that accepts the agreed fees; or
 - the Council agrees to pay the top up in addition to the fees it has agreed to pay.

We understand that often councils agree to pay the top up to avoid disruption to the service user.

- 48 If the service user is entitled to Funded Nursing Care⁵, the Health Board pays £179.79 per week in addition to the Council's agreed fees. And if the Health Board makes a placement under its Continuing Health Care (CHC) arrangements, it will pay different fees again.
- 49 In 2019, the Health Board had started to review its fees and the method used to set the CHC rate. The review of fees is set to take up to three years. If the service user has higher than average complex care needs, the Health Board will assess the additional costs and agree a rate above the standard CHC rates.
- 50 In some cases, councils and the Health Board will agree to jointly fund a placement. This sometimes increases the complexity of the placement process. In such cases this may require a separate agreement with a different fee.
- 51 In some cases, the Health Board may place a person in a nursing home and their health might improve, resulting in the Health Board no longer being liable for the

⁵ NHS-funded Nursing Care (FNC) is funding provided by the NHS to cover the cost of care by a registered nurse in a care home or nursing home. The rate is set nationally.

costs. In these cases, councils may come under pressure to pay the same rates as agreed with the Health Board, which may exceed the agreed standard rate.

- 52 The Health Board has also been allocated additional COVID-19 hardship funding and has been able to use some of this funding to speed up discharge from hospital. Having another funding stream adds further complexity to the care home fee structures. However, it may in turn add further pressures to councils where they take over responsibility for the placement for which providers have been receiving a higher weekly rate but now need to drop to agreed rates.
- 53 When a service user's needs change, this can result in changes in funding packages, at which stage responsibility for funding may change from council to health board. In line with national policy, care funded by a health board is free to the service user. The Health Board is planning work to support care homes to help the homes better identify and evaluate when changes to care packages are needed.

Providers consider the fees paid to be unfair and inequitable

- 54 The public sector in Wales has been dealing with the consequences of financial austerity for many years. The emphasis has therefore been on providing and commissioning services at the lowest possible cost. For care homes this has resulted in scrutiny of their fees to set affordable rates balanced against the need for providers to remain viable as businesses. In North Wales, this is done using the fee setting toolkit.
- 55 Providers we spoke to during this review raised concerns about the toolkit used to calculate the fee levels. The size of the homes differs considerably, therefore economies of scale may vary. Providers accepted that there needs to be a transparent process to agree fees but questioned the extent to which the toolkit satisfies this need, and we noted that many providers do not share their accounts. The need for change is recognised within the Statement where in 2018, partners committed to 'Reviewing the true (full) cost of council homes & cost of care at home in relation to value for money comparisons and to develop an urgent response procedure to react to changes in the cost of running homes or when the providers identify a financial problem.' The Unit Cost and Financial Modelling Subgroup which includes providers' representatives has begun work to assess the true cost of care in line with the Welsh Government's 'Let's Agree to Agree' Framework.
- 56 Some providers have several homes in different parts of North Wales where the agreed fees are different for what they see as the same service level and infrastructure costs. And some providers may have homes in other parts of Wales where fees are higher than in North Wales. While in many cases this will be because of local differences in costs, in some cases these variations could

potentially result in other councils effectively cross subsidising the lower care home fees paid by North Wales councils and the Health Board.

- 57 Providers recognise that they compete when recruiting staff but raised the perceived inequalities in the toolkit calculation. The toolkit includes carer costs based on the minimum wage⁶ whereas councils and the Health Board pay their own staff the living wage⁷ or above.

Commissioners consider they have little control over the fees they pay

- 58 Care home costs are considerable. For example, basic care in a Denbighshire or Gwynedd care home would cost £30,489 per year, increasing to £48,776 for nursing home care with continuing health care in Conwy or Denbighshire. In some cases, councils are sometimes left with no choice other than to accept responsibility for commitments made by the Health Board or relatives or friends who discontinue third-party top up payments at higher rates than those described here. This is a symptom of two separate national funding models across Health and Social Care as well as an interface between partners that is not truly integrated. It is unsurprising therefore that public sector bodies have such a keen focus on managing cost.

