

Bundle Audit Committee 29 June 2020

- 1.0 10:00 - OPENING BUSINESS - OPEN SESSION
- 1.1 10:01 - AC20/30: Apologies for Absence
- 1.2 10:02 - AC20/31: Declarations of Interest
- 1.3 10:03 - AC20/32: Procedural Matters
1. To confirm the Minutes of the last meeting of the Committee held on 19/03/20 (Annex 1) as a correct record;
2. To discuss any matters arising and further to Minute AC20/17.02, to note the Committee Breach log (Annex 2) reporting data from the start of this financial year. Further updates as we progress through the year will be reported to subsequent meetings.
3. To review the Summary Action Log (Annex 3); and
4. To formally note the changes to Standing Orders as documented in the two attached reports taken to the Board in April (Annex 4a) and May 2020 (Annex 4b) in view of the pandemic.
5. NHS Wales Guidance Note: Discharging Board Committee Responsibilities (Governance Principles) (Annex 5a&b). To note that the Audit Chair together with Internal and External Audit and the Board Secretary have reviewed the document in respect of the Audit Committee's specific responsibilities and can confirm compliance with all aspects. The Chair and Executive Lead of the Quality, Safety & Experience Committee have also reviewed the document and amended the Committee's agenda accordingly. The Health Board is currently undertaking the required Post Event Work which is required to be undertaken on the COVID-19 Emergency Management Expenditure for the Health Board to identify potential fraud. Details of the UK Cabinet Office COVID-19 Fraud Response Team - Fraud Control in Emergency Management has also been shared with Executive Management within the Finance team.
- AC20.32a: Annex 1_Minutes Audit Committee_Public_19.03.20 V0.02 approved by Chair.doc
- AC20.32b: Annex 2_Breach log for Audit Committee June 2020.docx
- AC20.32c: Annex 3_Public Summary Action Log_Audit Committee_live.docx
- AC20.32d: Annex 4a_Maintaining Good Governance Covid-19_April V1.0.docx
- AC20.32e: Annex 4b Maintaining Good Governance Covid-19_May V2.02 for Board 14.5.20.docx
- AC20.32f: Annex 5a - Governance principles.docx
- AC20.32g: Annex 5b - Governance principles annex.docx
- 1.4 10:13 - AC20/33: Issues Discussed in Previous Private Committee Session
- The Committee is asked to note the report on matters previously considered in private session.*
- AC20.33: Private Session Items Reported in Public.docx
- 2.0 10:18 - AC20/34 Risk Management Strategy / Policy
- The Audit Committee is asked to:*
- * Approve the further changes to the updated Risk Management Strategy and Policy as previously recommended.*
- * Gain assurance on the changes to the operational implantation of the strategy included within the Risk Management Improvement Plan.*
- * Approve the change in approach for managing risk from a 5 tier model to a 3 tier mode.*
- * Recommend the approval of the Risk Management Strategy to the Board.*
- AC20.34a Cover Sheet - Risk Management Strategy and Policy v2.docx
- AC20.34b Appendix 1 RM01 Risk Management Strategy and Policy - Draft 4.5.docx
- AC20.34c Appendix 2 Risk Management Improvement Plan v1.0.xlsx
- AC20.34d Appendix 3 Movement of Risks from 5 to 3 Tiers v3.doc
- AC20.34e Risk Management Strategy and Policy - EqlA Impact Assessment v2.docx
- 3.0 10:38 - AC20/35: Schedule of Financial Claims: Quarter Four of 2019/20 (over £50,000)
- The Audit Committee is asked to receive the report and approve payments in line with the Standing Orders.*
- AC20.35a Schedule of Financial Claims - Over £50k Spend Closed Q4 2019-20.docx
- AC20.35b Schedule Financial Claims_June 20_Word.docx
- 4.0 10:43 - AC20/36: Internal Audit Update

The Audit Committee is asked to:

- 1. Note and receive the Head of Internal Audit opinion and annual report for 2019/20.*
- 2. To approve the revised Internal Audit Plan 2020/21 which has been updated for COVID-19 Impact; and*
- 3. Note and receive the Deprivation of Liberty Safeguards (DoLS) limited assurance report. In view of the requirement to streamline virtual meetings and the progress made against the recommendations (all marked as implemented and approved by the responsible Executive) the Safeguarding Lead has not been asked to attend).*

AC20.36a BCUHB Internal Audit opinion and Plan 2020 Committee cover sheet June 2020.docx

AC20.36b BCUHB Opinion Annual Report 19-20Final.docx

AC20.36c BCUHB Internal Audit Plan 20-21 revised due to COVID-19v2.docx

AC20.36d Final internal audit report Deprivation of Liberty Safeguards.pdf

5.0 10:58 - AC20/37: Audit Wales Update Report

The Audit Committee is requested to:

- 1. Receive the report on the annual accounts.*
- 2. Receive and note the letters on the impact of covid on the external audit work programme.*
- 3. Receive and discuss the All-Wales report on Wellbeing of Future Generations progress.*

AC20.37a Audit Wales Coversheet.docx

AC20.37b: BCU ISA260 1920 final.pdf

AC20.37c: Letter to Chief Executives.pdf

AC20.37d: Update Letter on the AGW's programme of NHS Performance Audit work.pdf

AC20.37e: Well-being-of-Future-Generations-report-eng.pdf

6.0 11:08 - AC20/38: Issues of Significance for Reporting to Board

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

7.0 11:10 - AC20/39: Date of Next Meeting: 17/09/20

8.0 11:11 - AC20/40: Exclusion of Press and Public

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



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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

AUDIT COMMITTEE

**Draft Minutes of the Meeting Held in Public on 19.03.20
In the Boardroom, Carlton Court, St Asaph**

Present:

Medwyn Hughes Independent Member - Chair
Eifion Evans Independent Member
Jacqueline Hughes Independent Member
Lyn Meadows Independent Member

In Attendance:

Andrew Doughton Performance Audit Lead, Wales Audit Office (Via Skype for minute AC20/16)
Dave Harries Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP)
Sue Hill Acting Executive Director of Finance
Matthew Joyes Assistant Director of Patient Safety & Experience (for minute AC20/09 and AC2020/12)
Justine Parry Acting Board Secretary
Bethan Wassell Statutory Compliance, Governance & Policy Manager

| Agenda Item | Action |
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| <p>AC20/01 Opening Business and Apologies for Absence.</p> <p>A private meeting with Internal and External Auditors was held at 9.00am.</p> <p>The Chair welcomed Members and attendees to the meeting and advised that due to the current situation regarding COVID-19, a review of the agenda and attendees had been undertaken. Members agreed that agenda items would be taken out of order for efficiency.</p> <p>Apologies were received from: the Deputy Chief Executive / Executive Director of Nursing & Midwifery and the Executive Medical Director.</p> <p>Members proceeded with introductions in Welsh.</p> | |

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| <p>AC20/02: Declarations of Interest.</p> <p>AC20/02.01: The Acting Board Secretary declared an interest due to presenting the Corporate Risk & Assurance Framework which was aligned to her substantive role as the Assistant Director of Information Governance & Risk.</p> <p>AC20/02.02: The Acting Board Secretary proceeded to advise Members of the National update to the Electronic Staff Record (ESR) and the proposal to roll out an electronic Declaration of Interest module. This would duplicate the existing BCUHB provision. The Office of the Board Secretary would monitor the situation and feedback to Members whilst observing that COVID-19 work would take priority over any system assessment / evaluation.</p> <p>AC20/02.03: The Acting Board Secretary also drew Members attention to the recent email communication that was issued to all Independent Members regarding declarations of interest relating to the Betsi Cadwaldr University Health Board (BCUHB) Charitable Funds.</p> | |
| <p>AC20/03: Procedural Matters.</p> <ol style="list-style-type: none">1. The Minutes of the last meeting of the Committee held on 12/12/19 were reviewed and approved as a true and accurate record and;2. The Summary Action Log was noted and updated accordingly and;3. It was noted that Chair's Action has been taken on the following matters since the last meeting;<ul style="list-style-type: none">• Risk Management Strategy approval• Clinical Audit Policy approval | |
| <p>AC20/04: Issues Discussed in Previous Private Session.</p> <p>The Committee formally received the report in public session of those issues discussed in the private session at the meeting held on 12.12.19, which related to:</p> <ul style="list-style-type: none">• Financial Conformance report• Post Payment Verification Progress report• Primary Care Dental Contracts Assurance report• Counter Fraud Services Progress report• Welsh Risk Pool update report• Update on Internal and External Audit Actions <p>RESOLVED: That the Issues Discussed in Previous Private Session Report be noted.</p> | |

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| <p>AC20/05: Joint Audit & Quality, Safety & Experience (JAQS) Committees Minutes</p> <p>Recommendation: The Committee is asked to note the Joint Audit and Quality, Safety & Experience (QSE) Committee minutes of the meeting held on 05/11/19.</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • That the JAQS Minutes be noted. | |
| <p>AC20/06: Standing Orders Amendments (verbal update)</p> <p>The Acting Board Secretary advised that there were no updates to the Standing Orders (SOs).</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • That the verbal SO update be noted | |
| <p>AC20/07: Review of Amendments to Standing Financial Instructions (verbal update)</p> <p>The Acting Executive Director of Finance advised Members of an ongoing project being led by the Finance Academy to update and reformat the model Standing Financial Instructions (SFIs) and were hoping to have final sign off from Welsh Ministers later this year, after which, the new version would be circulated to Board Secretaries.</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • That the verbal SFI update be noted | |
| <p>AC20/08: Wales Audit Office Structured Assessment / Annual Final Report</p> <p>Recommendation: The Committee is asked to note the final report presented to Board in January 2020 and the management response that is now being monitored via the Audit Tracker.</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • That the Wales Audit Office Structured Assessment / Annual Final Report be noted | |
| <p>AC20/09: Schedule of Financial Claims</p> <p>Recommendation: The Committee is asked to note the contents of the report and approve the Schedule of Losses and Compensation.</p> <p>AC20/09.01: The Assistant Director of Patient Safety & Experience joined the meeting and proceeded to provide an overview of the report. Members noted that this was the first instance of the report being received at Audit Committee following a query raised previously by the Vice Chair in accordance with the Standing Orders and to strengthen</p> | |

governance.

AC20/09.02: The Assistant Director of Patient Safety & Experience provided further background as to the rationale behind the two reports received at the Audit Committee (details of all claims settled over £50,000) and the Quality, Safety & Experience Committee (QSE) (cause of claim and action taken to minimise future occurrences). It was also highlighted to Members that the QSE Committee report had recently been revised and improved with the new version first submitted in January 2020.

AC20/09.03: The Assistant Director of Patient Safety & Experience also brought Members attention to practical issues of reporting and the timings of Committees/Board. Further discussion was required.

AC20/09.04: The Chair queried the practical requirement to ‘approve’ the Schedule given liability and payment had already been conceded and was thus a fait accompli. The Assistant Director of Patient Safety & Experience explained that the nature of the process, the various stages and agencies involved (NHS Wales Shared Services, Legal & Risk) necessitated that prior approval was not possible before liability was conceded. An Independent Member stressed that it was therefore important that the Audit Committee was assured that sufficient assurance processes were in place. Members agreed that further information should be captured in the report and it was suggested to include a paragraph that highlighted the controls (Internal Audit review, signatories etc.) and to include reference to whom had signed off the decision. A further discussion ensued with regards to the length of time between incident date and the date the claim was opened. The Assistant Director of Patient Safety & Experience provided an overview of the time limits to bring a claim (individuals generally have 3 years to claim from the cause of action) with longer periods permitted in cases relating to minors (for example, in Maternity). The Chair stated that the report should include a ‘date closed’ column.

AC20/09.05: The Head of Internal Audit advised that he had reviewed the designated limits for other Health Boards and highlighted the differences whilst noting an observation that Aneurin Bevan University Health Board (ABMU) was probably the most comparable in size to BCUHB and required that everything above £100,000 required sign off by the Board. The Acting Executive Director of Finance queried whether a consistent approach across Wales was required and agreed to raise at the Directors of Finance Group.

AC20/09.06: An Independent Member agreed with the need for consistency and queried the requirement for additional information as to lessons learnt highlighting the process they had observed at county council meetings. The Assistant Director of Patient Safety & Experience advised that this information was reported at the QSE Committee with each individual claim now being listed though acknowledged that the QSE Committee report did require strengthening. Further assurance was gained due to the requirement to complete a Learning from Event Report that included a summary of the claim, lessons learnt and actions taken. This report was then submitted to the Welsh Risk Pool and reviewed at their committee. An Independent Member raised a concern that claims under the value of £25,000 were not sighted at the QSE Committee. The Assistant Director of Patient Safety & Experience provided Members with an overview of work being underway to review the entire system (concerns, incidents, claims) and cross divisional working though advised this was currently on hold due to COVID-19 priority.

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| <p>AC20/09.07: The Head of Internal Audit stressed that claims should be a fundamental driver in terms of the Clinical Audit and would expect to see reference to this in the Clinical Audit Plan.</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • That the Schedule of Financial Claims Report be noted and the Schedule of Losses and Compensation be approved. | <p>MM</p> |
| <p>AC20/10: Corporate Risk & Assurance Framework / Risk Management Strategy Update</p> <p>Recommendation: The Audit Committee (AC) is hereby requested to:</p> <ul style="list-style-type: none"> • Note, approve and recommend the Corporate Risk Register (CRR) to the Board and to gain assurance that the risks articulated on it are appropriately managed in line with the Health Board’s risk management strategy and best practice. • Review, scrutinise, approve and recommend the five new risks which were approved by the Quality, Safety and Experience Committee (QSE) for inclusion onto the CRR. • Recommend to the Board for approval, changes to risks that have been requested by the various committees. <p>AC20/10.01: The Acting Board Secretary advised Members that a Paper had been received with regard to the Implementation Plan and the proposed postponement of the new Risk Management Strategy. However, COVID-19 pressures had meant that she had been unable to review for submission but would share by the end of the day.</p> <p>AC20/10.02: The Chair noted that the plan would be resubmitted to Audit Committee in September/October with the proposal being that status quo would be maintained in the interim but with reduced training delivered by the Risk Management Team. The Chair queried what communications had been sent to staff that had not received the training.</p> <p>AC20/10.03: The Head of Internal Audit stated that if the implementation was to be paused, the Board would need to provide final approval. The Audit Committee would need to recommend to the Board that the implementation be postponed and the Strategy revert back to the 5 tier with effect from 1st April.</p> <p>AC20/10.04: An Independent Member raised concerns mirrored at the QSE Committee that any postponement may have an impact on business as usual and queried what assurance there was that risks would continue to be managed appropriately whilst staff were in the interim phase (i.e. holding off from review or management in anticipation of the transfer from 5 to 3 tiers). The Acting Board Secretary assured members that the Risk Management team were still managing and supporting business as usual as much as possible given COVID-19. It was agreed that the risks in question, discussed at the QSE Committee, would be forwarded to the Acting Board Secretary.</p> <p>AC20/10.05: The Head of Internal Audit advised that it would still be useful to review the current plan. As it stood, there were in excess of a thousand risks that would be re categorised from ‘5’ and ‘4’ to a tier ‘3’ and the Committee had not been sighted on the quality assurance process. Members had been assured in the October workshop that a plan was in place and that all tier 3, 4 and 5 risks scoring above 15 had been reviewed</p> | <p>JP</p> <p>JP</p> <p>BW</p> <p>JP</p> <p>JP</p> |

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| <p>with identified leads and handlers. An Independent Member raised further concerns as to the operational capacity to review the re categorised risks and stressed that it was important that the plan provided for this.</p> <p>AC20/10.06: (The Assistant Director of Patient Safety & Experience joined the meeting at a later point and provided further assurance that Members would receive the Implementation Plan that day and that a system was in place ready for launch)</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • That CRR be approved and recommend to the Board. • The five new risks approved by QSE are included on the CRR. • Recommend to the Board for Approval, changes to risks that have been requested by other Committees. • That the Audit Committee recommend to the Board, the deferment of the revised Risk Management Strategy (awaiting final paper) | <p>JP</p> |
| <p>AC20/11: Risk Management Group Chair's Assurance Report</p> <p>Recommendation: The Committee is asked to note the report.</p> <p>AC20/11.01: The Acting Board Secretary presented the report and advised that the purpose was to strengthen the arrangement and formalise reporting. This was to be a standard report that would come to each Audit Committee.</p> <p>AC20/11.02: An Independent Member highlighted concerns as to improvements required on the communication between the Quality & Safety Group (QSG) and the QSE Committee. The QSE Committee now received the QSG minutes and Cycle of Business (CoB). Another Independent member conferred highlighting similar communication issues as to the Strategic Occupational Health & Safety Group and the information feeding up to the QSE Committee. It was agreed to implement the same process for the Risk Management Group – minutes and CoB would be provided to the Audit Committee.</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • That the Risk Management Group Chair’s Assurance Report be noted. • Risk Management Group Minutes and CoB be provided to Audit Committee Members | <p>JP</p> |
| <p>AC20/12: Governance Review Update (verbal update)</p> <p>Recommendation: The Committee is asked to note the update</p> <p>AC20/12.01: The Assistant Director of Patient Safety & Experience provided and overview of the work undertaken to date though advised that work was on hold due to COVID-19. The review was split into three strands; the mapping of all governance meetings and reporting arrangements; the Quality and Safety reporting line, in particular the remit of the QSG, which was currently stood down; and working with individual divisions to look at their structures.</p> | |

AC20/12.02: The Chair asked for clarification on the status of the QSG as it was a concern that the group was not meeting. The Assistant Director of Patient Safety & Experience clarified that this was just the last meeting with future meetings to be reviewed. Members were provided assurance that the Command Structure for COVID-19 programme included clinical work streams.

AC20/12.03: The Assistant Director of Patient Safety & Experience concluded by highlighting the progress made with the Mental Health & Learning Disabilities Division (MHLDD) that included a review of all meeting Terms of Reference (ToRs) and CoBs as well as structures. The paper was due for review and approval in March though expected to be delayed due to COVID-19.

RESOLVED:

- **That the verbal update on the Governance Review be noted.**

AC20/13: Legislation Assurance Framework (LAF)

Recommendation: The Audit Committee is asked to:

1. Note the contents of this report and the current position in respect of the LAF development; and
2. Note the further work required to liaise with Divisional Leads to include legislation allocation agreement and assurance criteria completion; and
3. Approve items of previous ‘no’ or ‘limited’ assurance in Appendix 2, now reporting as reasonable or substantial assurance, to be removed from next report.

AC20/13.01: The Statutory Compliance, Governance & Policy Manager presented the revised report that had addressed the previous comments by Members in September Committee. Members agreed that the revised format was preferable. The Statutory Compliance, Governance & Policy Manager advised members that progress in the development of the Legislation Assurance Framework (LAF) had been limited due to staff absence and Divisional capacity. However, there had been significant progress made to review the legislation assigned to Estates & Facilities. This represented a significant portion of the total legislation identified as applicable to the Health Board.

AC20/13.02: Members proceeded to review each item on Appendix 2:

- **National Health Service Finance (Wales) Act 2014:** The Statutory Compliance, Governance & Policy Manager drew Members attention to an administrative error with the report, the Corporate Risk reference should be CRR06 and not CRR07.
- **Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013:** Members queried whether the assurance provided was adequate. An Independent Member (also a Member of the Strategic Occupational Health & Safety Group (SOHSG)) provided Members with an overview of some of the work undertaken by the Corporate Health & Safety team. This included support to managers in conducting Root Cause Analysis. Furthermore, the Executive Director of Workforce & Organisational Development was sighted on every RIDDOR. Members agreed the item was reporting as sufficient assurance and agreed to remove from the next iteration of

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| <p>the report.</p> <ul style="list-style-type: none"> • The Information and Consultation with Employees Regulations 1996 / 2004: An Independent member queried the Assurance provided. There was ambiguity as to whether the requirements of the legislation were met. Though members noted that as part of the previous work undertaken by the Corporate H&S team (Divisional Self-Assessment), H&S leads within each Division had been identified, further clarification as to the wording of the Act was to be provided. The Statutory Compliance, Governance & Policy Manager agreed to review with the Associate Director of Occupation Health, Safety and Equality and provide an update within the next iteration of the LAF report. Members agreed for the item to remain on the list until this was completed. <p>RESOLVED:</p> <ul style="list-style-type: none"> • The LAF report be noted as well as the additional work required to collate and report on assurances in place. • The Safety Representatives and Safety Committees Regulations 1977 now reporting as Reasonable Assurance to be removed from the next report noting that a bi-annual review is in place (or sooner should further information, for example an Audit, come to light) and should the assurance level decline, it will be added back on to Appendix 2 | <p>BW</p> |
| <p>AC20/14: Clinical Audit Plan</p> <p>Recommendation: The Audit Committee is asked to approve the draft 2020/21 Clinical Audit Plan</p> <p>AC20/14.01: Members noted correspondence from the QSE Committee to confirm that the Clinical Audit Plan had been deferred to September to enable national audit updates and additional Tier 2 audits to be included.</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • That the Clinical Audit plan be deferred to September 2020. | |
| <p>AC20/15: Internal Audit Progress Report and Plan</p> <p>Recommendation: The Audit Committee is asked to:</p> <ul style="list-style-type: none"> • Receive the progress report; and • Receive and discuss the limited assurance reports; Partnership Governance - Section 33 Agreements and the Quality Improvement Strategy; and • Approve the deferment of the Ysbyty Wrexham Maelor Hospital – Backlog maintenance risk management capital review; and • Approve the draft plan for 2020/21 and internal audit Charter 2020. | |

AC20/15.01: The Head of Internal Audit presented the Progress Report, drawing members attention to the Draft Reports issued on page 8. The Deprivation of Liberty Safeguards (DoLs) report had now been issued as final. The Welsh Risk Pool report was waiting on Executive clearance and the Staff Survey report had been issued as formal draft. The Conwy County Borough Council report had gone to the QSE Committee but the joint meeting with Social Services scheduled for 23rd March had been cancelled. The Head of Internal Audit stressed there was a need to formalise the current arrangement with a section 33 agreement (under the National Health Service (Wales) Act 2006). The Acting Executive Director of Finance provided assurance that Finance had identified the need and was being progressed by the Assistant Director of Finance.