Partners need to do more to demonstrate they are meeting their statutory responsibilities around the Welsh language, and the Well-being of Future Generations Act, when commissioning care homes provision and making individual placements

The Well-being of Future Generations (Wales) Act 2015 is not fully embedded in practice

- 59 The Well-being of Future Generations (Wales) Act 2015 (WFG Act) places a well-being duty on public bodies. To do this, they need to consider the sustainable development principle, acting in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The WFG Act requires public bodies to implement five ways of

⁶ A 23-year-old and over would be entitled to £8.91 per hour living wage.

⁷ The UK Living Wage is £9.50 per hour for 2021-22.

working in respect of their future decision making. Our observations on the five ways of working in respect of care home commissioning is as follows:

- **Long-term.** Partners are facing considerable growth in the North Wales older population as referred to in the Shaping the Market Statement, but partners have not yet set out their plans for meeting the consequential increasing care home needs.
- **Prevention.** Under the WFG Act, public bodies are required to deploy resources to prevent problems occurring or getting worse. In the case of older people's need for care home placements, partners face a clear challenge with the forecast increases in the older population in North Wales. The Market Shaping Statement lacks detail about how partners plan to reduce the demand for care home placements by investment in preventative services, although preventative action is evident through the RPB demonstrating that partners are meeting the prevention obligations under the Act.
- **Integration.** Whilst the precise wording of well-being objectives varies across public sector bodies in North Wales, there is commonality around care for vulnerable people, suitability of where people live and addressing inequalities. North Wales partners have developed a Dementia Strategy and a Carers Strategy, which demonstrates integrated planning in these areas, however, the lack of a strategy or delivery plan linked to the Shaping the Market Statement indicates that integrated planning to meet the needs of older people requiring care home accommodation is in its early stages.
- **Collaboration.** The WFG Act states that a public body must take account of how acting in collaboration with others could assist the body to meet its well-being objectives or assist another body to meet its objectives. Partners meet in a range of settings to consider the challenges they face in relation to the increasing older population, however, what is less clear is how partners are 'acting' collaboratively to address the challenges within the commissioning process.
- **Involvement.** In North Wales, the RPB includes a carer, and they can contribute to the business based on their experiences. However, in practice many discussions take place outside the RPB meetings between statutory partners or in sub-groups, forums or boards which will not generally involve the carer representative. North Wales partners have processes in place to seek the views of people living in the care home. Whilst those involved in the commissioning of care home placements are aware of service users' experiences, such as the costs they bear through third-party top ups, partners do not collate, report, or quantify these experiences and have not acted effectively as partners to learn from this feedback.

Service user language requirements are sometimes not protected, leading to communication difficulties

- 60 The Welsh Language Act 1993 put the Welsh language on an equal footing with the English language in Wales, and the Welsh Government has subsequently set legally binding standards⁸ to improve the bilingual service that the people of Wales can expect to receive from certain public and statutory bodies. The Language Standards are divided into five different categories that include service delivery and policy making. Partners are working with providers to improve access to care services in the service user's language of choice.
- 61 The North Wales More Than Just Words Regional Forum was awarded a special commendation for their work which promotes collaboration, to fulfil the requirements of the Welsh Government's strategic framework relating to the quality and availability of the Welsh Language in social care and health settings.
- 62 However, as described earlier in this report, the shape of the care home market in North Wales sometimes results in service users being placed in other parts of Wales or in England, because the specialist nature of the care is not available locally or to accommodate family links elsewhere. For relatives and friends this can mean long journeys to visit the service user and for people whose preferred language is Welsh, this makes communication difficult if the home does not employ Welsh-speaking staff, with potential consequences for the quality of care for the individual. This also represents a break in culture and a sense of place.

⁸ www.welshlanguagecommissioner.wales/public-organisations/welsh-language-standards

Recommendations

Exhibit 2: recommendations

Exhibit 2 sets out recommendations for North Wales councils and Betsi Cadwaladr University Health Board arising from this review.

Recommendations	
R1	North Wales councils and Betsi Cadwaladr University Health Board need to ensure the consistent use of pre-placement agreements across the region.
R2	The current approach for commissioning care home places can cause tensions between partners and result in poor value and poor service user experience. North Wales councils and Betsi Cadwaladr University Health Board need to work together to review local arrangements for commissioning care home placements to eliminate avoidable adverse impacts on service users, and each other.
R3	Accountability is a cornerstone of public sector decision making. Governance arrangements need to scrutinise decisions and hold decision makers to account. North Wales councils and Betsi Cadwaladr University Health Board need to strengthen their partnership governance arrangements to ensure proper accountability and effective scrutiny.
R4	North Wales councils and Betsi Cadwaladr University Health Board through the Regional Commissioning Board need to develop a regionally agreed care home commissioning strategy and following this, develop an associated delivery plan.
R5	North Wales councils and Betsi Cadwaladr University Health Board need to review their commissioning arrangements for care home placements to ensure they fulfil their statutory responsibilities around the Welsh language, and the Well-being of Future Generations Act.

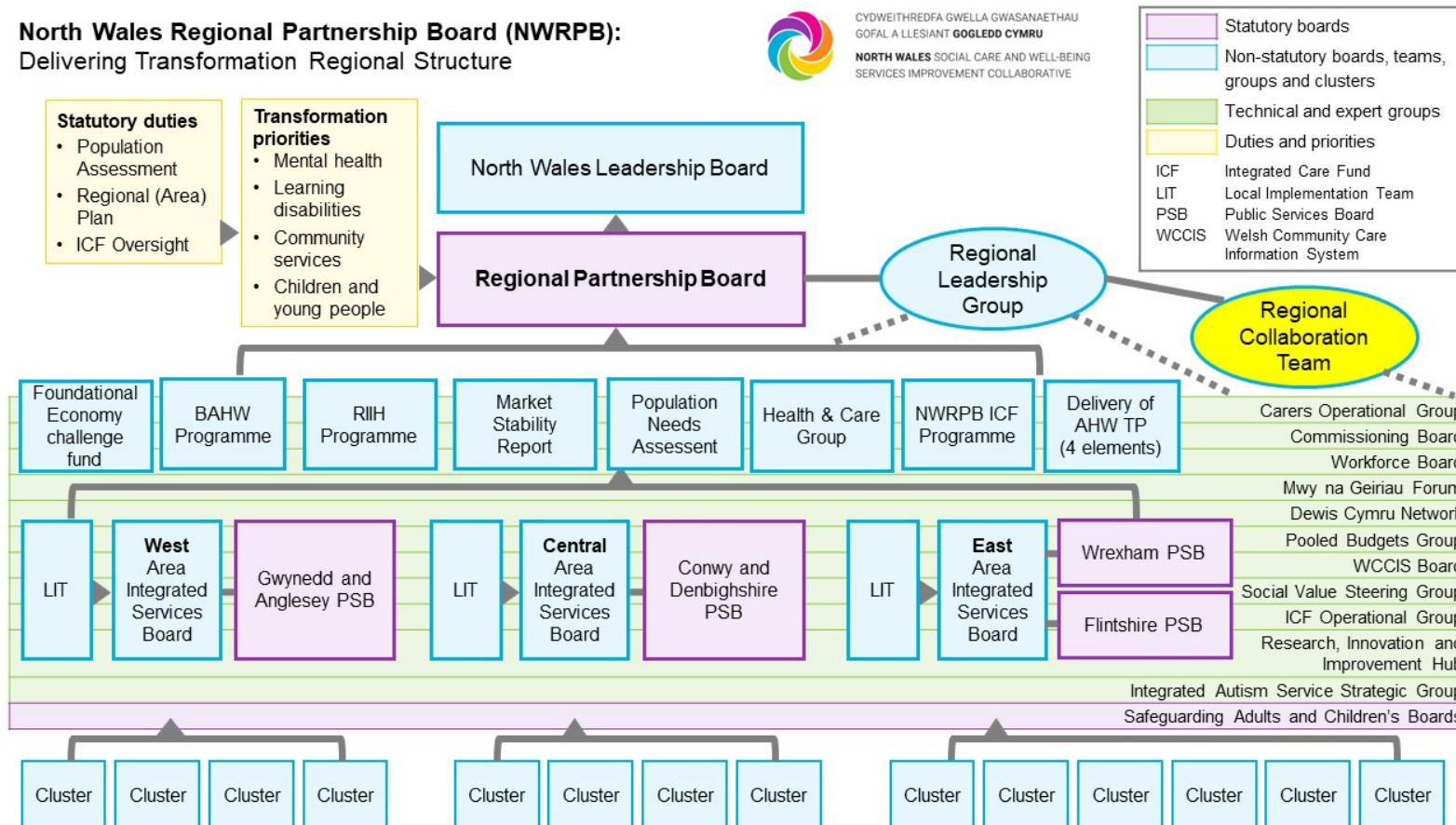
Appendix 1

Regional Partnership Board structure chart

North Wales Regional Partnership Board (NWRPB): Delivering Transformation Regional Structure



CYDWEITHREDFA GWELLA GWASANAETHAU
GOFAL A LLESIANT GOGLEDD CYMRU
NORTH WALES SOCIAL CARE AND WELL-BEING
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We welcome correspondence and
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Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.



Cyfarfod a dyddiad: Meeting and date:	Audit Committee – 15th March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Joint Management Response to the Audit Wales report on Commissioning Older People's Care Home Placements						
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director Transformation, Strategic Planning and Commissioning,						
Awdur yr Adroddiad Report Author:	Clare Darlington, Acting Associate Director Primary Care (Strategy)						
Craffu blaenorol: Prior Scrutiny:	Finance & Commissioning leads for CHC have had the opportunity to comment and amend the management response. Executive Team – 2 nd February 2022						
Atodiadau Appendices:	Appendix 1: Joint Management Response						
Argymhelliad / Recommendation:							
It is recommended that the committee:							