AC20/15.02: The Head of Internal Audit then drew members attention to page 9 (Fieldwork) and the Roster Management review. This review represented a significant governance and financial risk as to paying agency staff who were scheduled to work yet did not fulfil the shift allocation. Auditors had planned to physically attend wards to obtain timesheets (there were 30 hospital wards identified). However, given the current situation as to COVID-19, auditors needed to refrain from going to hospital sites. The Chair queried whether there were any indicators as to estimated figures. The Head of Internal Audit responded that this was currently unknown though advised that the Associate Director of Workforce, Performance & Improvement may be able to provide further information. A discussion ensued as to alternative methods of obtaining the timesheets. The Chair stated that given the current additional operational issues faced by frontline staff, it was not appropriate to request Managers/individuals to collate and send on individual timesheets to Internal Audit. The Acting Executive Director of Finance queried whether it would be feasible to request each agency to send timesheets and the Chair queried how many individual agencies were contracted, again this information was not available to hand but would be followed up with the Associate Director of Workforce, Performance & Improvement. The Head of Internal Audit stated that the fundamental issue was that there was insufficient controls in place. The Acting Executive Director of Finance queried whether this should be managed through Workforce rather than the Nursing Division. An Independent Member concurred that other agency staff were utilised outside of the Nursing division. The Chair highlighted that COVID-19 may result in a higher use of agency staff in the event that permanent members of staff were required to self isolate and/or not be fit for frontline duties. The Acting Executive Director of Finance recommended that the Agency Contract be revised to include an agreement of random sampling of time sheets to promote agency self declarations of discrepancies. An Independent Member queried why there was no IT solution available, the Chair stated that these were proactive payments, rather than payment being issued post shift completion. The Head of Internal Audit confirmed that this was due to the Prompt Payment requirements and the decision last summer to move to prospective payments.

AC20/15.04: The Head of Internal Audit concluded the Field Work update by advising Members that the North Denbighshire report was expected to be sent by the end of the week. The Head of Internal Audit stated that he wanted to bring Members attention to two reviews - the Ysbyty Glan Clwyd (YGC) open book and pain gain reviews had been delayed due to delays in receiving information from the cost advisors and supply chain partner. In addition the Final Accounts were yet to be finalised.

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AC20/15.05: Members noted a positive Follow Up report with all sampled recommendations being verified closed.

AC20/15.06: The Head of Internal Audit highlighted the deferment of the Ysbyty Wrexham Maelor Hospital – Backlog maintenance risk management on page 10. An Independent Member queried the rationale for the delay. The Head of Internal Audit advised that it was felt that it would be best to wait until the funds were confirmed and the scheme in place. The Independent Member suggested that ‘approval’ needed to be inserted.

AC20/15.07: An Independent Member raised concerns as to the Limited Assurance Report on the Quality Improvement Strategy and advised that it was important that the QSE Committee were informed of the report. A discussion ensued as to the mechanisms for cross Committee communications and ensuring sufficient oversight. The Acting Board Secretary advised that this was the purpose and role of the Committee Business Management Group. In addition, the Audit Committee could specifically refer items to other Committees. This would be noted as an action in the action log and reviewed by Members at the following meeting. Following Member’s concern with regards the Limited Assurance report, the Chair asked the Head of Internal Audit whether he was satisfied that the Management Response was sufficient and the Head of Internal Audit confirmed that he was, this was an essential requirement in order to formally issue the report as final.

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AC20/15.08: An Independent Member raised the oversight issue again with regard to the other Limited Assurance report of Partnership Governance – Section 33 Agreements, it was important that the Strategy Partnerships and Population Health (SPPH) Committee were sighted on the report and that the review/governance of Section 33 Agreements should be included in their CoB.

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AC20/15.09: The Head of Internal Audit wished to formally record thanks to the Executive Directors for their support in identifying key risks to inform the plan.

AC20/15.10: The Head of Internal Audit directed members attention to page 8 of the Draft Internal Audit Plan and the recharge for capital audit assurance work being reduced to £12,500. However, this was predicated upon the agreement of three major elements; the North Denbigh, Ablett Unit and Wrexham Maelor Hospital redevelopment/Backlog Requirements to be funded through business case submissions. This had been discussed with Finance and Planning. Members noted that Internal Audit may need to revisit this to ensure that adequate audit provision was provided within respective integrated audit and assurance plans.

AC20/15.11: The Head of Internal Audit then directed Members to Appendix A (from page 10) and the last point in the Corporate Governance, risk and regulatory compliance section – Engagement of interim appointments planned output, that had been added to the plan following the Interim Staffing report received from Wales Audit Office.

AC20/15.12: An Independent Member queried whether, given COVID-19, Members needed to consider all scheduled Internal Audit actions. The Head of Internal Audit advised that there was a risk that Internal Audit may not be able to physically deliver the plan. It was agreed that this would need to be re-evaluated with Finance, the Board Secretary and the Chair. The plan included some mandatory items but these were

subject to the Welsh Government direction on mandatory monitoring. The Acting Board Secretary updated Members that a proposal had been put forward to Welsh Government by the All Wales Board Secretary Group recommending levels of managing Boards and Committees, a response had been requested for as soon as possible.

A20/15.13: The Chair accepted that the plan was subject to changes of Internal Audit's capacity to conduct reviews. The Internal Audit team had completed the staff survey distributed by the Workforce & Organisation Development Division that sought to establish staff capabilities in the event of necessary redeployment, noting that the Head of Internal Audit was a NHS Wales Shared Services Partnership (NWSSP) staff member. The Chair queried whether the survey was BCUHB wide and it was confirmed that this had been sent to a number of staff groups. The survey was currently voluntary and sought to identify numbers of staff that could be deployed to support critical services (consummate with skills and experience). A discussion ensued as to how this piece of work was being undertaken. The Acting Executive Director of Finance explained that this was very much an evolving situation managed by the Workforce team. At present individual managers were monitoring their own respective teams and updating Workforce with details of staff that could be considered for alternative duties.

RESOLVED:

- That the progress report be noted
- That the limited assurance reports be received and discussed
- That the deferment of the Ysbyty Wrexham Maelor Hospital – Backlog maintenance risk management capital review be approved
- That the draft plan for 2020/21 and internal audit Charter 2020 be approved in principle though subject to review in light of COVID-19 and subsequent developments
- That the two Limited Assurance report be referred to the relevant Committees.

AC20/16: Wales Audit Office Update Report

Recommendation: The Audit Committee is requested to:

1. Note the content of the audit progress update.
2. Receive and discuss the Wales Audit Office Audit Plan
3. Receive and discuss the Review of arrangements for interim staff appointments (Welsh and English)

AC20/16.01: The Performance Audit Lead, Wales Audit Office joined the meeting via Skype video call and drew Members attention to the Structured Assessment (noted at minute: AC20/08) whilst there were some challenging recommendations, a good response had been received by the Health Board. Members acknowledged that some recommendations might not be met within the implementation date given the current situation of COVID-19. The Performance Audit Lead, Wales Audit Office agreed to revisit at a later date with the Health Board. The Recommendations had been input into the electronic TeamMate system and progress would be monitored by the Audit Committee (subject to meeting frequency and agenda reduction) whilst taking into

account competing COVID-19 pressures.

AC20/16.02: The Performance Audit Lead, Wales Audit Office provided an overview of the plan that included the mandatory items, local work and the fee, which Members noted a reduction of 5%, and set out the timescales. Members noted there would be a communication sent to all Chief Executives informing that from a performance audit perspective, all on site work would be halted. The Acting Executive Director of Finance advised Members that a revised dates for accounting had been received from Welsh Government though it was still draft.

AC20/16.03: The Performance Audit Lead, Wales Audit Office went on to provide an overview of the Interim Staffing report and asked Members to note that WAO had subsequently received additional information that had influenced the findings. Initially, there was a lower assurance reported but this had improved once the additional information had been received. The Performance Audit Lead, Wales Audit Office proceeded to go over the key findings that included that the Health Board had used the NHS framework to source the Interim Recovery Director but sought more preferential terms and as a result, went off framework (para 29). There was a, albeit small, legal risk of those who were not included in the full tender challenging the decision. The Chair asked for clarity on why this had occurred. The Acting Executive Director of Finance advised that in terms of risks to BCUHB, all terms and conditions applicable were still applicable to the Recovery Director and that the Health Board had tried to negotiate the fee to ensure value for money. The Acting Executive Director of Finance assured Members that the appointment of interims was now managed by herself, working with NWSSP. Furthermore, a mandate would be sent to all recruiting agencies that BCUHB will only recruit from the framework. The Acting Executive Director of Finance highlighted that the information received from various pieces of guidance could be ambiguous. Clear guidance on exactly what could and could not be done was needed. The Chair noted the mention of references within the report and the Head of Internal Audit advised that this was included in the Internal Audit Plan which would provide Members with a useful follow up on the WAO report.

SH

AC20/16.04: An Independent member queried why the report contained no recommendations. The Performance Audit Lead, Wales Audit Office advised that this was the nature of the report that was based on fact only, rather than an opinion type report that would provide an evaluative conclusion. The Independent Member accepted the differing natures of the reports though stressed that it would have been useful to still receive recommendations to demonstrate lessons learnt. The Performance Audit Lead, Wales Audit Office agreed to feed back into the team and Director responsible.

AD

AC20/16.05: The Chair concluded that the final report differed to previous draft versions received and apologised that the information required had not been provided in a timelier manner.

AC20/16.06: The Performance Audit Lead, Wales Audit Office advised that this was originally part of the National Assembly Wales, Public Accounts Committee (PAC) work that would be receiving further reports on asbestos and finance. It was understood that the scrutiny by PAC was postponed and likely to resume in the autumn.

RESOLVED:

- That the the content of the audit progress update be noted.

| | |
|---|-----------|
| <ul style="list-style-type: none"> • That the Wales Audit Office Audit Plan be received and discussed • That the Review of arrangements for interim staff appointments be received and discussed | |
| <p>AC20/17: Agree Audit Committee Cycle of Business</p> <p>Recommendation: The Audit Committee is asked to:</p> <ol style="list-style-type: none"> 1. Note the contents of this report and agree the 2020/21 Cycle of Business (CoB) <p>AC20/17.01: Members noted the priority of ongoing COVID-19 work as well as the requirement to minimise contact/infection and discussed the frequency and agendas of planned meetings. It was preliminary agreed, subject to further direction from Welsh Government, that the May Workshop be cancelled, that the 28th May meeting be held virtually via Skype or WebEx video conference and consideration be given to postponing the September meeting until October.</p> <p>AC20/17.02: An Independent Member raised a further query as to how and where breaches of SOs or SFIs, such as late papers, were reported. These were logged by the Board Secretary and included as part of the standing item of updates to SOs/SFIs. Members agreed that a standalone agenda item was necessary to strengthen governance and improve transparency.</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • That the Audit Committee 2020/21 CoB be approved pending COVID-19 developments/impact. • Breaches of SOs and SFIs be included as a standalone item on the CoB. | <p>BW</p> |
| <p>AC20/18: Issues of Significance for reporting to Board</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> • No issues | |
| <p>AC20/19: Date of Next Meeting - 28/05/20 (pending confirmation, subject to COVID-19 developments)</p> | |
| <p>AC20/20 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."</p> | |

Audit Committee

29.6.20

Record of Breaches of Publication of Committee Papers from 1.4.20 not in accordance with Standing Orders

| Date | Committee | Standing Order Requirement | Issue/Reason for Breach |
|-------------|---|---|--|
| 5.3.20 | Strategy Partnerships and Population Health | Publication of papers 7 days before meeting | Follow on papers required. Web publication not achieved. |
| 5.5.20 | Quality Safety Experience Committee | Publication of papers 7 days before meeting | Achieved on ibabs. Administrative error meant papers were not published to the website until the 6.5.20. |
| 9.6.20 | Strategy Partnerships and Population Health | Publication of papers 7 days before meeting | Papers published with exception of 1 x follow on paper due to amendment required before publication. |

In addition Members will be aware that in view of the Pandemic and press and public not being able to attend meetings the Board committed to making minutes of meetings held in public session available on the website within 3 working days. There are two occurrences where this was not achieved as follows (due to a timing and capacity challenge):-

| Target Date | |
|--------------------|---|
| 9.6.20 | Minutes of Finance and Performance Committee held in public on 4 th June sent for approval on 9 th June |
| 12.6.20 | Minutes of Strategy, Partnerships and Population Health Committee held in public on 9 th June |

Audit Committee Summary Action Log: Public Committee

| Officer | Minute Reference and Action Agreed | Original Timescale | Latest Update Position | Revised Timescale |
|-----------------------------|---|--------------------|--|-------------------|
| Last updated 10.03.20 | | | | |
| Justine Parry | AC19/61: BAF individual action ownership sub divided where appropriate | June | 01/04/2020 – Planning processes suspended due to COVID-19, will recommence and continue to work with Planning and Performance division once normal processes resumed. Recommendation to extend current CRAF arrangements during this time in line with extension to Risk Management Strategy. 19.6.20 – Work on the BAF is now to be progressed initially via a Board Workshop in July 2020 | Close |
| Bethan Wassell/Sally Baxter | AC19/81.5: WFG Review -Management Response to be provided to WAO | June | Update 03/03/20: Management response awaiting Executive sign off (Planning & Performance / Public Health) – Completed. | Close |
| Justine Parry / Matt Joyes | AC20/09.03: Schedule of Financial Claims - Practical issues of reporting and timings of Committees/Board | June | Chair’s action taken where timings of meetings are not aligned to the timeframe for approval. | Close |
| Matt Joyes | AC20/09.03: Schedule of Financial Claims - Report format – add paragraph highlighting controls (Internal Audit review/signatories etc.) include reference to whom has signed off each decision and ‘date closed’ | June | Revised report received | Close |
| Sue Hill | AC20/09.03: Schedule of Financial Claims - Consideration of an all Wales consistent approach for designated limits/sign off to be raised at DoF Group. | June | There is a current project reviewing SFIs across Wales. The Acting executive Director of Finance has requested that this item be considered as part of that project. | close |

| Officer | Minute Reference and Action Agreed | Original Timescale | Latest Update Position | Revised Timescale |
|--------------------------------|--|--------------------|--|-------------------|
| Melanie Maxwell | AC20/09.03: Schedule of Financial Claims - Members noted that claims should be a fundamental driver in terms of Clinical Audit and would expect to see reference to this is the Clinical Audit Plan. | June | 08/06/20 the planning process has been suspended whilst the Covid 19 response is in place and will recommence once the team is deployed back into their roles and we have confirmation from WG that national audits are recommencing. The plan was to be reviewed in September and we will work to this timeframe. | Sept. |
| Justine Parry | AC20/10.01: Corporate Risk & assurance Framework (CRAF) - Paper received with regard to implementation Plan and the proposed postponement but Board Secretary had been unable to review. Paper to be shared by end of day | June | Paper shared on the 21/05/2020 with apologies from JP on MJ and DT behalf. | Close |
| Justine Parry | AC20/10.02: Corporate Risk & assurance Framework (CRAF) - Information on what communications have been sent to staff that have not received training | June | Email correspondence provided by Assistant Director of Information Governance & Risk 08/06/20. Distributed to Members. | Close |
| Justine Parry | AC20/10.04: Corporate Risk & assurance Framework (CRAF) - Concerns raised re business continuity of specific risks raised at QSE, to be investigated | June | QSE will be reviewing all their risks again on the 3rd July, where IMs can further raise the issues. | Close |
| Justine Parry/Matt Joyes | AC20/10.05: Corporate Risk & assurance Framework (CRAF) - Members to be sighted on the current Implementation Plan / quality assurance process | June | See response to AC20/10.01 | Close |
| Bethan Wassell / Justine Parry | AC20/11.02: RM Group Chair's Assurance Report – minutes and CoB to be provided to AC | March | Received at March Committee and added to CoB for future meetings. | Close |

| Officer | Minute Reference and Action Agreed | Original Timescale | Latest Update Position | Revised Timescale |
|-----------------|--|--------------------|--|-------------------|
| Bethan Wassell | AC20/13.02: Legislation Assurance Report (LAF) - The Information and Consultation with Employees Regulations 1996 / 2004 to be reviewed with Associate Director of Health, Safety & Equalities. Requirements to be clarified and reported back to Committee | Sept | Meeting date to be confirmed with Assistant Director of Health, Safety & Equality (H&S team currently prioritising Covid-19 response). | |
| Lawrence Osgood | AC20/15.02: Internal Audit - Roster Management Review. Information to be provided as to any indicators for figures in relation to agency staff overpayments and how many individual agencies are currently contracted. | June | <p>In early 2019 a total of 81 credit notes with a value of circa £33k were received into the Bank team as Nurse agency shifts had been paid without the worker actually undertaking the shift. The bank team immediately raised this issue with Senior Nurse management and commenced a review which entailed seeking timesheets from the wards where credit notes had been received to marry them up to processed invoices. At the same time, the Internal Audit Team were engaged to begin field work on an internal review.</p> <p>The Audit commenced in April 2019 but due to the outbreak of COVID-19 there was limited capacity internally and with external agencies to provide enough data to produce a robust set of findings. In light of this, the initial review resulted in limited assurance with a recommendation to undertake a fuller review. The next steps are to re-schedule the review to be undertaken in summer 2020 when it is anticipated stakeholders involved will have capacity to input into the audit.</p> | close |

| Officer | Minute Reference and Action Agreed | Original Timescale | Latest Update Position | Revised Timescale |
|----------------------------|---|--------------------|--|------------------------------------|
| Sue Hill / Lawrence Osgood | AC20/15.02: Internal Audit - Agency Contract to be reviewed and revised to include agreement to random sampling of time sheets to promote agency self declarations of discrepancies. | June | This has not been progressed but will be implemented from 1st July in two phases: 1. an email to current suppliers 2. added to all new contracts | July |
| Bethan Wassell | AC20/15.07: Internal Audit - Quality Improvement Strategy Limited Assurance Report to be shared with QSE. | March | Email sent to Chair/Lead Exec and Secretariat 01/04/20 | Close |
| Bethan Wassell | AC20/15.08: Internal Audit – Section 33 Agreements Limited Assurance Report to be shared with QSE. | March | Email sent to Chair/Lead Exec and Secretariat 01/04/20 | Close |
| Sue Hill: | AC20/16.03: WAO – Mandate to be sent to all recruiting agencies that BCUHB will only recruit from the framework | June | An instruction was sent to any existing suppliers who had operated outside the framework | close |
| Andrew Doughton | AC20/16.04: WAO – lack of recommendations inhibit ability to demonstrate lessons learnt, Performance Audit Lead to feedback to team and responsible director | June | Following discussions between Audit Wales, Acting Executive Director of Finance and the Assistant Director - Strategic And Business Analysis, three recommendations have been proposed (awaiting review/sign off by Executive Director of Finance). Once finalised, these will be added to the TeamCentral electronic tracking system and reported/monitored by Members as part of the Tracker report for September' | Close but new action for September |
| Bethan Wassell | AC20/17.01: Committee Cycle of Business-Breaches of SOs and SFIs be included as a standalone item on the CoB. | March | Incorporated into CoB. First iteration to be received at June Committee | Close |



| | | | | | | | |
|---|---|---|--------------------------|--|--------------------------|--------------------------------------|--------------------------|
| Cyfarfod a dyddiad: Meeting and date: | Health Board 15 th April 2020 | | | | | | |
| Cyhoeddus neu Breifat: Public or Private: | Public | | | | | | |
| Teitl yr Adroddiad Report Title: | Maintaining Good Governance (Covid-19) | | | | | | |
| Cyfarwyddwr Cyfrifol: Responsible Director: | Mrs Justine Parry Acting Board Secretary | | | | | | |
| Awdur yr Adroddiad Report Author: | Mrs Kate Dunn Head of Corporate Affairs | | | | | | |
| Craffu blaenorol: Prior Scrutiny: | No formal prior scrutiny. Principles discussed between all Wales Board Secretaries. Paper agreed with Interim Chief Executive prior to publication. | | | | | | |
| Atodiadau Appendices: | Appendix 1 Chair's Action Standard Operating Procedure Appendix 2 scheduled of proposed variations from Standing Orders | | | | | | |
| Argymhelliad / Recommendation: | | | | | | | |
| The Board is asked to: | | | | | | | |
| <ol style="list-style-type: none"> 1. Note the report 2. Approve the variation to the Standing Orders as outlined 3. Approve the revised approach to Board decision making 4. Approve the approach to meetings in public 5. Note the suspension of Committees as set out | | | | | | | |
| 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 | <input checked="" type="checkbox"/> | Ar gyfer Trafodaeth For Discussion | <input type="checkbox"/> | Ar gyfer sicrwydd For Assurance | <input type="checkbox"/> | Er gwybodaeth For Information | <input type="checkbox"/> |
| Sefyllfa / Situation: | | | | | | | |
| <p>Given the current and developing situation with Covid-19 it is necessary to propose a range of variations to Board governance arrangements. This paper sets out the proposed approach to ensuring the appropriate level of board oversight and scrutiny to enable it to discharge its responsibilities effectively, whilst recognising the reality of executive focus and time constraints. A Recovery Programme is in development and will be managed and monitored as part of the COVID-19 Governance and Risk Workstream.</p> | | | | | | | |
| Cefndir / Background: | | | | | | | |
| <p>The following narrative sets out the Health Board's approach to ensuring the appropriate level of Board oversight and scrutiny to discharge its responsibilities effectively, whilst understanding and recognizing that the executive focus and commitment will be to respond to the COVID-19</p> | | | | | | | |

emergency. Part of this response includes changes to ways of working and the need to continually adapt to the crisis. This requires temporary variation from the legal framework to which the Board operates. To ensure a consistent approach across Wales, the national Board Secretaries Group, having a shared knowledge and expertise for good governance, have considered and developed a set principles for good governance during the Covid-19 pandemic and these are reflected in this paper.