<ul style="list-style-type: none"> Notes the recommendations in the Audit Wales (AW) report on Commissioning of Older People's Care Home Placements by North Wales Councils and Betsi Cadwaladr University Health Board Notes the Audit Wales request to bring the collective management response to the Health Board Audit Committee in March 2022. Endorses the actions in the joint Management Response to address the recommendations and agrees that regular updates on the implementation of the actions are received by the Partnerships People & Population Health Committee going forward. 							
Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	<input type="checkbox"/>	Ar gyfer Trafodaeth For Discussion	<input checked="" type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input checked="" type="checkbox"/>	Er gwybodaeth For Information	<input type="checkbox"/>
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:							
Audit Wales published their review of Commissioning of Older People's Care Home Placements by North Wales Councils and Betsi Cadwaladr University Health Board in December 2021, which was considered by the Audit Committee in private session on the 14 th December 2021.							

A joint Management Response was requested by 31st January 2022. This has been developed with partners and actually submitted on 4th February, noting that each partner would subsequently be taking the response through their individual governance processes.

Cefndir / Background:

As part of its Audit programme in August 2020 Audit Wales informed Local Authorities and the Health Board that it would be undertaking a review of Commissioning of Older People's Care Home Placements by North Wales Councils and Betsi Cadwaladr University Health Board. A workshop was held by AW with local authority and health board partners in September 2020 to work through the draft brief for this review. The final brief for the review was issued in November 2020.

The brief included the purpose of the Audit Wales review, which stated

"In our Assurance and Risk Assessments for North Wales councils we identified strategic commissioning of residential and nursing care placements as a risk to both councils and the Health Board for the following reasons:

- a. high level of spending on these services;*
- b. forecast increases in numbers of older people expected to need these services;*
- c. limited availability of new staff to support these services and recruitment competition with other health and social care providers; and*
- d. as yet untapped potential benefits of strategic commissioning across North Wales public sector bodies.*

Since identifying strategic commissioning of residential and nursing care placements as a risk, COVID-19 has highlighted the fragility and current capacity of the care market and the need to plan strategically and manage the market"

The brief explained that the review would seek to answer the question *"Are partners collaborating effectively to take account of demographic changes and other external pressures in the strategic commissioning of residential and nursing home care?"*

And focused on the following key questions:

- a) Are partners collaborating effectively to take account of demographic changes and other external pressures in the strategic commissioning of residential and nursing home care?
- b) Have partners formally committed to the strategic approach to commissioning residential and nursing home care?
- c) Have partners identified and secured commitment for the resources needed to deliver the strategy and is there commitment to manage these through the pooled budget arrangement?
- d) Does the strategy for commissioning residential and nursing home care align with other key strategies and meet legislative requirements?
- e) Is change related to delivery of this strategy being managed and reported effectively?

The Audit Wales team undertook fieldwork, document reviews, meeting observations and interviews with staff and service users from November 2020 to February 2021.

Audit Wales issued the draft final report to Local Authorities and the Health Board to comment on matters of accuracy in July 2021. The Health Board prepared a response and a collective response was prepared by the North Wales Local Authorities.

Audit Wales published the North Wales report on the 16th December 2021.

Asesiad / Assessment & Analysis

The Audit Wales report on the Commissioning of Older People's Care Home Placements by North Wales Councils and Betsi Cadwaladr University Health Board makes 5 recommendations:

- R1 North Wales councils and Betsi Cadwaladr University Health Board need to ensure the consistent use of pre-placement agreements across the region.
- R2 The current approach for commissioning care home places can cause tensions between partners and result in poor value and poor service user experience. North Wales councils and Betsi Cadwaladr University Health Board need to work together to review local arrangements for commissioning care home placements to eliminate avoidable adverse impacts on service users, and each other.
- R3 Accountability is a cornerstone of public sector decision making. Governance arrangements need to scrutinise decisions and hold decision makers to account. North Wales councils and Betsi Cadwaladr University Health Board need to strengthen their partnership governance arrangements to ensure proper accountability and effective scrutiny.
- R4 North Wales councils and Betsi Cadwaladr University Health Board through the Regional Commissioning Board need to develop a regionally agreed care home commissioning strategy and following this, develop an associated delivery plan.
- R5 North Wales councils and Betsi Cadwaladr University Health Board need to review their commissioning arrangements for care home placements to ensure they fulfil their statutory responsibilities around the Welsh language, and the Well-being of Future Generations Act.

In response to the report, the North Wales Local Authorities and the Health Board was asked to prepare an agreed collective management response detailing how they will work collectively to address each of the recommendations. Audit Wales asked for this collective response to be submitted by 31st January 2022. The Management Response was developed between the relevant leads and a final draft version submitted is in Appendix 1.

The draft management response was considered by the Executive team on the 2nd February who noted the following:

- That there was no explicit reference to exploring meaningful pooled budgets and felt that the AW report provided a helpful opportunity to give further thought to such opportunities;
- The need for the management response to be agreed through appropriate governance structures of each organisation and the RPB.

It was agreed with the Head of Regional Collaboration that pooled budgets would be considered as part of the actions contained within the management response.

Of note is the additional short report, '*Care Home Commissioning for Older People*', also published by AW in December 2021, which expands on their work in North Wales to further consider some issues of wider national significance and to make recommendations for the Welsh Government to consider. Their aim is to highlight challenges that should be considered as part of planned policy reform and to secure meaningful change. The report is rooted in evidence from their work in North Wales, but has

also drawn on their wider audit intelligence such as from our all-Wales review of the Integrated Care Fund in July 2019 and publicly available data on spending and activity.

The report recommends that Welsh Government:

- R1 considers what the findings from the work in North Wales mean for planned policy reform and whether these reforms will go far enough to tackle the root causes of the issues;
- R2 more specifically that it:
 - should reduce the complexity of the funding responsibilities across partners to streamline arrangements;
 - clearly describes and communicates how it expects pooled funds to operate across health and social care partners;
 - takes measures to require strengthened scrutiny arrangements and accountability of Regional Partnership Boards (following through with further action in response to a recommendation in our previous report on the Integrated Care Fund); and
 - develops a framework for outcome-based performance reporting, which links to policy ambition and the seven well-being goals for Wales

The delivery of the actions in the management response considered in this report will need to be cognisant of the work also being undertaken at a national level by Welsh Government.