1. INTRODUCTION

Whilst the Health Board undergoes significant changes to react to the coronavirus emergency the board should strip back the agenda and focus on the essential business only.

The Board's fundamental role and purpose will remain during this period and does not change. Crucially during the current COVID-19 crisis, the Board must require and receive positive assurance, not just on service preparedness and response but also on clinical leadership, engagement and ownership of developing plans; on the health and wellbeing of staff; on proactive, meaningful and effective communication with staff at all levels and on health and care system preparedness.

At the same time, we must remember that if mistakes are made and harm done in this period then the enquiry that would surely follow would look very closely at how the board assured itself, what questions it asked and what evidence it received.

This paper sets out BCUHBs approach to ensuring the appropriate level of board oversight and scrutiny to discharge its responsibilities effectively, whilst recognising the reality of executive focus and time constraints. Part of the response is about ways of working, which of course can and must adapt continually during such a crisis; but part of the response requires temporary variation from the legal framework to which the Board operates – the Standing Orders (SOs) and Scheme of Reservation and Delegation of Powers (SoRD).

As there is a need for us to continually adapt, the approach set out in this paper will remain under constant review by the Chair, Interim Chief Executive and Acting Board Secretary. Any further variations to SOs, will be brought to the Board for approval or ratification.

The Board is asked to approve the approach set out in this paper and the variations to SOs set out in the attached appendices.

2. WAYS OF WORKING PRINCIPLES

The differing ways of working set out in this paper will:

- Allow maximum flexibility to adapt to a rapidly evolving situation
- Minimise executive requirements for preparation of papers or attendance at meetings unrelated to the immediate requirements of COVID 19
- Be sensitive to the need to ensure executive wellbeing, particularly when there is a need for 24/7 involvement
- Ensure all Independent Members are briefed and engaged both through the crisis and beyond
- Ensure Independent Members expertise and contacts are appropriately available to execs during the crisis
- Provide an appropriate balance between short term operational imperatives and longer term requirements for a sustainable organisation

- Ensure that appropriate arrangements are in place to support the organisation to exit crisis in a planned way
- Ensure appropriate partnership arrangements are in place to deal with both short term necessities and longer term requirements to embed improvements
- All meeting arrangements should reflect current guidelines on social distancing
- Independent Member triangulation activities during this period should be minimised and will need to rely far more than usual on what is being told by the executive for assurance.
- The Chair and Interim Chief Executive will be in contact daily and the Chair will brief the Independent Members on a weekly basis.
- A range of communication arrangements are in place and include:
 - Daily bulletin to all staff (including all Board Members and primary care contractors)
 - Daily Primary Care Update from Primary Care Team to contractors and managed practises
 - Daily update to Board including Media Evening Update, Primary Care communications (as above) and HECC briefing
 - Daily update to partners inc AMs, MPs, CHC, LAs and third sector
 - Weekly message from CEO and Chair to all staff via email, Staff App and on intranet
 - Weekly teleconference with WG Communications and NHS Wales communications colleagues inc PHW
 - Workstream SITREP reporting 3 times a week and shared with Gold Command
 - Weekly briefing to all Independent Members (via telephone conference)
 - Weekly Skype between Chair and local AMs
 - Weekly Skype between Chair/CEO and Local Authority Leaders and CEOs and communications team representative dials in to daily LRF Media Cell call at 2pm
 - Weekly Skype between Chair/CHC leads
 - Vice Chair keeping in touch with Primary Care
 - Chair/Vice Chair speak weekly and as needed

3. GOVERNANCE PRINCIPLES

The Board Secretaries Group has framed a number of governance principles that are designed to help focus consideration of governance matters over coming weeks and months.

These are:

- **Public interest and patient safety** - We will always act in the best interests of the population of Wales and will ensure every decision we take sits in this context taking into account the national public health emergency that (COVID-19) presents.
- **Staff wellbeing and deployment** – we will protect and support our staff in the best ways we can. We will deploy our knowledge and assets where there are identified greatest needs.
- **Good governance and risk management** – we will maintain the principles of good governance and risk management ensuring decisions and actions are taken in the best interest of the public, our staff and stakeholders ensuring risk and impact is appropriately considered.
- **Delegation and escalation** – any changes to our delegation and escalation frameworks will be made using these principles, will be documented for future record and will be continually reviewed as the situation unfolds. Boards and other governing fora will retain appropriate oversight, acknowledging different arrangements may need to be in place for designated officers, deputies and decisions.

- **Departures** - where it is necessary to depart from existing standards, policies or practices to make rapid but effective decisions - these decisions will be documented appropriately. Departures are likely, but not exclusively, to occur in areas such as standing orders (for example in how the Board operates), Board and executive scheme of delegation, consultations, recruitment, training and procurement, audit and revalidation.
- **One Wales** – we will act in the best interest of all of Wales ensuring where possible resources and partnerships are maximised and consistency is achieved where it is appropriate to do so. We will support our own organisation and the wider NHS to recover as quickly as possible from the national public health emergency that COVID-19 presents returning to business as usual as early as is safe to do so.
- **Communication and transparency** - we will communicate openly and transparently always with the public interest in mind accepting our normal arrangements may need to be adapted, for example Board and Board Committee meetings being held in public.

4. GOVERNANCE AND RISK

4.1 Decision Making and variation from Standing Orders

The SOs and SoRD set out, together with a range of other framework documents, the arrangements for the Board and the wider organisation to make decisions. In principle, the current Board scheme of delegation and specifically the matters the Board reserves for its own decision (schedule 1 of the SOs) will remain. The aim would be to retain whole Board decision making for as long as possible, however, if the full Board was not available or could not be convened at speed it will operate with a quorum as set out in standing orders.

In the event of a critical or urgent decision(s) needing to be made, Chair's action will be utilised. The process for considering Urgent Action is set out in Appendix 1.

- Where possible the full Board will retain decision making;
- If the full Board is not available or practical, it will operate with a quorum of 3 executives and 3 independent members that can be convened at speed;
- Chair's Action will be used sparingly and only as a last resort. Any Chair's Action will of course be recorded and ratified.

To ensure that the Health Board can facilitate agile decision making and reduce unnecessary bureaucracy, without compromising strong governance, a temporary variation to parts of the Standing Orders (November 2019 edition) will need to be considered. The proposed variations are set out in the table within Appendix 2.

The Board and Committee structure will need to be streamlined. Executive Directors will have little time for the preparation of reports, so the Board is asked to accept oral reports where appropriate, and to accept that reports may not be received in accordance with the agreed 7 day timescale. It is important to ensure that there is a clear audit trail with minutes recording how decisions have been made.

The Interim Chief Executive, as Accountable Officer, is delegated authority by the Board to make decisions with regard to the management of the Health Board. Executive Directors have been delegated certain responsibilities and decision making powers through the Board's SoRD. These arrangements will remain in place with regard to the ongoing functioning of the organisation. In respect of COVID-19, the Chief Executive will deploy decision making through the established command and control structure.

In addition to the formal Committees, there will be a short term **Recovery Group**, focussed on exiting the crisis as smoothly as possible and ensuring actions to improve organisational sustainability are progressed where appropriate.

Decision making guidance during COVID-19 is being developed for agreement with Gold Command. This will detail at which level decision can be made, who can make them and where it must be recorded. This is being developed in accordance with the Health Board's SOs, Standing Financial Instructions (SFIs) and the SoRD. All decision logs will be reviewed by Gold Command on a weekly basis, with escalation for Board approval in place.

4.2 Financial Guidance

Welsh Government has issued financial guidance to NHS Wales Organisation given the immediate challenges presented by the COVID-19 pandemic, recognising that routine financial arrangements and disciplines are disrupted and need to adapt on an interim basis. The guidance has been developed to support organisations and provide clarity on expectations for this disrupted period and until organisations return to business as usual arrangements.

4.3 Board Meetings

The Board is unlikely to meet in person for foreseeable future and so will meet through electronic/telephony means. As a result of this, members of the public will be unable to attend or observe. Board meetings will continue to be held bimonthly.

To facilitate as much transparency and openness as possible the Health Board will undertake to:

- Publish agendas and papers as far in advance as possible – ideally 7 days in advance of the meeting. Increase the use of verbal reporting which will be captured in the meeting minutes
- Provision for written questions to be taken from Independent Members 24 hours beforehand to assist with the flow and reduced time of meetings
- As well as a live action log, a pending log will be kept of actions that will not be progressed during the crisis
- Publish a set of minutes from the meeting (a draft approved by the Chair) to the public website as soon as possible – ideally within 3 working days.

Health Board agendas will be stripped back to essential business only and should focus on matters requiring a decision from the Board. It is accepted that Executives will attend meetings only to present specific items. The agenda for the Board Meeting during this period will cover the following as a minimum:

- COVID-19 (update and urgent issues)
- Advice, requirements and guidance from Welsh Government
- Risk Register
- Recovery Programme
- Financial Report
- Minutes of the previous meeting

The website (which constitutes our official notice of Board meetings) has been updated to explain why the Board is not meeting in public.

The Chair, Interim Chief Executive and Acting Board Secretary will agree the substantive items to be brought to the Board. Any decisions that are taken at this time should be those that could not be held over until it is possible to resume the requirement to meet in public.

Board papers will be kept brief and deal with issues that require the board to make a decision. Information not requiring a decision can be sent electronically outside of the meeting.

Executive Directors will need to broaden powers of delegation, so the Board will need to accept that there may be situations where they will be informed after the event, rather than consulted as current practice.

4.4 Standing down of Committee and Officer Groups

The Board's Committees and Advisory Group meetings have been suspended for the months of April and May 2020 other than Audit Committee, Finance & Performance Committee and the Quality, Safety & Experience Committee which will continue to meet remotely with a stripped back attendance and agenda. A decision regarding meetings from June onwards will be undertaken by the Chair in conjunction with the Interim Chief Executive and the Acting Board Secretary by the end of April.

A range of officer-led groups have also been suspended including the Drug and Therapeutics Group and Quality & Safety Group and a Chair's Action process will be utilized for approval of pan BCU written control documentation relating to non Covid-19 matters. This approach has been endorsed by the Executive Director of Nursing & Midwifery / Deputy Chief Executive.

Asesiad / Assessment & Analysis

Strategy Implications

There will be some interruption to aspects of the Board's statutory functions including the suspension by Welsh Government of the normal IMTP and reporting arrangements.

Financial Implications

There are no financial implications directly attributed to the implementation of the proposals set out in this paper. Welsh Government has issued financial guidance to NHS Wales Organisations given the immediate challenges presented by the COVID-19 pandemic, recognising that routine financial arrangements and disciplines are disrupted and need to adapt on an interim basis. It is anticipated that there will be changes required to the Standing Financial Instructions especially in relation to the changes to procurement processes and financial delegations. It is anticipated that guidance will be issued to NHS Wales organisations to confirm the changes that would be required. Once this has been received a further report will be considered by the Health Board.

Risk Analysis

Without the proposed changes there would be a significant risk to the safety and welfare of individuals, therefore the aim of the changes is to ensure the Health Board complies with the need to protect individuals and not meet in person, whilst also trying to reduce the burden on staff from normal reporting arrangements, and thus allowing them to focus on responding to the COVID-19 emergency.

Legal and Compliance

To ensure that agile decision making can continue and to reduce unnecessary bureaucracy without compromising strong governance, parts of the Standing Orders are to be varied on a temporary basis. These variations have been agreed on an All Wales basis and with Welsh Government and are in accordance with the provision within the NHS (Wales) Act 2006 – Schedule 3, Part 2 which states that “*An NHS trust may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.*”

In addition the ability within the Public Bodies (Admission to meetings) Act 1960 S.1(2) to exclude the public from a meeting for “*other special reasons stated in the resolution*” will be applied to protect members of the public and Health Board employees during the period of the pandemic situation.

Impact Assessment

The approach set out in this paper will remain under constant review by the Chair, Interim Chief Executive and the Acting Board Secretary. Any further variations to SOs, whether as a result of further reflection or in response to direction from Welsh Government, will be brought to the Board for approval or ratification.

**OFFICE OF BOARD SECRETARY (OBS)
STANDARD OPERATING PROCEDURE (SOP)**

| | |
|---------------|--|
| Title | Chair's Action During Covid-19 |
| Author | Mrs Kate Dunn Head of Corporate Affairs |

1. Purpose

To describe the procedure for agreeing, recording and reporting Chair's Action on behalf of the Board and its Committees and/or Advisory Groups during the Covid-19 pandemic.

2. Responsibility / Scope

In line with Standing Order Para 2.1, Chair's Action can be taken to allow decisions to be taken between scheduled meetings, when it is not practicable to call an extraordinary meeting.

The procedure applies to Chairs and officers who support the Board or its Committees and/or Advisory Groups. The Head of Corporate Affairs will manage the procedure on behalf of the Board Secretary.

3. Process

3.1 The need for an action to be brought to the attention of the Chair for Chair's Action should be raised via the lead responsible officer.

3.2 The appropriate template (attached) should be completed and presented with any explanatory of background paperwork

3.3 Approval via email will be sought from the Chair, Chief Executive and Board Secretary in the case of the Board, and from the Committee Chair, Lead Executive and Board Secretary in the case of Committees.

3.4 Two Independent Members will also be consulted via email.

3.4 Actual signed documentation will be prepared when the organisation comes out of the pandemic situation and retained corporately within the Office of the Board Secretary.

4. Reporting

The Chair should report to the next available meeting on the action taken, to ensure an appropriate minute is generated.



Health Board Chair’s Action on Urgent Matters

Title:

Introduction / Context: *(why is Chair’s action necessary)*

Issue for Consideration: *(what are the key points, associated risks, background etc)*

Recommendation: *(what is the Chair being asked to approve/agree)*

Recommendation Approved By:

Health Board Chairman / Vice-Chair

Chief Executive

Board Secretary

Independent Members Consulted (print name):

- 1.
- 2.

Dated:



Committee Chair's Action on Urgent Matters

Name of Committee:

Title:

Introduction / Context: *(why is Chair's action necessary)*

Issue for Consideration: *(what are the key points, associated risks, background etc)*

Recommendation: *(what is the Chair being asked to approve/agree)*

Recommendation Approved By:

Committee Chairman / Vice-Chair

Board Secretary

Independent Members Consulted (print name):

- 1.
- 2.

Dated:

Appendix 2

| SO Number | Heading / Sub Heading | Proposed Change |
|-----------|--|--|
| Xxxii | Variation and amendment to Standing Orders | Changes to the standing orders will be agreed at Board first and communicated to Audit Committee (not the other way round) |
| 3.3 | Committees established by the Health Board | <ol style="list-style-type: none"> 1. Audit Committee continue to operate in a remote format with an agenda focussed on ensuring compliance, in particular with the Annual Accounts, Governance Statements and Annual Report 2. Quality, Safety and Experience Committee continue to operate in a remote format with an agenda focussed on ensuring compliance in particular with the Annual Quality Statement, Complaints and Putting Things Right. The Committee will also have an assurance role linked to COVID-19. 3. Finance & Performance Committee to be determined 4. Charitable Funds Committee suspended for the foreseeable future. 5. Digital & Information Governance Committee suspended for the foreseeable future. 6. Remuneration & Terms of Service Committee suspended for the foreseeable future. 7. Mental Health Act Committee suspended for the foreseeable future. 8. Strategy, Partnerships & Population Health Committee suspended for the foreseeable future. <p>Whilst the range of Committees are suspended:</p> <ul style="list-style-type: none"> • HR/people decisions to come to full Board where required. • Information Governance decisions will come to Audit Committee where required. • Health and Safety decisions to come to Quality, Safety and Experience Committee where required. |
| 7.1 | Putting citizens first | Variation – see section 3 of this report |
| 7.2 | Annual plan of | Suspended for the foreseeable future |

| | | |
|--------|--|--|
| | board business | |
| 7.2.5 | Annual General Meeting | We are unlikely to run the AGM by the end of July; we will run it when it becomes feasible to do so. |
| 7.4.3 | Notifying and equipping Board members | <p>We will try our best to publish agendas 7 days in advance.</p> <p>We are unlikely to be able to publish a complete set of papers at the same time, we will also be making greater use of verbal reporting which will be captured in the meeting minutes.</p> |
| 7.5 | Conducting Board meetings <i>Admission of the public, the press and other observers</i> | Variation – see section 4 of this report. |
| 7.5.8 | Chairing Board meetings | In the absence of the Chair and Vice Chair, stipulate the Chair of Audit Committee as the 3 rd Chair |
| 7.5.11 | Executive nominated deputies | <p>The standing orders allow for a nominated deputy to represent an Executive Director, but not to have voting rights.</p> <p>The organisation currently has 9 Executives with voting rights; in the event that none are available the Board would need to determine if the nominated deputies should have voting rights. We propose to make recommendations on this if the need occurs.</p> |

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| | | | | | | | |
|--|---|---|--|--|--|--|--|
| Cyfarfod a dyddiad: Meeting and date: | Health Board 14 th May 2020 | | | | | | |
| Cyhoeddus neu Breifat: Public or Private: | Public | | | | | | |
| Teitl yr Adroddiad Report Title: | Maintaining Good Governance (Covid-19) | | | | | | |
| Cyfarwyddwr Cyfrifol: Responsible Director: | Ms Dawn Sharp Interim Board Secretary | | | | | | |
| Awdur yr Adroddiad Report Author: | Mrs Kate Dunn Head of Corporate Affairs | | | | | | |
| Craffu blaenorol: Prior Scrutiny: | Previous version approved by Health Board 15.4.20. Updates scrutinized by Interim Board Secretary.. | | | | | | |
| Atodiadau Appendices: | Appendix 1 revised Chair's Action proforma Appendix 2 scheduled of additional proposed variations from Standing Orders Appendix 3 Covid-19 Cabinet Terms of Reference | | | | | | |
| Argymhelliad / Recommendation: | | | | | | | |
| The Board is asked to: | | | | | | | |
| <ol style="list-style-type: none"> 1. Note the updated report 2. Approve the additional variations to the Standing Orders 3. Note the continued revised approach to Board decision making 4. Note the continued revised approach to meetings in public 5. Approve the Covid-19 Cabinet Terms of Reference | | | | | | | |
| 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 | X | Ar gyfer Trafodaeth For Discussion | | Ar gyfer sicrwydd For Assurance | | Er gwybodaeth For Information | |
| Sefyllfa / Situation: | | | | | | | |
| <p>Given the current and developing situation with Covid-19 it is necessary to sustain a range of variations to Board governance arrangements as agreed by the Board on 15.4.20. This updated paper sets out the proposed approach to ensuring the appropriate level of Board oversight and scrutiny to enable it to discharge its responsibilities effectively, whilst recognising the reality of executive focus and time constraints.</p> <p>A summary of changes since the Health Board considered this paper at its meeting on 15th April 2020 are:</p> <ul style="list-style-type: none"> • Further proposals to vary Standing Orders – as set out in Appendix 2 • The inclusion of Cabinet terms of reference – see Appendix 3 | | | | | | | |

- Amendment to para 4.3 to reflect the Health Board is currently meeting monthly
- Amendment to para 4.4 to reflect proposals for Committee and Advisory Group meetings from June onwards
- Consolidation of Chair's Action proforma and updating of standard operating procedure – see Appendix 1

Cefndir / Background:

The following narrative sets out the Health Board's approach to ensuring the appropriate level of Board oversight and scrutiny to discharge its responsibilities effectively, whilst understanding and recognizing that the executive focus and commitment will be to respond to the COVID-19 emergency. Part of this response includes changes to ways of working and the need to continually adapt to the crisis. This requires temporary variation from the legal framework to which the Board operates. To ensure a consistent approach across Wales, the national Board Secretaries Group, having a shared knowledge and expertise for good governance, have considered and developed a set principles for good governance during the Covid-19 pandemic and these are reflected in this paper.

1. INTRODUCTION

Whilst the Health Board undergoes significant changes to react to the coronavirus emergency the Board should strip back the agenda and focus on the essential business only.

The Board's fundamental role and purpose will remain during this period and does not change. Crucially during the current COVID-19 crisis, the Board must require and receive positive assurance, not just on service preparedness and response but also on clinical leadership, engagement and ownership of developing plans; on the health and wellbeing of staff; on proactive, meaningful and effective communication with staff at all levels and on health and care system preparedness.

At the same time, we must remember that if mistakes are made and harm done in this period then the enquiry that would surely follow would look very closely at how the Board assured itself, what questions it asked and what evidence it received.

This paper sets out BCUHBs approach to ensuring the appropriate level of Board oversight and scrutiny to discharge its responsibilities effectively, whilst recognising the reality of executive focus and time constraints. Part of the response is about ways of working, which of course can and must adapt continually during such a crisis; but part of the response requires temporary variation from the legal framework to which the Board operates – the Standing Orders (SOs) and Scheme of Reservation and Delegation of Powers (SoRD).

As there is a need for us to continually adapt, the approach set out in this paper will remain under constant review by the Chair, Interim Chief Executive and Acting Board Secretary. Any further variations to SOs, will be brought to the Board for approval or ratification.

2. WAYS OF WORKING PRINCIPLES

The differing ways of working set out in this paper will:

- Allow maximum flexibility to adapt to a rapidly evolving situation

- Minimise executive requirements for preparation of papers or attendance at meetings unrelated to the immediate requirements of COVID 19
- Be sensitive to the need to ensure executive wellbeing, particularly when there is a need for 24/7 involvement
- Ensure all Independent Members are briefed and engaged both through the crisis and beyond
- Ensure Independent Members expertise and contacts are appropriately available to execs during the crisis
- Provide an appropriate balance between short term operational imperatives and longer term requirements for a sustainable organisation
- Ensure that appropriate arrangements are in place to support the organisation to exit crisis in a planned way
- Ensure appropriate partnership arrangements are in place to deal with both short term necessities and longer term requirements to embed improvements
- All meeting arrangements should reflect current guidelines on social distancing
- Independent Member triangulation activities during this period should be minimised and will need to rely far more than usual on what is being told by the executive for assurance.
- The Chair and Interim Chief Executive will be in contact daily and the Chair will brief the Independent Members on a weekly basis.
- A range of communication arrangements are in place and include:
 - Daily bulletin to all staff (including all Board Members and primary care contractors)
 - Daily Primary Care Update from Primary Care Team to contractors and managed practises
 - Daily update to Board including Media Evening Update, Primary Care communications (as above) and HECC briefing
 - Daily update to partners inc AMs, MPs, CHC, LAs and third sector
 - Weekly message from CEO and Chair to all staff via email, Staff App and on intranet
 - Weekly teleconference with WG Communications and NHS Wales communications colleagues inc PHW
 - Workstream SITREP reporting once a week and shared with Gold Command
 - Weekly briefing to all Independent Members (via telephone conference)
 - Weekly Skype between Chair and local AMs
 - Weekly Skype/Telephone conference with the Trade Unions
 - Weekly Skype between Chair/CEO and Local Authority Leaders and CEOs and communications team representative dials in to daily LRF Media Cell call at 2pm
 - Weekly Skype between Chair/CHC leads
 - Vice Chair keeping in touch with Primary Care
 - Chair/Vice Chair speak weekly and as needed

3. GOVERNANCE PRINCIPLES

The All Wales Board Secretaries Group has framed a number of governance principles that are designed to help focus consideration of governance matters over coming weeks and months.

These are:

- **Public interest and patient safety** - We will always act in the best interests of the population of Wales and will ensure every decision we take sits in this context taking into account the national public health emergency that (COVID-19) presents.

- **Staff wellbeing and deployment** – we will protect and support our staff in the best ways we can. We will deploy our knowledge and assets where there are identified greatest needs.
- **Good governance and risk management** – we will maintain the principles of good governance and risk management ensuring decisions and actions are taken in the best interest of the public, our staff and stakeholders ensuring risk and impact is appropriately considered.
- **Delegation and escalation** – any changes to our delegation and escalation frameworks will be made using these principles, will be documented for future record and will be continually reviewed as the situation unfolds. Boards and other governing fora will retain appropriate oversight, acknowledging different arrangements may need to be in place for designated officers, deputies and decisions.
- **Departures** - where it is necessary to depart from existing standards, policies or practices to make rapid but effective decisions - these decisions will be documented appropriately. Departures are likely, but not exclusively, to occur in areas such as standing orders (for example in how the Board operates), Board and executive scheme of delegation, consultations, recruitment, training and procurement, audit and revalidation.
- **One Wales** – we will act in the best interest of all of Wales ensuring where possible resources and partnerships are maximised and consistency is achieved where it is appropriate to do so. We will support our own organisation and the wider NHS to recover as quickly as possible from the national public health emergency that COVID-19 presents returning to business as usual as early as is safe to do so.
- **Communication and transparency** - we will communicate openly and transparently always with the public interest in mind accepting our normal arrangements may need to be adapted, for example Board and Board Committee meetings being held in public.

4. GOVERNANCE AND RISK

4.1 Decision Making and variation from Standing Orders

The SOs and SoRD set out, together with a range of other framework documents, the arrangements for the Board and the wider organisation to make decisions. In principle, the current Board scheme of delegation and specifically the matters the Board reserves for its own decision (schedule 1 of the SOs) will remain. The aim would be to retain whole Board decision making for as long as possible, however, if the full Board was not available or could not be convened at speed it will operate with a quorum as set out in standing orders.

In the event of a critical or urgent decision(s) needing to be made, Chair's action (Health Board Chair and Committee Chairs) will be utilised. The process for considering Urgent Action is set out in Appendix 1.

- Where possible the full Board will retain decision making;
- If the full Board is not available or practical, it will operate with a quorum of 3 executives and 3 independent members that can be convened at speed;
- Chair's Action will be used sparingly and only as a last resort. Any Chair's Action will of course be recorded and ratified by reporting to the next available meeting in public session.

To ensure that the Health Board can facilitate agile decision making and reduce unnecessary bureaucracy, without compromising strong governance, a temporary variation to parts of the Standing Orders (November 2019 edition) were agreed by the Health Board on 15th April 2020 and some additional proposed variations are set out in the table within Appendix 2.

The Board and Committee structure will need to be streamlined. Executive Directors will have little time for the preparation of reports, so the Board is asked to accept oral reports where appropriate, and to accept that reports may not be received in accordance with the agreed 7 day timescale. It is important to ensure that there is a clear audit trail with minutes recording how decisions have been made.

The Interim Chief Executive, as Accountable Officer, is delegated authority by the Board to make decisions with regard to the management of the Health Board. Executive Directors have been delegated certain responsibilities and decision making powers through the Board's SoRD. These arrangements will remain in place with regard to the ongoing functioning of the organisation. In respect of COVID-19, the Chief Executive will deploy decision making through the established command and control structure.

Decision making guidance during COVID-19 has been agreed with Gold Command. This details at which level decision can be made, who can make them and where it must be recorded. This has been developed in accordance with the Health Board's SOs, Standing Financial Instructions (SFIs) and the SoRD. All decision logs will be reviewed by Gold Command on a weekly basis. A Covid-19 Cabinet has been established with the purpose of being responsible for oversight of key high-level strategic matters relating to the Health Board's response to the health emergency presented by the Covid-19 pandemic. As such, the Cabinet will be the vehicle to consider whether any decisions require escalation to Board. A copy of the Cabinet Terms of Reference are attached at Appendix 3 for approval.

4.2 Financial Guidance

Welsh Government has issued financial guidance to NHS Wales Organisation given the immediate challenges presented by the COVID-19 pandemic, recognising that routine financial arrangements and disciplines are disrupted and need to adapt on an interim basis. The guidance has been developed to support organisations and provide clarity on expectations for this disrupted period and until organisations return to business as usual arrangements.

4.3 Board Meetings

The Board is unlikely to meet in person for the foreseeable future and so will meet through electronic/telephony means. As a result of this, members of the public will be unable to attend or observe. Board meetings will continue to be held bimonthly or more frequently as business requires.

To facilitate as much transparency and openness as possible the Health Board will undertake to:

- Publish agendas and papers as far in advance as possible – ideally 7 days in advance of the meeting. Increase the use of verbal reporting which will be captured in the meeting minutes
- Provision for written questions to be taken from Independent Members 24 hours beforehand to assist with the flow and reduced time of meetings
- As well as a live action log, a pending log will be kept of actions that will not be progressed during the crisis
- Publish a set of minutes from the meeting (a draft approved by the Chair) to the public website as soon as possible – ideally within 3 working days.

Health Board agendas will be stripped back to essential business only and should focus on matters requiring a decision from the Board. It is accepted that Executives will attend meetings only to present specific items. The agenda for the Board Meeting during this period will cover the following as a minimum:

- COVID-19 (update and urgent issues)
- Advice, requirements and guidance from Welsh Government
- Risk Register
- Recovery Programme
- Financial Report
- Minutes of the previous meeting

The website (which constitutes our official notice of Board meetings) has been updated to explain why the Board is not meeting in public.

The Chair, Interim Chief Executive and Acting Board Secretary will agree the substantive items to be brought to the Board. Any decisions that are taken at this time should be those that could not be held over until it is possible to resume the requirement to meet in public.

Board papers will be kept brief and deal with issues that require the Board to make a decision. Information not requiring a decision can be sent electronically outside of the meeting.

Executive Directors will need to broaden powers of delegation, so the Board will need to accept that there may be situations where they will be informed after the event, rather than consulted as current practice.

4.4 Standing down of Committee and Officer Groups

The Board's Committees and Advisory Group meetings have been suspended for the months of April and May 2020 other than Audit Committee and the Quality, Safety & Experience Committee which will continue to meet remotely with a stripped back attendance and agenda. From June 2020 onwards it is proposed that Committee and Advisory Group Chairs and Lead Executives review the cycles of business and forward plans to determine whether there is a need for a meeting to take place.

A range of officer-led groups have also been suspended including the Drug and Therapeutics Group and Quality & Safety Group and a Chair's Action process will be utilized for approval of pan BCU written control documentation relating to non Covid-19 matters. This approach has been endorsed by the Executive Director of Nursing & Midwifery / Deputy Chief Executive.

Asesiad / Assessment & Analysis

Strategy Implications

There will be some interruption to aspects of the Board's statutory functions including the suspension by Welsh Government of the normal IMTP and reporting arrangements.

Financial Implications

There are no financial implications directly attributed to the implementation of the proposals set out in this paper. Welsh Government has issued financial guidance to NHS Wales Organisations given the immediate challenges presented by the COVID-19 pandemic, recognising that routine financial arrangements and disciplines are disrupted and need to adapt on an interim basis. It is anticipated that there will be changes required to the Standing Financial Instructions especially in relation to the changes to procurement processes and financial delegations. It is anticipated that guidance will be issued to NHS Wales organisations to confirm the changes that would be required. Once this has been received a further report will be considered by the Health Board.

Risk Analysis

Without the proposed changes there would be a significant risk to the safety and welfare of individuals, therefore the aim of the changes is to ensure the Health Board complies with the need to protect individuals and not meet in person, whilst also trying to reduce the burden on staff from normal reporting arrangements, and thus allowing them to focus on responding to the COVID-19 emergency.

Legal and Compliance

To ensure that agile decision making can continue and to reduce unnecessary bureaucracy without compromising strong governance, parts of the Standing Orders are to be varied on a temporary basis. These variations have been agreed on an All Wales basis and with Welsh Government and are in accordance with the provision within the NHS (Wales) Act 2006 – Schedule 3, Part 2 which states that “*An NHS trust may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.*”

In addition the ability within the Public Bodies (Admission to meetings) Act 1960 S.1(2) to exclude the public from a meeting for “*other special reasons stated in the resolution*” will be applied to protect members of the public and Health Board employees during the period of the pandemic situation.

Impact Assessment

The approach set out in this paper will remain under constant review by the Chair, Interim Chief Executive and the Acting Board Secretary. Any further variations to SOs, whether as a result of further reflection or in response to direction from Welsh Government, will be brought to the Board for approval or ratification.

**OFFICE OF BOARD SECRETARY (OBS)
STANDARD OPERATING PROCEDURE (SOP)**

| | |
|---------------|--|
| Title | Chair's Action During Covid-19 |
| Author | Mrs Kate Dunn Head of Corporate Affairs |

1. Purpose

To describe the procedure for agreeing, recording and reporting Chair's Action on behalf of the Board and its Committees and/or Advisory Groups during the Covid-19 pandemic.

2. Responsibility / Scope

In line with Standing Order Para 2.1, Chair's Action can be taken to allow decisions to be taken between scheduled meetings, when it is not practicable to call an extraordinary meeting.

The procedure applies to Chairs and officers who support the Board or its Committees and/or Advisory Groups. The Head of Corporate Affairs will manage the procedure on behalf of the Board Secretary.

3. Process

3.1 The need for an action to be brought to the attention of the Chair for Chair's Action should be raised via the lead responsible officer.

3.2 The template (attached) should be completed and presented with any explanatory of background paperwork

3.3 Approval via email will be sought from individuals as required by the template

3.4 Two Independent Members will also be consulted via email.

3.5 Interim Board Secretary to confirm that correct process has been followed

3.6 Actual signed documentation will be prepared when the organisation comes out of the pandemic situation and retained corporately within the Office of the Board Secretary.

4. Reporting

The Chair should report to the next available meeting on the action taken, to ensure an appropriate minute is generated.



Chair's Action on Urgent Matters

Health Board / Committee: *(Please state)*

Title:

Introduction, Context and Justification for not submitting this matter to the full Board/Committee: *(why is Chair's action necessary?)*

Issue for Consideration: *(what are the key points, associated risks, background? Also note where this matter has received prior scrutiny)*

Recommendation: *(what is the Chair being asked to approve/agree?)*

Name of individual being asked to agree the recommendation: *(with explanation where this is not the Chair or Chief Executive e.g due to conflict of interest relating to the urgent matter)*

Date when this Chair's Action will be reported to full Board/Committee:

Independent Members Consulted *(print names):*

1.
Comments:

2.
Comments:

Recommendation Approved by:

Health Board / Committee Chair or Vice-Chair

Chief Executive / Nominated Deputy

Board Secretary
(sign to confirm compliance with agreed process)

Dated:.....

| SO Number | Heading / Sub Heading | Proposed Change |
|------------------|--|--|
| 7.5.11 | Executive nominated deputies | <p>The standing orders allow for a nominated deputy to represent an Executive Director, but not to have voting rights.</p> <p>The organisation currently has 9 Executives with voting rights; in the event that none are available and the quorum was compromised the Board would need to determine if the nominated deputies should have voting rights. We propose to make recommendations on this if the need occurs.</p> |
| 10.2.2 | Annual Reporting of Committees and Advisory Groups | <p>The only Annual Reports required for 2019-20 will be from Audit Committee and the Quality, Safety & Experience Committee. All other Committees and Advisory Groups will provide a summary of activity for inclusion within the Annual Governance Statement.</p> |

**Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements**

Covid-19 Cabinet Meetings

1) INTRODUCTION

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

2) PURPOSE

2.1 The purpose of the Cabinet is to be responsible for oversight of key high-level strategic matters relating to the Health Board's response to the health emergency presented by the Covid-19 pandemic. This will involve consideration of the outputs of Gold Command and other levels within the Command Structure as necessary - providing scrutiny, challenge and seeking assurance - and also decision-making on those matters requiring escalation to the full Board.

3) DELEGATED POWERS

3.1 The Cabinet is authorised by the Board to:-

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

3.1.2 ensure the adequacy of key arrangements fundamental to assurance, including the command structure, situation reports, decision logs, preparedness, resilience, risk registers, and intelligence gathering capability.

3.1.3 seek assurance on the progress made, through the Gold Commander in critical strategic and tactical areas such as clinical pathways (including but not limited to both COVID-19 and Non COVID-19 related care and treatment), capacity and surge planning and mobilisation (including but not limited to temporary hospitals), testing, workforce, equipment and recovery..

3.1.4 seek assurance that lessons are being learnt and that learning is being applied throughout the COVID-19 Response as appropriate.

3.1.5 seek assurance that recovery plans are in hand for a return to business as usual, incorporating lessons learned and changes in practice achieved as part of the COVID-19 Response, including a transition plan to be activated at an appropriate point in the Plan prior to the conclusion of the activation.

3.1.6 oversee the effectiveness of joint working with partners and of communications, ensuring the avoidance of reputational harm as appropriate.

4) AUTHORITY

4.1 The Cabinet may investigate or have investigated any activity (clinical and non-clinical) to enable it to discharge its responsibilities. It may request from officers or groups within the Command Structure and through the Gold Commander, any information it deems necessary to maintain visibility of critical issues and transparency of the full Board.

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

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

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

5) MEMBERSHIP

5.1 Members

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

5.2 In attendance

- Covid-19 Gold Commander
 - Health Emergency Control Centre Commanders
 - Deputy Chief Executive / Executive Director of Nursing and Midwifery
 - Senior Responsible Officer, Governance and Risk
- Other Executives, officers and special advisers will join as required by the Chair, as well as any others from within or outside the organisation who the Cabinet considers should be invited, taking into account the matters under consideration at each meeting.

5.3 Member Appointments

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

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

5.4 Secretariat

The Secretariat will be determined by the Board Secretary.

5.5 Support to Committee Members

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

6) CABINET MEETINGS

6.1 Quorum

At least two Independent Members must join a meeting to ensure the quorum of the Cabinet, one of whom should be the Cabinet Chair or Vice-Chair. In the interests of effective governance, it is expected that the Chief Executive and a minimum of two COVID-19 Commanders (including the Gold Commander or nominated deputy and at least one HECC Commander) must join the meeting. In the event that the Commanders are unable to attend, then deputies will be agreed.

6.2 Frequency of Meetings

Meetings shall be held at least once per fortnight.

6.3 Withdrawal of individuals in attendance

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

6.4 Conduct of Meetings

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

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

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

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

8) REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Cabinet Chair shall:

8.1.1 report formally, regularly and on a timely basis to the full Board on the Cabinet's activities.