Strategy Implications

Strategic commissioning of residential and nursing care placements was identified by Audit Wales as a risk to both councils and the Health Board. The recommendations in the final Audit report and subsequent management response seek to address this risk.

Options considered

n/a

Financial Implications

There are ongoing financial implications in relation to CHC commissioning generally which will need to be constantly reviewed as part of the implementation of the recommendations of the Audit Wales report.

Risk Analysis

The risk assessment in implementing the management response is outlined below:

Ref	Description and mitigating action
Risk1	Officer capacity and time to implement the actions in the Management Response may delay meeting the deadlines given Mitigation: Allocated leads with dedicated time to undertake the work required
Risk2	Relationship between local commissioning plans and the required regionally agreed care home commissioning strategy and associated delivery plan. Mitigation: Mapping the relationship between local and regional plans and clarity on which aspects of the delivery plan are implemented locally and which regionally
Risk3	Failure to ensure that we fulfil statutory responsibilities around the Welsh language, and the Well-being of Future Generations Act in our care home placement provision. Mitigation: Mwy na Geiriau implementation and ensuring the Local Wellbeing Assessments and 7 Wellbeing Goals inform our commissioning plan for the future as part of the Population Needs Assessment and Market Stability Report work

Legal and Compliance

L&R advice will be sort as required for the management actions, independently and in partnership as necessary.

Impact Assessment

Equality Assessments will be undertaken as required in relation to the delivery of the management actions.

Management response

Report title: Commissioning Older People's Care Home Placements – North Wales Councils and Betsi Cadwaladr University Health Board

Completion date: December 2021

Document reference: 2467A2021-22

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Management response	Completion date	Responsible officer
R1	North Wales councils and Betsi Cadwaladr University Health Board need to ensure the consistent use of pre-placement agreements across the region.	Increased transparency of roles and responsibilities to support the contracting process. Additional level of service user protection.	Yes	<p>We are currently finalising the review of the North Wales PPA. A new PPA agreed with CFW will be in place by April 2022.</p> <p>Following this LA and HB commissioners will issue the new PPA to their providers and track providers who have signed and returned the PPA.</p> <p>We will also develop an agreed consistent approach and process for dealing with those providers who refuse to sign the PPA.</p>	Sept 2022	<p>Lead: Joint Chairs of Regional Commissioning Board</p> <p>Operational: Local Authority Commissioning Managers</p> <p>Health Board Commissioning Managers Regional</p> <p>Supported by: Business Manager – Commissioning & Workforce</p>

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Management response	Completion date	Responsible officer
R2	The current approach for commissioning care home places can cause tensions between partners and result in poor value and poor service user experience. North Wales councils and Betsi Cadwaladr University Health Board need to work together to review local arrangements for commissioning care home placements to eliminate avoidable adverse impacts on service users, and each other.	Identification of organisational blockages within the process to aid resolution	Yes	<p>We will hold workshops with all Local Authority and Health board commissioners to review their current care home commissioning arrangements in order to:</p> <ul style="list-style-type: none"> - ensure all commissioners are aware of each other's processes - to identify and share process improvement ideas and learning - to identify common practice and why / where different commissioning practice and processes occur. 	Sept 2022	<p>Lead: Local Authority Commissioning Managers</p> <p>Health Board Commissioning Managers</p> <p>Supported by: Regional Business Manager – Commissioning & Workforce</p>

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Management response	Completion date	Responsible officer
R3	Accountability is a cornerstone of public sector decision making. Governance arrangements need to scrutinise decisions and hold decision makers to account. North Wales councils and Betsi Cadwaladr University Health Board need to review and strengthen their partnership governance arrangements to ensure proper accountability and effective scrutiny.	Better accountability of people working in partnership by increasing transparency and opportunity for robust challenge and scrutiny of decisions by sponsoring organisations. This will also reduce the potential for external challenge and/or judicial review.	Yes	Review of RPB membership, terms of reference, accountability and decision making scope is currently underway. This will look at the link between local decision making and RPB decision making with a focus on how to ensure and evidence local decision making input in to the RPB's decisions and also how the RPB is accountable to local democratic structures in the Local Authorities and the Health Board.	Dec 2022	Lead: Chair of Regional Partnership Board Operational: Head of Regional Collaboration Advice from: Regional Legal Service & Local Authority Governance leads