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

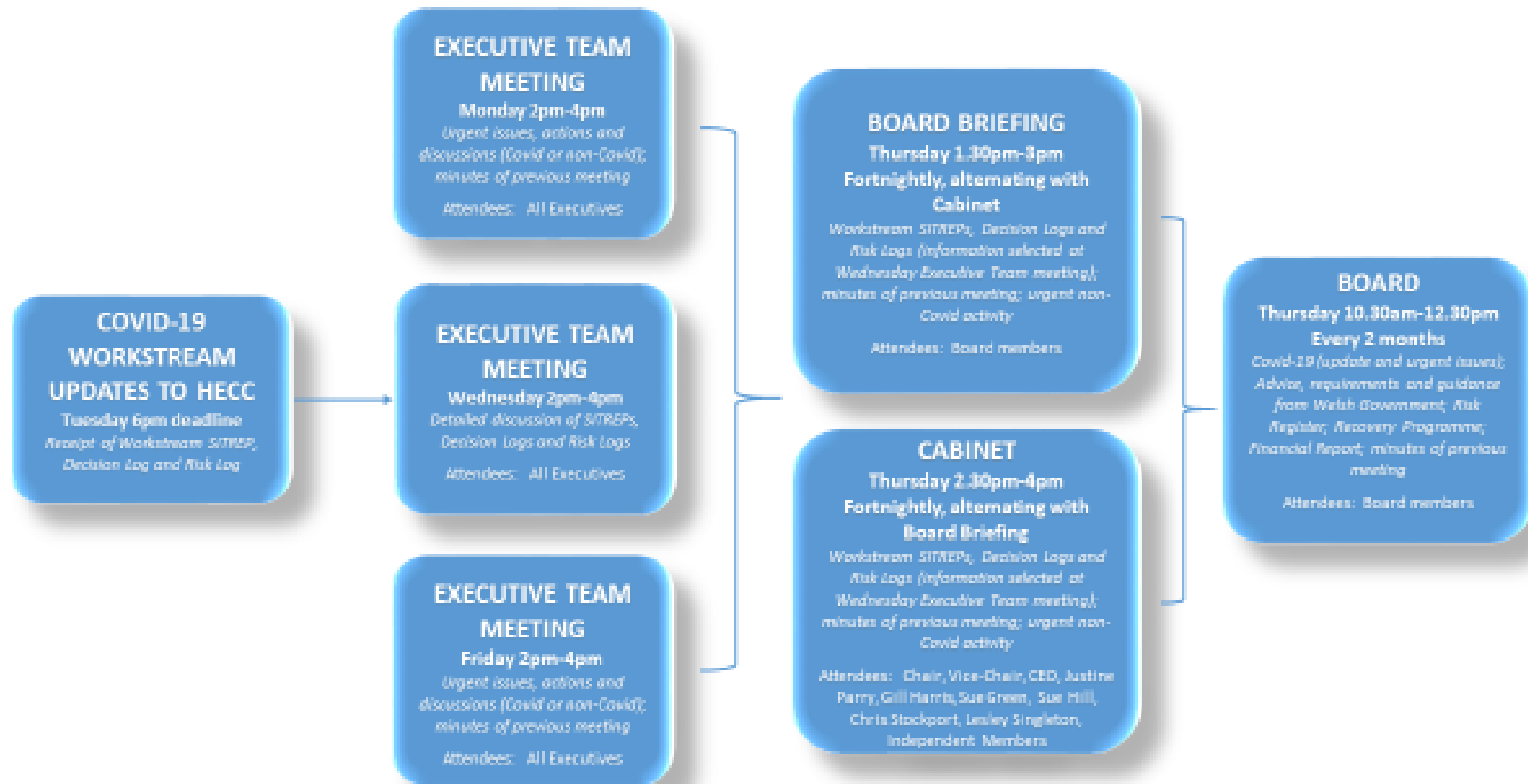
8.1.3 please see attached annex (i) - COVID-19 Board and Exec meeting reporting structure.

9) REVIEW

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

Date of approval: 23/04/2020 (by Cabinet)

Annex (i) – COVID-19 Board and Exec Meeting Reporting Structure





Guidance Note : Discharging Board Committee Responsibilities during COVID-19 response phase

Introduction

The NHS in Wales is currently facing unprecedented and increasing pressure in planning and providing services to meet the needs of those who are affected by COVID-19. Alongside this is the need for organisations to balance continuing to provide and commission life-saving and life impacting essential services. As a result of the pressure placed on the NHS bodies and the Welsh Government response to managing the impact of the pandemic it has been necessary to adapt governance arrangements. The Welsh Government in its response (dated 26 March 2020) to a letter received on behalf of the Board Secretaries Group, agreed the Governance Principles that are designed to help focus consideration of governance matters over the coming weeks and months (see below).

Governance Principles:

- **Public interest and patient safety** – We will always act in the best interests of the population of Wales and will ensure every decision we take sits in this context taking in to account the national public health emergency that (COVID-19) presents.
- **Staff wellbeing and deployment** – we will protect and support our staff in the best ways we can. We will deploy our knowledge and assets where there are identified greatest needs.
- **Good governance and risk management** – we will maintain the principles of good governance and risk management ensuring decisions and actions are taken in the best interest of the public, our staff and stakeholders ensuring risk and impact is appropriately considered.
- **Delegation and Escalation** – any changes to our delegation and escalation frameworks will be made using these principles, will be documented for future record and will be continually reviewed as the situation unfolds. Boards and other governing for a will retain appropriate oversight, acknowledging different arrangements may need to be in place for designated officers, deputies and decisions.
- **Departures** – where it is necessary to depart from existing standards, policies or practices to make rapid but effective decisions – these decisions will be documented appropriately. Departures are likely, but not exclusively, to occur in areas such as standing orders (for example in ow the Board operates), Board and executive scheme of delegation, consultations, recruitment, training and procurement, audit and revalidation.
- **One Wales** – we will act in the best interest of all of Wales ensuring where possible resources and partnerships are maximised and consistency is achieved where it is

appropriate to do so. We will support our own organisation and the wider NHS to recover as quickly as possible from the national public health emergency that COVID-19 presents returning to business as usual as early as is safe to do so.

- **Communication and transparency** – *we will communicate openly and transparently always with the public interest in mind accepting our normal arrangements may need to be adapted, for example Board and Board Committee meetings being held in public.*

The purpose of this guidance note is to assist the Board in discharging their responsibilities during this time, paying particular attention to the role of the Quality and Safety Committee and Audit Committee.

Background

NHS Boards are required to establish a number of Committees, including a Quality and Safety and an Audit Committee in accordance with the Model Standing Orders for NHS organisations in Wales.¹ In responding to the pandemic, NHS organisations in Wales have revised their arrangements, standing down some board committees and partnership forums, and reviewing the remit of others. Two committees which will continue to meet in all organisations are the Quality and Patient Safety Committee and the Audit Committee, operating where required, through revised arrangements.

Assessment of Board and Committee Roles in Responding to the Pandemic

Whilst the Quality and Patient Safety (Q&PS) and Audit Committees may operate with more focused agendas as the organisation responds to the pandemic a number of areas will still require their attention which are not directly COVID-19 related. Organisations should consider their current governance arrangements including the operation and frequency of the Board and appropriate committees.

It may be sensible for the Board to consider an integrated approach to assurance that limits the amount of management time needed, particularly on those with clinical responsibility where the impact of COVID-19 will be most felt.

As the organisation moves into the recovery and re-activation phase it will be necessary to consider the currency of previous audits and reviews as it is recognised that some services/activities will inevitably change in the long term as a result of the different ways of working that have been established. In the interests of openness and transparency it will be necessary to ensure there is a log of Committee activity pre-Crises to ensure this does not get overlooked and there is a clear audit trail.

Some areas for the Board to consider for the Q&PS Committee and Audit Committee to discharge include:

¹ *Model Standing Orders*, Welsh Government, September 2019, <http://www.wales.nhs.uk/governance-emanual/standing-orders>

Quality and Safety Committee

Workforce and volunteers

- Safety and use of temporary staff/staff working in unfamiliar environments (including field hospitals)/with unfamiliar patient mix and use of volunteers
- Sickness absence levels/need for staff to self-isolate and impact on safer staffing
- Capacity of other non-patient areas, e.g. pathology with regard to COVID-19 and non-COVID workloads
- Health and well-being of staff (in the absence of a Workforce Committee this may fall to the Quality and Safety Committee or the Board may decide they wish to maintain oversight of this area).

Equipment, Medicines, Supplies and Facilities Management

- Availability of appropriate PPE, its procurement, deployment, staff training, guidance and communication.
- Availability of equipment and consumables - procurement, deployment, risk assessment and training requirements , monitoring supplies and stocks,
- Medicines management - access to critical medicines, community access etc.
- Cleaning and hygiene – cleaning regimes for all areas, potential impact on other hospital acquired infections, ability of staff to shower and change as appropriate at the end of their shift etc.

Safety, Quality and Clinical Effectiveness

- Maintaining an oversight and monitoring of the organisations ability to provide/ commission essential services and agree action where there are significant risks to delivery.
- Serious incident management – to include any changes to the arrangements for reporting and managing incidents, monitoring and tracking themes as a result of COVID-19
- Responding to patient safety alerts and notices and other improvement actions needed, including any requirements from inspections in line with advice from Healthcare Inspectorate Wales and other regulatory bodies.
- Mortality reviews – maintain oversight of mortality reviews for those deaths where there may be a concern or unusual circumstances. Committees should ensure immediate ‘make safes’ are put in place and learning shared across the organisation in the usual way
- Triggers for clinical harm reviews of those on waiting lists – how will these be identified and will there be any change to the pre-COVID arrangements?
- Understanding position regarding the organisations clinical audit programme (Note – National Programme suspended)
- Arrangements for approving amendments to policies, procedures and protocols – how will this be managed during the phases of the response?
- How is the organisation keeping a track of the published guidance? Are there arrangements for evaluating and ensuring an appropriate response?

- Is the Committee clear regarding the expectations of staff regarding following guidance and maintaining parameters of clinical practice?
- Potential risk to patients if unable to fulfil assessment of specialising needs leading to potential increased Deprivation of Liberty concerns e.g. if clinical areas are locked to maintain patient safety.
- Ensuring that services delivered in surge facilities such as field hospitals have clear operating procedures in place and in line with the organisation's clinical/quality governance arrangements

Patient Experience

- Patient Experience and Concerns Reporting – arrangements for managing and responding during response, recovery and re-activation phases.
- Consideration of issues and concerns which may be raised by the Community Health Council.
- Impact on patients due to their ability to access essential services such as end of life and palliative care, pain control, value based decision making.
- Concerns and mitigation regarding ability to ensure Welsh language, other language and needs as a result of protected characteristics are met.
- DNACPR and ensuring its appropriate use.
- Impact on patients and their families regarding visiting policies, ability to ensure supplies of clothing and basic toiletries, provide for hygiene and nutrition needs, provide comfort towards end of life, pastoral needs etc.

Capacity

- Ability to meet demand of COVID and patients requiring essential services
- Status and utilisation of surge capacity
- Plans for use during response, recovery and re-activation phase.
- Status of life saving and life enhancing services
- Performance split between COVID- and non-COVID patients.

Annual Reporting

- Agree Annual Quality Statement for approval by the Board before 30 September 2020.
- Receive Annual Putting Things Right Report
- Receive information regarding annual reports/programmes which have been suspended (e.g. National Clinical Audit Programme) and arrangements for receiving exception reports if required.

**Decision Making and Delegation of Powers/Risk Management and Assurance*

See below in Audit Committee Section. The Q&PS Committee will need to consider matters which fall within their Terms of Reference and decision making powers.

Audit Committee

Annual Reporting

Revised timescales were issued in the Welsh Government letter dated 26 March 2020 (see References section below). This will inform the work of the Committee during the annual reporting period.

- Review and recommend the annual accounts for adoption and approval by the Board
- Review the Annual Governance Statement to ensure it is an accurate reflection of the position for 2019/20 and up to the date of approval, prior to signature by the Chief Executive/Accountable Officer – ensure the impact of the need to respond to COVID-19 is clear.
- Review the Remuneration Report and recommend for approval by the Board
- Review the Annual Report and accountability statements in accordance with revised timetable issued by Welsh Government and recommend for approval by the Board

Note: Whilst it is for each organisation to agree the level of assurance required and content of reports consideration should be given to the potential impact of diverting resources to prepare reports which will add limited value to the response, recovery and reactivation of services.

Internal Audit

The Chair may benefit from holding a discussion with the Head of Internal Audit and Board Secretary to help inform the activity of the Committee during the response, recovery and reactivation phase. The Committee will be required to:

- Receive the Annual Audit Opinion of the Head of Internal Audit and Annual Internal Audit Report which will inform the Annual Governance Statement
- Assess the status of the Annual Internal Audit Plan 2019/20 and the potential impact on the 2020/21 Plan
- Review and agree a revised plan for 2020/21 with the Head of Internal Audit. This will need to remain fluid as it is not clear at this stage when the programme will be able to commence or what revisions will be required to cover both supporting recovery and reflecting the revised risk profile of the organisation.
- Agree the arrangements for tracking internal audit actions during the period. The Committee may wish to focus on:
 - Reports which received a Limited Assurance or No Assurance Rating
 - Actions assessed as high priority where the “action by date” has passed
- As the organisation moves into the recovery and reactivation phase consider whether previous reports and resulting actions still remain relevant
- Assess whether any decisions/ways of working which were established during the response phase would benefit from an Internal Audit Review to provide assurance to the organisation.

Audit Wales

As indicated for Internal Audit it is suggested that Chair holds a discussion with the Audit Wales Partner and Board Secretary to inform the activity of the Committee during the response, recovery and reactivation phase. Annual Reports and Structured Assessment reports for 2019 were published before the COVID-19 pandemic was declared. The Auditor General for Wales has advised on the Audit Wales website² that whilst delivering his statutory responsibilities, he wants to ensure that audit work does not have a detrimental impact on audited bodies and their staff at a time when the public service is stretched and focused on more important matters.

Arrangements will be put in place to ensure delivery of the statutory end of year duties in accordance with the revised accounting timetable.

*Risk Management and Assurance**

Although the Committee should not be directly involved in the process of risk management, the organisation's risk management system will underlie the assurance system and the Committee needs to review the risk management processes in exercising its functions in relation to this system of assurance³.

- It is likely that the organisations risk appetite will be higher than in the pre-crises phase to ensure the organisation is able to respond effectively and at pace. This may be evidenced in the speed that decisions have been arrived at for example.
- The Committee should seek assurance that risks have been assessed and evidenced transparently including disproportionate impact on other areas.
- What level of assurance is available from external sources for the risks and what is the level of confidence that can be gained from this as it is likely their programmes have also been impacted? Is there confidence in the sources of internal assurance during this time to help mitigate against the impact on sources of external assurance?
- As the organisation moves into the recovery and reactivation phase it will be necessary to further consider the risk appetite and tolerance of the organisation. Whilst accepting that it unlikely to be appropriate to revert back to the position before the pandemic it is important to ensure that any changes have been considered and agreed by the Board and arrangements are in place to manage appropriately.

*Decision Making and Delegation of Powers**

The Governance Principles recognise there may be changes to the delegation and escalation frameworks, together with departures from existing standards, policies or practice to make rapid but effective decisions. They also recognise the need to document such departures for future record and to ensure their continual review as the situation unfolds.

² <https://www.audit.wales/news/covid-19>

³ Welsh Government Audit Committee Handbook , June 2012,
<http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf>

- Committee has a role to consider any variation in Standing Orders, approving these where it considers appropriate and providing a formal report to the Board.
- Assess robustness of the arrangements for recording decisions and arrangements for ensuring business continuity if individuals are not able to discharge their responsibilities.
- Receive information regarding any variation from Schemes of Delegation/Organisational Policies and Procedures/Standard Operating Procedures

* Note –The Audit Committee together with the Quality and Patient Safety Committee will have a role in advising the Board regarding the appropriateness of this risk management arrangements, decision making and the delegation of powers.

Financial Control and Management

The HFMA have published COVID-19 Financial Governance Considerations⁴ which advises of areas which will require consideration such as review of scheme of delegation, authorised signatory arrangements, coding of expenditure etc. The Audit Committee will have a role in:

- Receiving information on the changes to control procedures and delegations which have been necessary to ensure the organisation is able to respond
- Receiving information relating to the arrangements for recording any deviations
- Receiving information regarding these deviations – this may be a list of contracts entered into which have not been subject to the full procurement controls
- Review losses and special payments
- Assurance that there where appropriate legal advice has been sought prior to entering into agreements

Counter Fraud

The Local Counter Fraud Specialist (LCFS) is the main point of contact and will advise regarding reports which should be received by Audit Committees during this time.

The fraud threat posed during emergency situations is higher than at other times and organisations should put in appropriate controls to mitigate where possible.

The UK government are issuing information regarding safeguards which should be put in place⁵ and alerts are also being issued in Wales

⁴ COVID-19 Financial Governance Considerations, Healthcare Financial Management Association (HFMA), <https://www.hfma.org.uk/docs/default-source/publications/covid19-financial-governance-implications.pdf?sfvrsn=0>

⁵ Fraud control in Emergency Management:COVID-19 UK Government response, Government Counter Fraud Function, <https://www.gov.uk/government/publications/fraud-control-in-emergency-management-covid-19-uk-government-guide>

The Audit Committee should consider the arrangements for undertaking post-event assurance to look for fraud and ensure access to fraud investigation resources. This should be undertaken as soon as practicable and the Committee should receive the findings.

Recommendation

NHS organisations should consider the information and guidance provided in this document to inform the arrangements for their Board Committees during the COVID-19 response phase. They will also need to consider the relevance as they move into the recovery/reactivation phase.

Further guidance will be issued if required.

References

COVID-19 Financial Governance Considerations, Healthcare Financial Management Association (HFMA), <https://www.hfma.org.uk/docs/default-source/publications/covid19-financial-governance-implications.pdf?sfvrsn=0>

Fraud control in Emergency Management: COVID-19 UK Government response, Government Counter Fraud Function, <https://www.gov.uk/government/publications/fraud-control-in-emergency-management-covid-19-uk-government-guide>

Strengthening the health system response to COVID-19, Recommendations for the WHO European Region Policy brief, World Health Organisation, 1 April 2020, http://www.euro.who.int/_data/assets/pdf_file/0003/436350/strengthening-health-system-response-COVID-19.pdf

COVID-19: Operational guidance for maintaining essential health services during an outbreak, World Health Organisation, 25 March 2020, <https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak>

Welsh Government Audit Committee Handbook, June 2012, <http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf>



Guidance Note : Discharging Board Committee Responsibilities during COVID-19 response phase

References – Including those Internal to WG/NHS References

COVID-19 Financial Governance Considerations, Healthcare Financial Management Association (HFMA), <https://www.hfma.org.uk/docs/default-source/publications/covid19-financial-governance-implications.pdf?sfvrsn=0>

Fraud control in Emergency Management: COVID-19 UK Government response, Government Counter Fraud Function, <https://www.gov.uk/government/publications/fraud-control-in-emergency-management-covid-19-uk-government-guide>

Strengthening the health system response to COVID-19, Recommendations for the WHO European Region Policy brief, World Health Organisation, 1 April 2020, http://www.euro.who.int/_data/assets/pdf_file/0003/436350/strengthening-health-system-response-COVID-19.pdf

COVID-19: Operational guidance for maintaining essential health services during an outbreak, World Health Organisation, 25 March 2020, <https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak>

Framework for Maintaining Life Saving and Life Impacting Essential Services during the COVID 19 Pandemic, v7, 15 April 2020, Welsh Government



Life Saving and Life
Impacting Services r

Welsh Government Audit Committee Handbook , June 2012, <http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf>

Quality committees and COVID-19, 20 April 2020, Good Governance Institute, <https://www.good-governance.org.uk/blog-post/quality-committees-and-covid-19/>

Letter from Welsh Government regarding Implementation of Putting Things Right during the time of coronavirus (COVID-19) – 18 March 2020



Letter re
Coronavirus (COVID

Letter from Welsh Government regarding Proposals for Corporate Governance on COVID-19 – 26 March 2020



200326 - Response
to Letter Advice_Pro

Letter from Welsh Government regarding COVID-19 – Decision Making & Financial Guidance – 30 March 2020



2020-03-30 AG to
CEs AO letter COVID

COVID-19 Financial Guidance to NHS Wales' organisations



COVID-19 Financial
Guidance_FINAL.pdf

Letter from Welsh Government regarding Mortality Reviews during the time of coronavirus (COVID-19) – 17 April 2020



20200406 Mortality
Reviews Covid 19.pc

| | | | | | | | |
|---|--|---|--------------------------|--|--------------------------|--|-------------------------------------|
| Cyfarfod a dyddiad: Meeting and date: | Audit Committee 29/06/20 | | | | | | |
| Cyhoeddus neu Breifat: Public or Private: | Public | | | | | | |
| Teitl yr Adroddiad Report Title: | Summary of business considered in private session to be reported in public | | | | | | |
| Cyfarwyddwr Cyfrifol: Responsible Director: | Acting Board Secretary | | | | | | |
| Awdur yr Adroddiad Report Author: | Statutory Compliance, Governance & Policy Manager | | | | | | |
| Craffu blaenorol: Prior Scrutiny: | Acting Board Secretary | | | | | | |
| Atodiadau Appendices: | None | | | | | | |
| Argymhelliad / Recommendation: | | | | | | | |
| The Committee is asked to note the report. | | | | | | | |
| Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category) | | | | | | | |
| Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval | <input type="checkbox"/> | Ar gyfer Trafodaeth For Discussion | <input type="checkbox"/> | Ar gyfer sicrwydd For Assurance | <input type="checkbox"/> | Er gwybodaeth For Information | <input checked="" type="checkbox"/> |
| Sefyllfa / Situation: | | | | | | | |
| To report in public session on matters previously considered in private session | | | | | | | |
| Cefndir / Background: | | | | | | | |
| Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings. | | | | | | | |
| The issues listed below were considered by the Audit Committee at its private in committee meeting of: 19.03.20. | | | | | | | |
| <ul style="list-style-type: none"> • Draft Annual Quality Statement (AQS). • Financial Conformance report (including review of Annual Accounting Process). • Post Payment Verification Progress report • Counter Fraud Services Progress report. • Update on Internal and External Audit Actions • Recovery Programme report. | | | | | | | |

Asesiad / Assessment & Analysis**Strategy Implications**

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

Financial Implications

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

Risk Analysis

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

Legal and Compliance

Compliance with Standing Order 6.5.3

Impact Assessment

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



| | | | | | | |
|---|---|---|-------------------------------------|--|-------------------------------------|--------------------------------------|
| Cyfarfod a dyddiad: Meeting and date: | Audit Committee 29 th June 2020 | | | | | |
| Cyhoeddus neu Breifat: Public or Private: | Public | | | | | |
| Teitl yr Adroddiad Report Title: | Risk Management Strategy and Policy | | | | | |
| Cyfarwyddwr Cyfrifol: Responsible Director: | Gill Harris – Deputy Chief Executive/Executive Director of Nursing and Midwifery | | | | | |
| Awdur yr Adroddiad Report Author: | Mrs Justine Parry, Assistant Director of Information Governance and Risk Mr David Tita, Head of Risk Management | | | | | |
| Craffu blaenorol: Prior Scrutiny: | The Risk Management Strategy and Policy has been reviewed and discussed previously at the Risk Management Group in April and November 2019, at the Audit Committee workshop in December 2019 and the Board in March 2020. In addition significant scrutiny, conversations and updates have been provided by the Audit Committee Chair, the Quality, Safety and Patient Experience Committee Chair and the Chair of the Digital and Information Governance Committee. | | | | | |
| Atodiadau Appendices: | Appendix 1 – RM01 Risk Management Strategy and Policy Appendix 2 – BCU Risk Management Improvement Plan Appendix 3 - Movement of Risks from 5 to 3 Tiers | | | | | |
| Argymhelliad / Recommendation: | | | | | | |
| The Audit Committee is asked to: <ul style="list-style-type: none"> • Approve the further changes to the updated Risk Management Strategy and Policy as previously recommended. • Gain assurance on the changes to the operational implantation of the strategy included within the Risk Management Improvement Plan. • Approve the change in approach for managing risk from a 5 tier model to a 3 tier mode. • Recommend the approval of the Risk Management Strategy to the Board. | | | | | | |
| Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category) | | | | | | |
| Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Ratification | <input checked="" type="checkbox"/> | Ar gyfer Trafodaeth For Discussion | <input checked="" type="checkbox"/> | Ar gyfer sicrwydd For Assurance | <input checked="" type="checkbox"/> | Er gwybodaeth For Information |
| Sefyllfa / Situation: | | | | | | |
| This paper presents the new Risk Management Strategy and Policy for the Health Board. The new strategy underlines the intention and commitment of the Health Board to embark on the implementation and embedding of an Enterprise Risk Management (ERM) Model across all its Services and Directorates from `Ward to Board` in 2020/21. | | | | | | |
| Cefndir / Background: | | | | | | |

This new Risk Management Strategy and Policy, has been developed following a number of risk management workshops which were held with members of the Board (20th Dec 2018 & 18th July 2019) and the Audit Committee (2nd Dec 2019). In addition to the above workshops, two other workshops were held with staff at Abergele hospital. These workshops provided an opportunity to engage with staff on the development of the new Strategy document.

The results of the recent Risk Management Gap and Training Needs Analysis undertaken by the risk management team across the Health Board indicate a commitment by staff to regularly review and update their risks. Colleagues also mentioned competing demands, the lack of clarity around the risk escalation process and lack of risk management training as some of the issues undermining the robust implementation and embedding of risk management in their services and Directorates.

In response, whilst the new Risk Management Strategy and Policy clarifies the governance and escalation process for risks from 'Ward to Board', a risk management training pack and targeted support have been developed to ensure that staff are sufficiently trained, in the identification, assessment and management of risks in their areas. The Risk Management Strategy and Policy will also be supported by the following documentation:

- RM02 Risk Register Procedure and Guidance
- RM03 Risk Management and Assurance Training Plan
- RM04 Model Risk Management Procedure
- Annual Risk Management Improvement Plan

Asesiad / Assessment & Analysis

The Health Board recognises the need to improve its risk management culture and the Risk Management Team will support the organisation with the implementation of the Strategy through the delivery of training to build staff capability and capacity. An implementation plan has been developed to facilitate the delivery of the Strategy and the Enterprise Risk Management (ERM) Model.

The Health Board's Risk Management Annual Improvement Plan has been updated to reflect recent current changes whilst the organisation has realigned resources to support the management of the COVID-19 Pandemic response, so that it aligns with the new Risk Management Strategy and Policy. The other supporting documentation will also be updated in the coming months to also reflect the strategy changes and these have been incorporated in the Annual Improvement Plan.

The plan going forward is to continue to develop and build staff capacity and capability in risk management, support Directorates to review all risks on their risk registers with focus on narrative and accuracy in scoring in view of the launch of the new Risk Management Strategy planned for 1st October 2020. Work will continue to ensure compliance after this date due to the Health Board continuing to resume a level of business as usual post the first phase of our response to the COVID-19 pandemic. Training will also support staff member's ability to manage risks and clarify the distinctions between a risk and an issue as well as controls and actions/further actions implemented in mitigating risks.

Some of the key features of this new Risk Management Strategy and Policy include:-

- A risk management vision statement, which clearly defines our strategic approach to risk management.
- Better clarification and definition of our risk appetite statements.
- Change from the 5 Tiers to a 3 Tier risk management model.

- Articulation of BCU risk management process and governance arrangements for risks.
- Risk management escalation and de-escalation flow chart.
- Brief discussion of the Board Assurance Framework (BAF) and its link to the CRR.
- Placing performance measurement and monitoring using KPIs at the heart of our risk management culture.
- Consistent reference to the Enterprise Risk Management model throughout the new Risk Management Strategy and Policy demonstrates the Health Board`s commitment to incorporate and embed risk management into its organisational and business planning, objective setting and prioritisation, performance reporting, Financial management and the general day-to-day management of its activities and services.



Strategy Implications

The new Risk Management Strategy and Policy provides the organisation's approach to managing risk and its risk appetite. Along with a detailed training programme, it will support the consistent identification, assessment and management of risks and strengthen decision making.

Financial Implications

The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thereby leading to enhanced quality, less waste and no claims.

Implementation of the revised Risk Management recommendations and arrangements will incur additional costs, which will include:

- Consultancy support to facilitate the workshops for the Board and very senior managers.
- Development of alternative training delivery methodology including Train the Trainer and E learning programmes.
- Project Management support for the implementation and delivery of the revised arrangements including the Health Boards response to the All Wales Integrated Datix CloudIQ Project.
- Additional staffing resources within the Corporate Risk Team to deliver the ongoing support to divisional teams, training requirements and increased reporting arrangements to the Quality and Safety Governance Groups and Committees of the Board.

Risk Analysis

The risk of not having an effective Risk Management Strategy in place or failing to successfully implement it may prevent the organisation from achieving its objectives including impacting upon patient safety.

Legal and Compliance

The Risk Management Strategy supports the Health Board's statutory obligations.

Impact Assessment

Due regard of any potential equality/quality and data governance issues has been addressed within the quality impact assessment and factored into writing this report and the new Risk Management Strategy and Policy.

A copy of the revised Equality Impact Assessment is attached to Appendix 1 – RM01 Risk Management Strategy and Policy.



Risk Management Strategy and Policy

| | | | | | | | | | |
|--|--|----------|-----------|-----------|-----------|----------|-----------|----------|-----|
| Authors & Titles | David Tita: Head of Risk Management Justine Parry: Assistant Director of Information Governance & Risk. | | | | | | | | |
| Responsible dept / director: | Risk Management Gill Harris: Deputy Chief Executive | | | | | | | | |
| Approved by: | Audit Committee | | | | | | | | |
| Date approved: | | | | | | | | | |
| Date activated (live): | | | | | | | | | |
| Documents to be read alongside this document: | Board Assurance Framework Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Datix Risk Register – Procedure and User Guide (RM02) Model Risk Management Procedure (RM04) | | | | | | | | |
| Date of next review: | March 2021 | | | | | | | | |
| Date EqIA completed: | Refreshed June 2020 (Original 2016) | | | | | | | | |
| First operational: | | | | | | | | | |
| Previously reviewed: | Dec 2015 | Mar 2016 | July 2016 | July 2017 | July 2018 | Dec 2018 | July 2018 | Dec 2019 | |
| Changes made yes/no: | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

PROPRIETARY INFORMATION

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| | |
|---|---|
| <p>PURPOSE To provide a framework and structure for the consistent management of both operational and strategic risks as drivers for better decision-making and the provision of high quality personalised patient-centred care and enhanced experience.</p> | <p style="text-align: center;">Vision Statement</p> <p>BCU’s vision for risk management is underpinned by Good Governance and a dynamic, proactive, integrated, Enterprise-wide strategic approach which emphasises the appropriate and timely management of risks in order to foster the achievement of its objectives and priority areas as articulated in its 3 Year Plan. The destination of the Health Board’s vision for risk management is an Enterprise Risk Management (ERM) Model which will be rolled out in the 2nd year. BCU’s ambition in the first year of this vision as articulated below will seek to lay down the ground work and foundation on which a robust risk management architecture will be built. The aim will be to fully integrate ERM with strategy and performance.</p> <p><u>First Year – 2019/20</u>: Review of Risk Management Strategy and Policy, Design and delivery of RM training to Senior Managers, undertake a Gap and Training Needs Analysis, Update Risk Improvement Annual Plan and clarification of the Health Board’s governance and escalation arrangements for risk management.</p> <p><u>Second Year – 2020/21</u>: Roll out of Risk Management Training and new Risk Management Strategy and Policy, implementation of risk governance and escalation architecture, embedding BCU’s Risk Management strategy and Policy/culture and review of its risk management annual health check as well as implementation of the Enterprise Risk Management Model.</p> <p><u>Third Year 2021/22</u>: Embed Enterprise Risk Management Model while continuously supporting Directorates.</p> |
|---|---|

Our Strategic approach to Risk Management

| 1. Principles | 2. Benefits | 3. Realisation |
|---|--|--|
| Our approach to risk management is built on the following principles: | Through our risk management approach, the following benefits will be realised: | Realisation of the principles and benefits will be achieved through: |
| <p>It is dynamic, open, iterative; transparent, reacts to changes & consistently applied.</p> <p>It triangulates information and intelligence in informing better decision making.</p> <p>It is integrated into our processes and aligns with our objectives.</p> <p>It engineers continuous improvements in patient care and organisational learning.</p> <p>It is wrapped around the values of the Health Board.</p> <p>It is underpinned by staff engagement and informed by innovation and best practice.</p> | <p>Enhance organisational resilience via facilitating continuous improvement and innovation.</p> <p>Strengthen governance to enable informed decision-making.</p> <p>Promote a culture of proactive management of risks and opportunities</p> <p>Improvements in patient care, safety, enhanced experience and flexibility to respond to pressure and challenges.</p> <p>Help in embedding the values of the HB.</p> <p>Stakeholder confidence, empowerment and trust.</p> | <p>Strong risk-focussed leadership that ensures the effective operationalisation of BCU’s Risk Management Strategy.</p> <p>Strong and transparent risk governance arrangements, including reporting and risk escalation.</p> <p>Consistent application of the risk strategy and framework.</p> <p>Clarity in communication of the HB’s risk management approach and better staff engagement.</p> <p>Staff development and continuous support in embedding ERM.</p> |

1. Introduction

BCU's Risk Management Strategy and Policy provides a structured, comprehensive and coherent framework to support staff in identifying, assessing and managing risks arising from its activities as the effective management of risks is an inherent part of its approach to quality improvement and Good Governance. The Health Board is committed to implementing and embedding the robust management of both clinical and non-clinical risks as an integral part of business as usual and its strategic and operational management. Staff are encouraged to integrate BCU's risk management process into key business/service planning and decision-making in order to effectively and efficiently manage risks in real time and in a dynamic way. This Risk Management Strategy and Policy notes that risk management is everyone's responsibility across the Health Board.

It draws from best practice, the AS/NZS ISO 31000:2018, policy and legislative instruments such as the National Health Service (Wales) Act 2006, the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. This strategy and policy underscores the fact that effective risk management is a tool for improving productivity, ensuring business continuity and achieving robust organisational planning and performance reporting. It identifies staff and senior leadership engagement, clarity of roles and responsibilities, consistency, regular monitoring and review of risks including Good Governance, scrutiny and assurance as key drivers for embedding effective risk management across the Health Board.

2. Statement of Intent

The Health Board is committed to implementing effective risk management across all its services through a comprehensive system of internal controls and compliance with this strategy and policy in order to minimise risks to its patients, staff, visitors, contractors and other stakeholders. The Health Board's approach to risk management is proactive, integrated, enterprise-wide and is informed by an open and transparent culture in which staff feel empowered and confident to raise and discuss risks without fear. It thus seeks to engage staff across the entire organisation in exploring risk management as a tool for better decision-making and in achieving its objectives and priority areas as defined in its 3 Year Outlook and Annual Plan.

Over the next two years, the Health Board's approach to risk management will progress into an Enterprise Risk Management (ERM) model. This will enable staff to better integrate risk management into how they lead, organise, plan and deliver the Health Board's business activities while ensuring financial viability and sustainability. This revised Strategy and Policy will support the new "Duty of Quality" outlined within the Health and Social Care (Quality and Engagement) (Wales) Bill by requiring the Health Board to exercise its functions with a view to securing improvement in the quality of health services. This will be achieved and monitored by the implementation of the Health Board's Clinical Strategy.

The Health Board is keen to ensure that risk management is not seen as an end in itself or a bureaucratic exercise, but as a great managerial tool for enhancing decision-making, the quality of patient care and experience, organisational resilience and raising productivity. This strategy and policy thus signals the Health Board's commitment to building, implementing and

embedding a proactive risk management culture that maximises opportunities and improves service and health outcomes for our patients and wider community.

3. Definition of key concepts

This Risk Management Strategy and Policy is underpinned and informed by the following definitions: -

Risk: A risk is the uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's objectives and priority areas. It is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring).

Risk Management: The Chartered Institute of Internal Auditors (CIIA) defines risk management as "the discipline that identifies, assesses, evaluates and takes actions to influence the likelihood of a risk event occurring or its impact if it does".

Risk Assessment: This is the overall process of risk analysis and risk evaluation. This is achieved by comparing the individual risk against the Health Board's risk appetite.

Assurance: This is a process to provide evidence that the controls in place are effective and working and that the Health Board is doing its best to manage its risks in order to achieve its objectives of efficiently and sustainably delivering high quality patient-centred care, safety and enhanced experience.

Controls: These are measures being implemented by the Health Board to mitigate the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised.

Actions: Actions are steps which the Health Board are required to implement to reduce the likelihood and/or consequence of a risk were it to be realised. Actions are also the things the Health Board is doing or planning to do that will help us achieve the risk target score and thus mitigate the risk in the long run.

Enterprise risk management (ERM) is a process whereby an organisation plans, organises, leads and controls its activities in order to minimise the negative effects of any potential danger (risks) on its operations, business continuity and the achievement of its objectives.

4. Objectives

The main objectives of this strategy and policy are:

- To provide a framework including a clearly defined structure, consistency and standardisation in the effective management of strategic, operational and commissioning risks.
- To set out the organisational governance arrangements and responsibilities for risk management.
- To enable staff to understand our risk environment and to use the Health Board's risk appetite statements to identify and assess risks which cannot be tolerated.

- To facilitate the use of risk management as a tool for better decision-making, driving continuous improvements and linking these to organisational planning and performance reporting.
- To foster an open, transparent and blame-free culture in driving and embedding an integrated approach to risk management that is intelligence-led, evidence-based and informed by continuous learning.
- To enable the Health Board to identify and manage risks emanating from the well-being goals and ways of working included in the Well Being of Future Generations Act 2015. Also, overtime to seek alignment with the risk management approaches used in our key partnership mechanisms e.g. Public Service Boards and the Regional Partnership Board (Social Services and Well Being Act).

5. Scope

Risk management is an intrinsic strand of good management at all levels across the Health Board and sits at the heart of its business continuity, patient safety and values. Staff are encouraged to continuously scan the horizon for emerging risks and to ensure risks are appropriately assessed, mitigated and managed in accordance with this strategy and policy as well as best practice.

This strategy and policy thus clearly defines the Health Board's vision, approach, objectives, systems and processes for risk management and governance as well as underscores the principles, framework, model, best practice and emerging thinking which underpin and shape its overarching risk management culture. It is applicable to everyone involved in providing services for and on behalf of the Health Board.

6. The Board's Appetite for Risk

Risk appetite is defined as the amount and type of risk an organisation is able to take on in order to achieve its objectives and priority areas while risk capacity refers to the maximum amount of risk that an organisation is able to take on. These are underpinned by the Health Board's risk capability and the maturity of its risk management culture. The Health Board's risk appetite for individual risks will thus be different depending on its current performance, strategic objectives or priority areas as defined in the "3 Year Outlook, Annual Plan" and risk maturity level.

The Risk Appetite Statement sets out the amount and type of risks that the Health Board is able to take on in order to achieve its objectives and priority areas. The Board accepts that there is an element of risk in every activity it undertakes from the provision and commissioning of healthcare services and recognises that its risk appetite for any risk will change depending upon the individual risk and current performance. It also recognises that the transformation journey it has embarked on will involve taking on some transformation and project improvement risks which may sit outside its risk appetite. The Board is directly accountable for setting its risk appetite and risk culture.

The Health Board has articulated its risk appetite statement to demonstrate the various range of often complex and complicated risks it may take on or accept in order to achieve its objectives and priority areas. The risk appetite statement will be measurable and shaped by

three key determinants (the risk score, potential impact and type of risk), as these will vary or change over time depending on the context, type and risk environment.

The Health Board's risk appetite statement aligns with its proactive, inclusive and enterprise-wide approach to risk management as well as its commitment to actively mitigate, control and manage risks which could compromise the achievement of its objectives and priority areas. However, the Health Board realises that in some instances it may have to take on risks which sit outside its risk appetite in order to achieve its objectives and priority areas. It thus recognises that agreement to pursue a risk outside the above risk appetite will be openly discussed at the appropriate governance meeting and a conscious decision made to do so based on the added value. Risk appetite and risk tolerance are thus at the heart of the Health Board's operational and strategic agendas as the latter implies the amount of risk it can actually cope with.

The Health Board's Risk Appetite Statement is included at Appendix A, and sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds. It is a live document that will be regularly reviewed and modified so that any changes to the organisational strategy, objectives, priority areas or capacity to manage risk are properly reflected.

The risk appetite statement is monitored by the Board to ensure Executive Directors and managers are able to make robust decisions based on the appropriate level of risk for the organisation and/or their potential reward. The risk appetite statement will be communicated and disseminated across the Health Board through a range of mechanisms. These will include training, drop-in sessions, Quality & Safety/ Governance meetings, newsletters, global emails and the weekly bulletins.

7. BCU's Risk Management Process

The Health Board's risk management process as shown in the following diagram is informed by the AS/NZS ISO 31000:2018 and the ERM model. It emphasises the need to identify, assess, review, monitor and effectively manage risks within the wider context of organisational business planning/objectives and service priorities while considering the specific risk environment.

This strategy and policy is supported by a suite of procedural documents and guidance as full details on how to articulate controls and assurance can be found in the supporting [RM02 Risk Register Procedure and Guide](#).

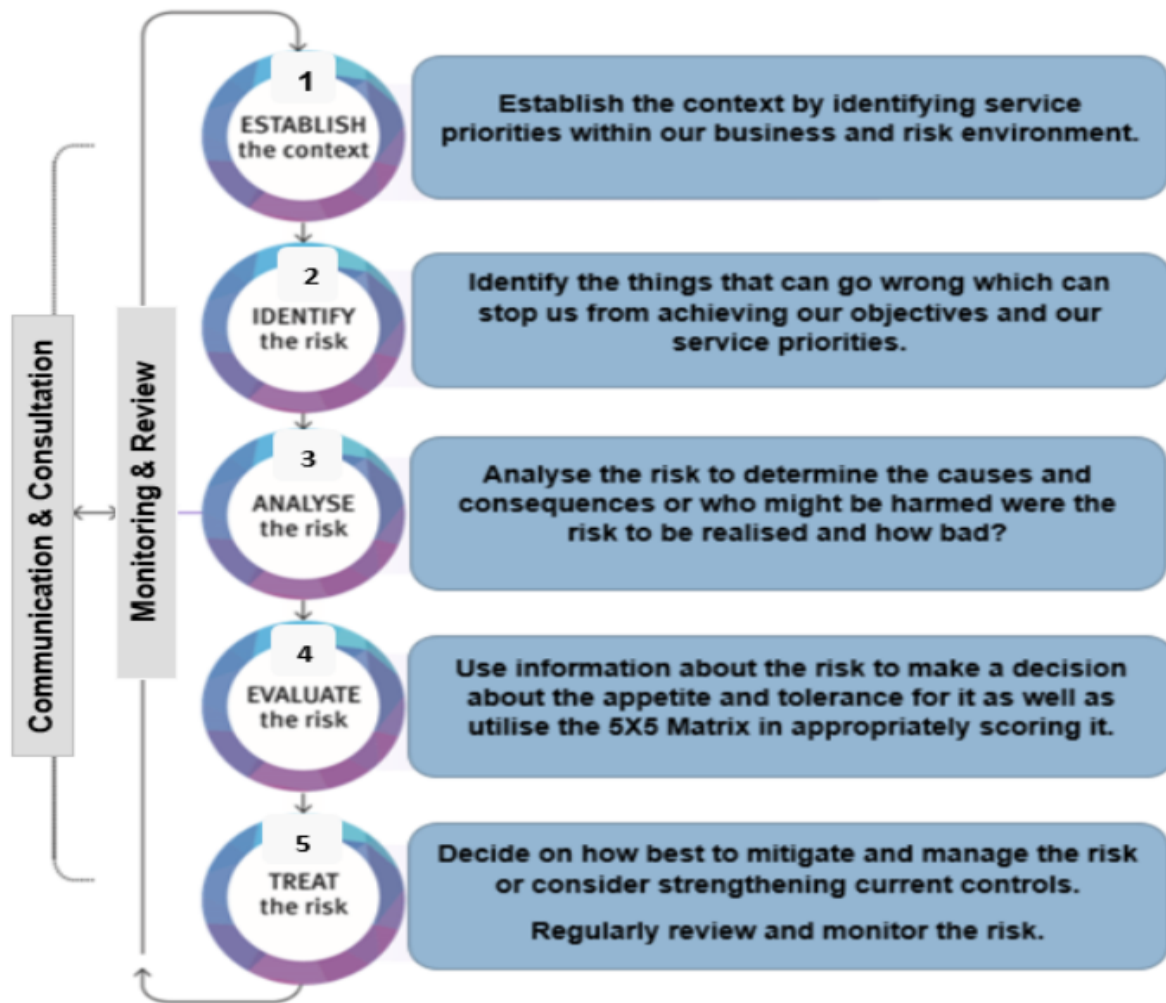


Figure 5 - BCU's Risk Management Process.