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Management response	Completion date	Responsible officer
R4	North Wales councils and Betsi Cadwaladr University Health Board through the Regional Commissioning Board need to develop a regionally agreed care home commissioning strategy and associated delivery plan.	A clear, agreed and approved approach for public sector partners in North Wales to address the major strategic challenges experienced both currently and projected in the longer term in relation to care home commissioning. Together with an approved plan detailing how they intend to get from where they are today to where they want to be in the future.	Yes	We will build on work undertaken to develop the Regional PNA and MSR documents and the Steering Group will remain in place to move forward with the themes from the PNA-MSR in to the Regional Commissioning Strategy for Care Home Commissioning. They will also be responsible for developing the delivery plan which will cover regional, sub-regional and local actions and link in to the local MSR and PNA documents / analysis.	March 2023	<p>Lead: Joint Chairs of Regional Commissioning Board</p> <p>Operational: MSR-PNA Steering Group Members</p> <p>Regional Business Manager – Commissioning & Workforce</p> <p>Local Authority Commissioning Managers</p>

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Management response	Completion date	Responsible officer
						Health Board Commissioning Managers

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Management response	Completion date	Responsible officer
R5	North Wales councils and Betsi Cadwaladr University Health Board need to review their commissioning arrangements for care home placements to ensure they fulfil their statutory responsibilities around the Welsh language, and the Well-being of Future Generations Act.	Clear and upfront consideration of statutory responsibilities around the Welsh language, and the Well-being of Future Generations Act in strategic planning of care home placements.	Yes	<p>The Mwy Na Geiriau Steering Group are already looking at way to improve staff confidence and capabilities in providing services in Welsh. Recruitment of Welsh speaking staff is a priority and a focus in the Regional We Care campaign.</p> <p>The Regional PNA-MSR Steering Group will build on their existing links with the Wellbeing Assessments and embed the delivery of the WFGA wellbeing goals in to their commissioning of care home placements and wider social care and community health provision.</p>	March 2023	<p>Lead: LA Directors of Social Care and Health Board Welsh Language Lead</p> <p>WFGA Goals = PNA_MSR Steering Group members</p> <p>Operational: Local Authority Commissioning Managers</p> <p>Health Board Commissioning Managers</p>

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Management response	Completion date	Responsible officer
						<p>LA and Health Board Workforce Managers</p> <p>Supported by: Regional Business Manager – Commissioning & Workforce</p>

Responsible Officer / Key Leads

Regional Partnership Board	
RPB Chair	Mary Wimbury
Regional Commissioning Board	
Joint Chair of Regional Commissioning Board	Morwena Edwards and Clare Darlington
Local Authority Commissioning Managers	
Mon Local Authority	Bethan Williams / Iola Richards
Gwynedd Local Authority	Rhion Glyn / Hawis Jones
Conwy	Mark Bowler
Denbighshire	Lianna Duffy
Flintshire	Jane Davies and Dawn Holt
Wrexham	Victoria Bishop and Angharad Owen
Health Board Commissioning Managers	
Contracts and Commissioning	Tracy Pope
CHC Commissioning	Kath Titchen
Regional Collaboration Team	
Head of Regional Collaboration	Catrin Roberts
Regional Business Manager	Catrin Perry
Regional Legal Support lead	??
PNA-MSR Steering Group leads	
Mon	Emma Edwards
Gwynedd	Hawis Jones
Conwy	Mark Bowler
Denbighshire	Sue Hudson
Flintshire	Emma Murphy
Wrexham	Victoria Bishop
BCUHB	Wendy Hooson
Mwy Na Geiriau Steering Group members	
TBC	??