Step 1: Establish the context

As the starting point for a robust risk assessment, it is important to establish the context by clearly setting out the service objectives and priority areas so as to clearly identify risks which can negatively impact on their achievement.

Step 2: Risk Identification

The focus here is to identify the risk or what can go wrong. A risk can be proactively identified from incidents, complaints, claims, 'near misses', external and internal reports, clinical audits, external visits and Peer Reviews, new service development including service reconfiguration/transformation etc.

The recommended form for risk descriptions is to identify the cause, the event and the effect.

The risk should be articulated clearly and concisely with appropriate use of language, suitable for the public domain with acronyms spelt out in the first instance. When wording the risk it is helpful to think about it in three parts and write it using the following phrasing:

- There is a risk of....if... (this relates to not achieving an objective as intended)
- This may be caused by.....
- Could lead to an impact/effect on

An example of this is “There is a risk that patients may not be discharged promptly if medications are not dispensed due to pharmacy delays. This could lead to poor patient experience and delays impacting on bed capacity.”

Step 3: Risk Analysis

Determine the cause and effect and analyse what can happen, where, when, why and decide who might be harmed and how. Consider how the risk could negatively impact on say patient safety, the quality of clinical care, Workforce, Finance, patient experience for example and then decide what needs to be done.

Step 4: Risk Assessment/Evaluation

Evaluate, assess and quantify the risk by deciding on how bad (consequence) and how often (likelihood) if the risk were to be realised. The NPSA consequence and likelihood descriptors are a useful guide and the 5 x 5 grading matrix (appendixes C1 and C2) in assessing and scoring the risk.

Step 5: Risk Treatment & Prioritisation

Once you have identified and assessed a risk, you will then need to record your findings, identify appropriate controls to mitigate the risk and then identify further actions which can be implemented to reduce the risk and decide who will lead on each of them. Design and implement an action plan and also decide on how best to manage it.

Step 6: Risk Review and Monitoring

Risk management is a dynamic and iterative process; hence the risk lead/handler will need to periodically review, re-assess and monitor the risk in line with the following timescales, as a minimum to ensure controls are robust and effective in mitigating the risk.

- Risks scored 15 and above should be reviewed bi-monthly
- Risks scored 9-12 should also be reviewed bi-monthly
- Risks scored 1-8 should be reviewed quarterly.

NB: Please note that the above is just a guide and does not replace the timely, dynamic and effective review and management of risks in real time.

8. Three Tier Risk Management Model

Risks within risk registers across the Health Board held on Datix will be categorised and managed within a three tier model as depicted in **Figure 3** below.

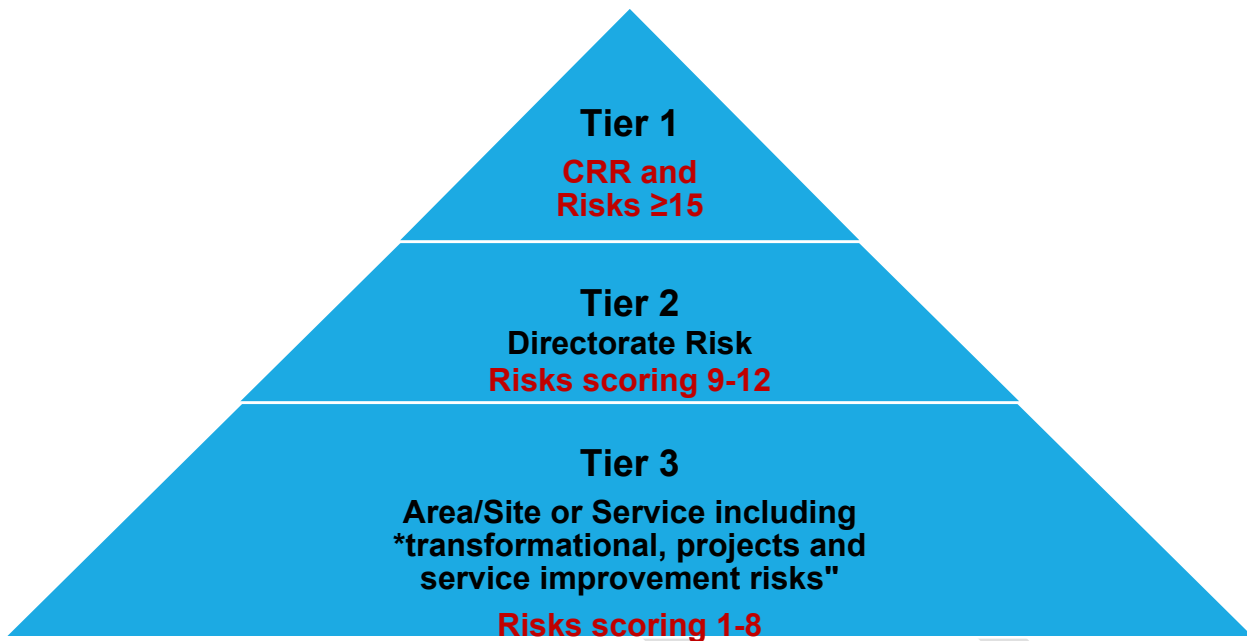


Figure 3 – Risk Management Tiers and oversight.

***Any decision to manage a risk outside the above 3 tier framework (e.g. a risk scoring more than 8 as a Tier 3) must be clearly agreed, regularly reviewed/monitored and minuted at the relevant governance meeting with delegated authority to manage their risks as part of the governance meetings' terms of reference. All risks scoring outside the risk scoring framework will be regularly monitored and reported through the corporate governance structures with oversight at the Risk Management Group. An exception report will be provided to the Audit Committee from the Risk Management Group so that oversight of the appropriate management of these risks and compliance with the Risk Management Strategy is maintained.**

Within the three tier risk model:

- Tier 1 risks will refer to extremely high risks scored ≥ 15 which have the greatest potential to negatively impact on or disrupt business continuity;
- Tier 2 risks will refer to those scored 9-12 which will also be known as Directorate risks;
- Tier 3 risks will refer to those scored 1-8 and have the lowest potential to disruption our smooth operations or commissioning arrangements.

Determining at which Tier the risk will be managed will be dependent on the assessed score (which takes into account the likelihood, potential impact, size and scope upon the Health Board) should the risk be realised. It is expected that the decision around the appropriate Tier, score, potential impact, risk handler/manager including escalation and/or de-escalation of a risk should be agreed and minuted at the relevant governance meeting.

8.1 Corporate Risk Register (CRR)

There are two determinants either of which can qualify a risk for escalation and approval by the appropriate Committee of the Board for inclusion onto the CRR:

- Such risks associated with the delivery of the Health Board's Integrated Medium Term

Plan (IMTP) and / Annual Plans and/or a risk which threatens the achievement of the Health Board's key deliverables and objectives. It is worth noting that irrespective of its score, such a risk should be escalated and if approved, recommended by the appropriate committee for inclusion onto the CRR with ratification of such a decision awaited from the Board.

- Risks scored ≥ 15 that are escalated will be reviewed by the relevant Executive Director and must be approved by the appropriate committee, for ratification from the Board for inclusion onto the CRR.

The CRR will thus encompass all risks including those linked to the IMTP/Annual Plan irrespective of their scores and operational risks with scores ≥ 15 where there is heightened concern of their potential impact on business continuity. **It is the responsibility of very senior managers and Executive Directors to ensure that updates/actions and recommendations from relevant committees and the Board are reflected in the related risk entries on Datix.**

8.2 Directorate Risk Management (Tier 2)

Executive Directors are expected to ensure that there are appropriate processes, systems and governance arrangements in place for regularly reviewing, scrutinising and effectively managing, escalating and de-escalating Tier 2 risks within their Directorate. They will be required to periodically present their Tier 2 risk register and any assurance thereof at the Risk Management Group (RMG)

8.3 Area, Site, Service or Transformational / Improvement Risk Management (Tier 3)

These are risks which score 1-8 and should be regularly reviewed, scrutinised, approved and escalated where appropriate by the relevant governance or Quality and Safety meeting. Extreme and high risks including those with potential high impact should not be held at Tier 3 except where a conscious governance decision and rationale have been made to do so and documented.

9. Source of Risks

Risks can be identified from the following sources as shown in figure 4 below. This list is not exhaustive, but can include:

Risk Identification - Source of Risks

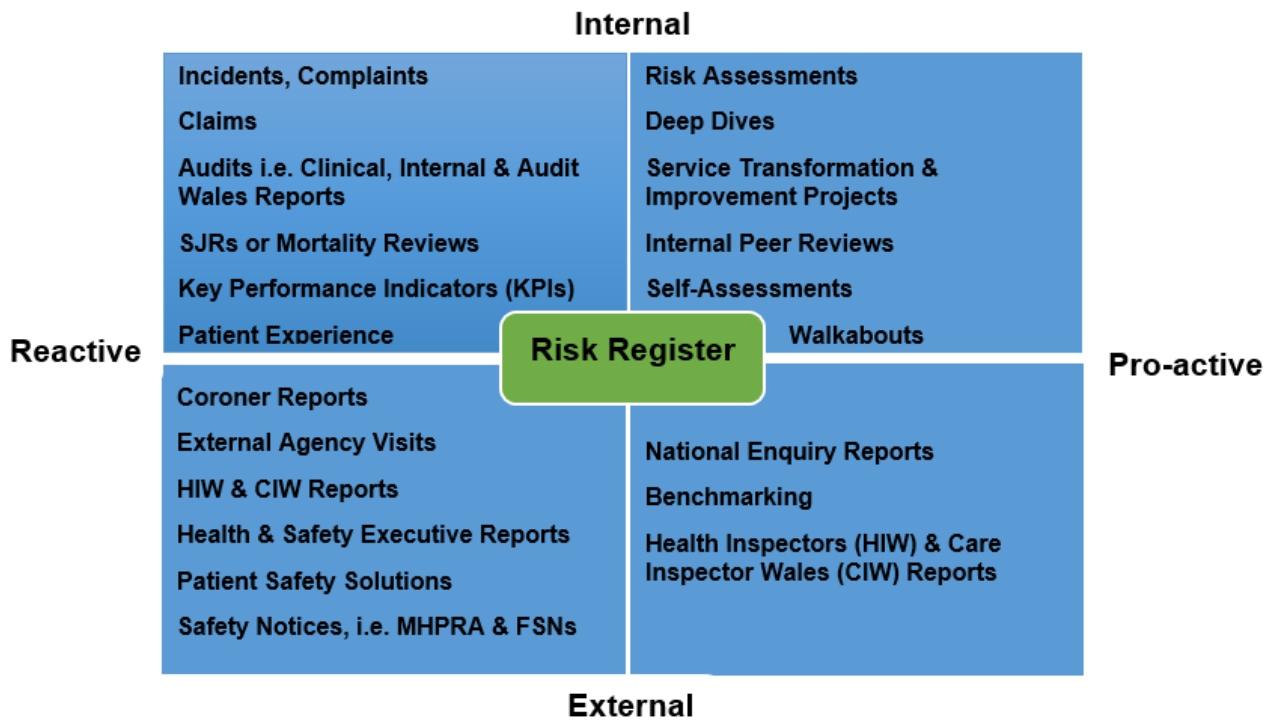


Figure 4 - Shows some examples of different source of risks.

10. BCU`s Enterprise Risk Management (ERM) Framework

BCU`s approach to risk management will be shaped, informed and underpinned by the ERM Model. This is important as it will provide a framework through which BCU will seek to integrate effective and efficient risk management and governance into performance reporting, business continuity, organisational planning, priority setting and continuous improvements in patient care and journey. It will emphasise the need for open and transparent communication and consultation with all staff or key stakeholders at each stage of the risk management process to ensure engagement, shared understanding and awareness of the intelligence on controls in place. Staff are encouraged to ensure risks are regularly presented at the relevant governance and Quality and Safety meetings for review, scrutiny, approval and assurance.

The following figure depicts BCU`s Enterprise risk management framework.



Figure 6 - BCU's Enterprise Risk Management Framework

11. BCU's Risk Management Escalation and De-escalation Process

Underpinning BCU's risk management framework is the governance arrangement for escalating and de-escalating risks that staff are advised to adhere to. Each service and directorate within the Health Board is expected to maintain a risk register on Datix and a local risk management procedural document (RM02) which defines how risks are identified, assessed and managed within the service or directorate as these interrelated activities constitute the key building blocks in BCU's risk management process.

Datix is the sole repository for capturing risks being managed by services across BCU. Staff are not advised to record risks on paper-based systems or spreadsheets.

Extreme operational and strategic risks identified within services and directorates should be escalated via appropriate governance routes for consideration and approval so that such risks can be held at the right Tier and assigned the right profile, handler, manager and resources. It is worth noting that escalation and de-escalation of any risk is based on the following distinct but interrelated criteria:-

- Its potential negative impact were it to materialise.
- Its high score and/or high profile nature.

There are thus two pathways for escalating or de-escalating risks:

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- Through appropriate governance or Quality and Safety meetings.
- Through the Senior Management team and/or Executive Director in the case of where an urgent decision is required as the next governance meeting is due in the distant future. Any decision taken will need to be presented at the relevant governance or Quality and Safety meeting for noting and ratification.

Simply put, escalating a risk does not free the service or Directorate where the risk has been identified of the responsibility to appropriately assess, mitigate and manage the risk as risks are locally owned, led and managed. Escalation provides an opportunity for raising the visibility of a risk, requesting for support/resources and keeping the Health Board aware of those which are high profile. The next table depicts BCU's escalation and risk governance arrangements for risk management.

| Tier | Risk Score | Category of risk | Level at which risk is managed | Approval Group or Committee | Escalation and De-escalation |
|-----------------------------------|------------|------------------|--|---|--|
| Tier 1 Corporate Risk Register | 15-25 | Extreme | Risks scored 15 and above, escalated and approved for the CRR will be led on by Executive Directors although responsibility for managing and mitigating them on a daily basis will remain with original owner. Reviewed bi-monthly | Board/ Committee Executive Team | Appropriate Committee with the assigned risks on the CRR. Once reviewed, the RMG will have sight of the entire CRR prior to sharing with the Audit Committee / Board. |
| Tier 2 | 9-12 | High | Managed at Directorate level and led on by Executive Directors with local ownership and input. Reviewed bi-monthly | Appropriate Directorate Governance meeting RMG | Risks with a current score 9-12 will be managed under the leadership of an Executive Director. Risks scoring above 12 are escalated to the Executive Team for consideration and approval as Tier 1 risks *CRR. |
| Tier 3 | 4-8 | Moderate | Managed at local level Area/Site or Service including those for | Relevant group meeting or | Risks with current score 1-8 are managed at local level with |

| | | | | | |
|--|-----|-----|---|---------------------------|--|
| | | | transformational projects and Service Improvement. Reviewed quarterly | local governance meeting. | oversight from relevant local governance meeting. Those which score >8 will be escalated to the local governance meeting for consideration and presentation to the appropriate Executive Director. |
| | 1-3 | Low | | | Risks escalated are still locally owned and managed. |

Figure 7 - The Health Board's escalation and risk governance arrangements for risk management.

*** CRR: Corporate Risk Register**

*The above timescales for reviewing risks are only a guide and do not replace the dynamic and timely review and escalation of risks in real time.

The next figure shows BCU's escalation and de-escalation route:

Risk Escalation / De-escalation Process

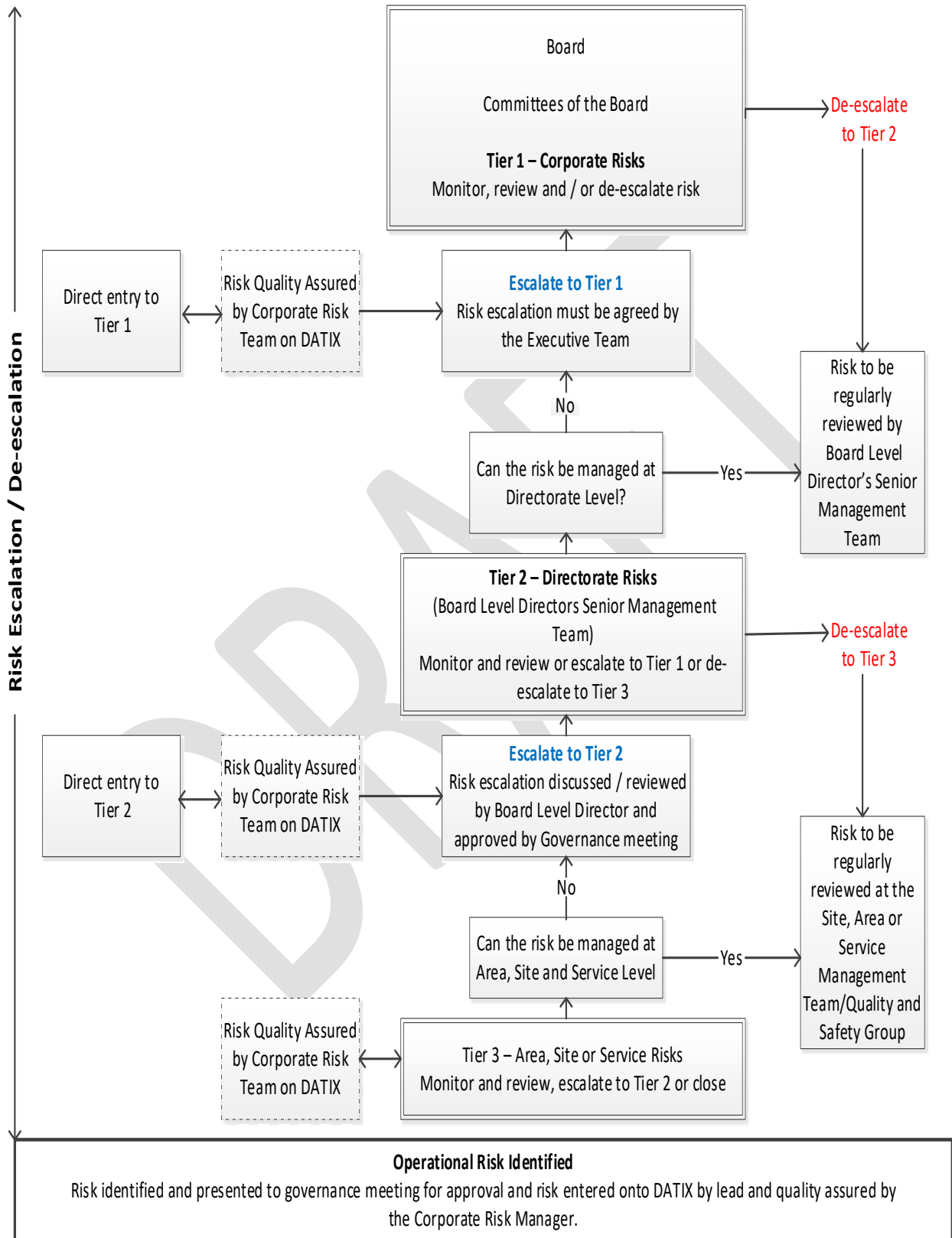


Figure 8 - Escalation/De-escalation route

12. Roles and Responsibilities

The following section provides a synopsis of the roles and responsibilities of individuals, groups and committees in ensuring the timely and effective identification, assessment and management as well as review and scrutiny of risks across the Health Board: -

12.1 The Board

The Board have collective responsibility for the setting and ensuring delivery of strategic objectives and priority areas. Key strategic risks are identified and monitored by the Board. The CRAF provides a central record of risks to the delivery of its strategic objectives and priority areas. The Board is also accountable for setting the risk appetite of the Health Board and in providing scrutiny, oversight and constructive challenge while gaining assurance that the Health Board has robust systems and processes in place to ensure the effective management of risks, associated controls and assurances across its length and breadth.

The Board is also responsible for ensuring that the health board consistently follows the principles of good governance, ensuring that the systems, policies and people in place to manage risk are operating effectively, focused on key risks and driver the delivery and commissioning of the health board's strategic objectives.

In the context of this Strategy and Policy the Board will:

- Demonstrate its continuing commitment to risk management through the endorsement of this strategy;
- Ensure, through the Chief Executive that the responsibilities for risk management outlined in this strategy are communicated, understood and maintained;
- Take a lead role in "horizon scanning" for emerging threats/risks to the delivery of the health board's strategic objectives and priority areas and ensuring that controls put in place in response, manage risks to an acceptable level;
- Oversee and participate in the risk assurance process;
- Ensure communication with partner organisations on problems of mutual concern including risks;
- Ensure that appropriate structures are in place to implement effective risk management;
- Commit those financial, managerial, technological and educational resources necessary to adequately control identified risks;
- Ensure that lessons are learned and disseminated into practice from complaints, claims and incidents and other patient experience data;
- Receive reports from the Committees of the Board in line with terms of reference and workplans of those committees.

12.2 Chief Executive

The Chief Executive is accountable for the Board's risk management and governance arrangements and has executive responsibility for ensuring organisational compliance with the Health Board's risk management strategy and policy. He/she also has responsibility for communicating, implementing and monitoring the Health Board's risk appetite as delegated by the Board and for ensuring that the Annual Governance Statement aligns with this risk management strategy and policy.

12.3 Deputy Chief Executive

The Deputy Chief Executive has been delegated responsibility by the Chief Executive to develop the governance arrangements and strengthen the Health Board's risk management systems and processes by:

- Embedding an effective risk management culture throughout the health board;
- Working closely with the Chair, Vice Chair, Chief Executive, Chair of the Audit Committee and Executive Directors to implement and maintain appropriate risk management and related processes;
- Developing and communicating the Board's risk awareness, appetite and tolerance;
- Leading and participating in risk management oversight at the highest level, covering all risks across the health board;
- Leading the development of, and Chair of the Risk Management Group;
- Working closely with the Chief Executive and Executive Directors to support the development and maintenance of the Corporate and Directorate level risk registers;
- Developing and implementing the health board's Risk Management Strategy and Policy.

The Deputy Chief Executive will discharge these responsibilities through the Assistant Director of Information Governance and Risk and the Head of Risk Management.

12.4 Board Secretary

In accordance with the NHS Wales Governance Framework and Guidance from IRM and CIIA, the Board Secretary provides advice and guidance to the Board on all aspects of governance and it is the Board's responsibility to approve the governance framework. The Board Secretary is responsible for designing, developing and maintaining the Health Board's Board Assurance Framework (BAF).

12.5 Executive Directors

Executive Directors have overall responsibility for the operational management of risk within their portfolios and will be the responsible officer for risks on the Corporate Risk Register. They are also responsible for the effective allocation of resources to timely mitigate risks within their remit, while ensuring prompt escalation and de-escalation of risks where appropriate.

12.6 Independent Members

Independent Members have an important role in risk management in seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust and effective challenge to the Executive Directors and senior management. The role of Independent Members is not to manage individual risks but to understand and question risk on an informed and ongoing basis.

In addition, Independent Members chair Board level Committees and in line with the relevant committee's terms of reference, should provide assurance to the Board that risks within its remit are being managed effectively by the risk owners and report any areas of concern to the Board.

12.7 Clinical Executive Directors

The Executive Director of Nursing and Midwifery, Executive Medical Director, Executive Director of Therapies and Health Sciences and the Executive Director of Public Health have collective responsibility for clinical quality governance which includes patient safety, incident management and patient experience and will therefore have a responsibility to ensure that clinical risks are appropriately managed in line with this strategy.

12.8 Senior Information Risk Officer

The Board will nominate an Executive Director as the Senior Information Risk Officer (SIRO) with delegated responsibility by the Chief Executive for ensuring that information risks are treated as a priority for business outcomes.

12.9 Senior Managers (including Directors)

Senior managers take the lead on risk management within their divisions, sites and areas and set the example through visible leadership. They are also responsible for the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit.

12.10 All Staff

All staff including Trade Union colleagues and contractors are required to comply with this Risk Management Strategy and Policy, bring any issues of concern to the attention of their line manager and to appropriately mitigate and manage risks to the best of their knowledge and ability. Controls and actions implemented in mitigating risks must be timely disseminated to all staff involved with the management of the risk were it to be realised. All staff are expected to share intelligence around any potential risks with contractors providing services within and on behalf of the Health Board.

13. Committee Duties & Responsibilities

The key responsibility of committees here is to provide assurance to the Board that there are robust and effective arrangements in place to appropriately identify, assess, review, monitor and manage Tier 1 risks and those on the Corporate Risk Register (CRR) within their portfolio. Each risk on the corporate risk register is aligned to a Committee of the Board which will regularly review and scrutinise their risks prior to the CRR being presented to the Board. With the approval of Executive Directors and ratification by the Board, Committees can recommend risks for inclusion onto the CRR. Committees here include:

- Quality, Safety and Experience Committee (QSE)
- Finance and Performance Committee (F&P)
- Strategy, Partnerships and Population Health Committee (SPPH)
- Digital and Information Governance Committee (DIGC)

13.1 Audit Committee

The Audit Committee is responsible on behalf of the Board for providing oversight and scrutiny of the CRR in order to assure the Board that there are robust processes and systems in place for appropriately managing risks across the Health Board and especially those on the CRR. This involves reviewing how risks which could impact on the achievement of the objectives

and priority areas as noted in the 3 Year Outlook and Annual Plan are being managed and mitigated. The Audit Committee will also review and approve the Risk Management Strategy and Policy annually as required as part of the Health Board's Standing Orders in advance of ratification by the Board.

13.2 The Risk Management Group

The Risk Management Group will maintain oversight of the risk management system and overall governance and reporting arrangements ensuring that it is fit for purpose and embedded across all areas of the Health Board in line with this Risk Management Strategy and Policy. It is also responsible for the oversight and monitoring of risks at Directorate level (Tier 2) and providing oversight of the full Corporate Risk Register prior to review by the Audit Committee. As part of the Health Board governance arrangements, the Risk Management Group will report to the Audit Committee.

13.3 Directorate Risk Management Arrangements

All Directorates must have the necessary arrangements in place for good governance, quality, safety and risk management.

Directorates, through management have the responsibility for risks to their services and for putting in place appropriate arrangements in line with this Risk Management Strategy and Policy and supporting documentation. They are also responsible for developing their local arrangements for monitoring their risks and communicating risk information.

14. Management and Governance of shared risks

The Health Board recognises that there will be instances where the effective management of a risk will require input from other colleagues and stakeholders who may sit outside the area or service where the risk has been identified. For example, a service may identify a risk in their area which requires input from Informatics, Estates and Facilities, Health & Safety etc. In such a situation the Health Board encourages risk handlers and managers to ensure all key stakeholders are involved in the initial discussions, assessment, scrutiny and approval of such risks. This will entail clarity of roles, responsibilities as well as allocation of actions/resources to mitigate the risk.

15. Board Assurance Framework (BAF)

The BAF is a mechanism that should enable the Board to gain assurance that principal risks to the achievement of the Health Board's strategic objectives and priority areas have been identified, assessed and are properly mitigated and managed in line with best practice. It thus provides a structure and process through which the Health Board can focus on those principal risks which can compromise the achievement of its core objectives as defined in its 3 Year Plan/IMTP and Clinical Strategy.

While the BAF focuses on principal risks to the Health Board's strategic objectives and priority areas, the Corporate Risk Register on the other hand, will focus on ensuring that extreme risks scored ≥ 15 and operational risks to the achievement of the organisation's objectives and priority areas as defined in the 3 Year Plan/IMTP are effectively and efficiently identified, assessed, mitigated and managed. The Health Board's BAF and CRR will be symbiotically

linked, inform, shape and feed-off each other as both documents will be received, reviewed and scrutinised by relevant committees and the Board each time they sit.

The BAF is thus the main tool that the Board will use in discharging its key responsibility of internal controls and in gaining assurance that objectives are being delivered and that the Health Board is managing its principal risks in accordance with the vision, strategy, process and assurance mapping that informed the design of its BAF.

16. Risk Management Training

As the Health Board embarks on a journey to implement and embed ERM across all its services, it recognises the importance of developing local capacity and capability in risk management as a driver for embedding its risk management culture. Risk management training needs analysis has recently been undertaken across services within the Health Board and its results will help in focusing minds and resources on addressing the gaps and staff risk management training needs identified.

A series of classroom-based risk management training and awareness sessions, Corporate Induction and the delivery of risk management training through existing governance and Quality and Safety meetings will be delivered in supporting the Health Board embed its risk management culture. On the other hand, all staff (including Board Members) will receive training and refreshers in risk management appropriate to their roles and responsibilities at defined and agreed intervals.

17. Equality Impact Assessment

The Health Board has undertaken an Equality Impact Assessment on the implementation of this strategy and policy to ensure that it is inclusive and does not discriminate against any protected characteristics. The assessment has highlighted an equality impact concern regarding the availability of the documentation in a format to address any visual impairment disabilities. Positive action including support and the availability to transcribe the document will be provided to support individuals and the Health Board to positively meet its responsibilities under the equalities and human rights legislation.

18. Performance Measurement and Monitoring of Risk Management Culture

The Health Board will undertake an annual internal audit or health check of its risk management culture through the use of key performance indicators in determining the effectiveness of risk management across all its services. This health check will explore a sample of 20 risks randomly selected from each Directorate risk registers and 10 from the Corporate Risk Register in measuring a set of agreed key performance indicators which will be further developed throughout the year. The below is an example of some of the indicators which will be used (please note this list is not exhaustive):-

Compliance: This will measure whether the Health Board is compliant with its own risk management strategy and policy by evaluating the following components:-

- % of risks in the Directorate reviewed in line with the Risk Management Strategy and Policy;

- % of risks which are in date and/or out of date;
- % of actions linked to Directorate risks which have been completed within set timescales.

Maturity: This measure will focus on evaluating the completeness of risks on risk registers across the Health Board and will concentrate on the following aspects:-

- % of risks with all fields appropriately completed;

Data Quality: This measure will focus on evaluating the accuracy and appropriateness of information captured in the description of risks, their controls, actions and titles. It will consider:-

- % of risks with titles clearly articulated.
- % of risks with appropriate descriptions

19. Conclusion:

The use of ERM will thus provide a framework through staff across the Health Board to timely and proactively identify, assess, manage and mitigate potential events or risks that may compromise the achievement of the organisation's objectives and Priority Areas as outlined in its 3 Year Plan/IMTP. In conclusion, this risk management strategy and policy will foster standardisation, engagement, consistency and help embed ERM across all services within BCU from 'Ward to Board'.

20. References

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- Welsh Government (2015a) Health and Care Standards for Wales.
- www.gov.wales/topics/health/publications/health/guidance/carestandards.
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- Deloitte (2015) Enterprise Risk Management – A 'risk-intelligent' approach. Deloitte Advisory Publication.
- Committee of Sponsoring Organizations of Treadway Commission (2017) Guidance on Enterprise Risk Management – Integrating with Strategy and Performance. <https://www.coso.org/Pages/erm.aspx>

21. Glossary

| | |
|---------------------------------------|---|
| Action plan | Sets out the activities that will address the identified gap between the current and acceptable (target) rating of a risk |
| Assurance | Objective evidence that risks are being managed effectively (e.g. management information, corporate oversight reviews, clinical audit / service evaluation, inspections, etc.). |
| Control(s) | Processes in place to eliminate, transfer or treat a risk. |
| Corporate risk register | A record of the risks identified through internal processes that will impact on the delivery of the Health Board's key deliverables and objectives. |
| Gaps in controls or assurances | Deficiencies, either in current control actions or in the assurances being used to determine the effectiveness of controls, that indicate where an additional system or process is needed, or evidence of effective management of the risk is lacking |
| Impact | Is the result of a particular threat or opportunity should it actually occur. |
| Issue | A relevant event that either will happen or is already happening and that requires some management action. |
| Incident | An untoward event that has occurred and that requires management action. |
| Likelihood | The measure of the probability that the risk event will happen. |
| Operational risks | A risk or risks that have the potential to impact on the delivery of business, project or programme objectives. Operational risks are managed locally within teams and significant operational risks are escalated, where appropriate, to the Executive Team via the Divisional senior management team. |
| Opportunity | An uncertain event that would have a favourable impact on objectives or benefits if it occurred. |
| Risk | An uncertain event or set of events that, should it occur, may have an effect on the achievement of objectives. A risk can arise from a threat or an opportunity. |
| Risk Tolerance | A threshold, set by type of risk that, indicates at what magnitude a risk is considered acceptable. |
| Risk assessment | The process used to evaluate the risk and to determine whether controls are adequate or more should be done to mitigate the risk. The risk is compared against predetermined acceptable levels of risk (tolerances) |
| Threat | An uncertain event that could have a negative impact on the delivery of objectives or benefits, should it occur. |

Appendix A – Risk Appetite Statement – May 2020

The Health Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that it understands and is aware of the risks it is prepared to accept in pursuit of its aims, strategic objectives and priority areas.

The Health Board places fundamental importance on the delivery of its strategic objectives and priority areas and its relationships with its patients, the public and strategic partners in achieving delivery of its “*Living Healthier Staying Well*”, 3 year plan.

The Health Board is not open to risks that materially impact on the quality or safety of services that we provide or commission; or risks that could result in us being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which we operate.

The Health Board has the greatest appetite to pursue innovation and challenge current working practices and financial risk in terms of our willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

| Risk Domains | Description |
|---|---|
| Risk Appetite Category: Cautious (Low Score 1 - 6) | |
| Patient and Staff Safety | <p>The Health Board consider the safety of patients and staff to be paramount and core to our ability to operate and carry out the day-to-day activities. We have a low appetite to risks that result in, or are the cause of incidents of avoidable harm to our patients or staff.</p> <p>This means we are not open to risks that could result in poor quality care or clinical risk assessment, non-compliance with standards of clinical or professional practice, unintended outcomes or poor clinical interventions.</p> <p>We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual’s competence to perform roles or tasks safely and, nor any incidents or circumstances which may compromise the safety of any staff member or group.</p> |
| Quality and Patient Outcomes | <p>The Health Board’s ambition is to ensure that the health services it provides to individuals, patients and the population improve and achieve desired health outcomes and are informed by current professional and cutting-edge knowledge and best practice. The Health Board recognises that it’s quality risks will include those which relate to clinical effectiveness and patient experience amongst others.</p> |

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| | <p>The provision of high quality services is of the utmost importance to the Health Board and for ensuring value for money in a challenging arena. We therefore have a cautious appetite to risks that impact adversely on quality of care and depending on the circumstances will accept some risks that could limit our ability to fulfil this activity.</p> |
| Workforce and OD | <p>The Health Board will continue to employ and retain staff that meet our high quality standards and provide on-going training to ensure all staff reach their full potential, always mindful of the professional and managerial capacity and capability of the Health Board. We will also actively promote staff well-being.</p> <p>In certain circumstances we will accept risks associated with the delivery of this activity, however the preference is for safe delivery options with a low degree of inherent risk.</p> <p>There might be occasions as part of a future strategy to meet changing needs that we seek to develop new staffing models, which in their development might require a greater level of risk.</p> |
| Regulation and Compliance | <p>The Health Board will continue to comply with all legislation relevant to us and will avoid risks that could result in the Health Board being non-compliant with UK law or healthcare legislation, or any of the applicable regulatory frameworks in which we operate.</p> |
| <p>Risk Appetite Category: Moderate (Moderate Score 8 - 10)</p> | |
| Reputation & Public Confidence | <p>The Health Board will maintain high standards of conduct, ethics and professionalism at all times, espousing our Values and Behaviours, and will not accept risks or circumstances that could damage the public's confidence in the organisation.</p> <p>Our reputation for integrity and competence should not be compromised with the people of North Wales, Partners, Stakeholders and Welsh Government.</p> <p>We have a moderate appetite for risks that may impact on the reputation of the health board when these arise as a result of the health board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory environment.</p> |
| Partnership Working | <p>The Health Board will continue to work with other organisations to ensure we are delivering the best possible service to our patients/service users and are willing to accept risks associated with this collaborative approach.</p> <p>Partnership working is a fertile ground for innovation in service delivery, new ways of delivering services and new service models. However, not where this compromises safety and quality of care for patients and service users.</p> <p>This is key to ensuring patients, carers and stakeholders receive</p> |

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|---|--|
| | <p>seamless care from all agencies, especially with regard to legislation such as Social Care and Well Being Act and the Well Being of Future Generations Act, which will support the Health Boards commitment to improving population health and the general well being of local people through the implementation of “Living Healthier Staying Well”.</p> |
| Finance | <p>The Health Board have been entrusted with public funds and must remain financially viable. We will make the best use of our resources for patients and staff. Risks associated with investment or increased expenditure will only be considered when linked to supporting innovation and strategic change.</p> <p>We will not accept risks that leave us open to fraud or breaches of our Standing Financial Instructions.</p> |
| <p>Risk Appetite Category: Open (High Score 12 - 15)</p> | |
| Innovation & Strategic Change | <p>The Health Board wishes to maximise opportunities for developing and growing our services by encouraging entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the 3 Year outlook, Annual Plan, whilst respecting and abiding by our statutory obligations.</p> <p>We are willing to accept risks associated with innovation, research and development to enable the integration of care, development of new models of care and the use of technology to address changing demands. This will include new ways of working, trials and pilot programmes in the delivery of healthcare.</p> |

This Statement will be regularly reviewed and modified so that any changes to the Health Board’s strategy, objectives, priority areas or our capacity to manage risk are properly reflected. It will be communicated throughout the Health Board in order to embed sound risk management and to ensure risks are properly identified and managed.

| | | | | | | |
|-------------|---|---|------------|------------|--|--|
| RM19 | (a) to include best practice and previous comprehensive KPI reporting to ensure the Risk Management System and Process remains active and fit for purpose to support Internal Audit Processes. (b) to monitor compliance with the implementation plan for the revised Risk Management Strategy and Policy across the Health Board. | Head of Risk Management | 01/06/2020 | 31/12/2020 | | |
| RM20 | To commence assurance and performance monitoring and reporting in line with refined and agreed key performance indicators and report to the Risk Management Group. | Head of Risk Management | 01/10/2020 | 31/12/2020 | | |
| RM21 | To undertake a Risk Management annual Health Check of the Health Board's Risk Management culture. | Corporate Risk Management Team | 01/02/2021 | 31/03/2021 | | |
| RM22 | To meet with the Internal Audit Team to discuss and understand their focus during annual RM internal Audits. | AD Information Governance and Risk and Head of Risk Management | 1/1/2021 | 31/03/2021 | | |
| RM23 | Develop and present Quality Assurance and Project Evaluation Report on the revised risk management arrangements | Head of Risk Management and Project Management support | 31/12/2020 | 31/03/2021 | | |
| RM24 | Develop and present Quality Assurance and Project Evaluation Report on the All Wales IQ Cloud | Head of Risk Management, Integrated Governance Manager and Project Management support | 31/12/2020 | 31/03/2021 | | |
| RM25 | To provide continuous support to services/Divisions and Directorates with regularly reviewing and updating their risk registers in line with the Risk Management Strategy and Policy to improve the quality of information captured on their risk registers. | Corporate Risk Management Team | 01/06/2020 | 31/03/2021 | | |



Making the case for moving risks on BCU's risk management system from a 5 to 3 tier risk management model:

During the past year considerable consultation has taken place with senior individuals, teams and services during the delivery of the current risk management support and training. In addition to undertaking a training needs analysis, feedback from these events raised concern regarding the current 5 tier risk management model used across BCU. This has included comments such as, it is confusing and difficult to use. It is also difficult to assess when a high scoring risk should be escalated or supported to be managed within an agreed level, thus affecting the Health Board to maintain focus on its high level risks.

Most healthcare organisations which use the tier risk management system, prefer to opt for the 3 tier model over the 5 because it is simple and makes it easy for effective escalation. The 3 tier model most effectively clarifies the level at which a risk should be managed and strengthens local ownership, responsibility and accountability. As is done in most organisations, the 3 tier risk management model is based on the score of each risk which is supposed to be a reflection of its potential impact were it to materialise. Using the 3 Tier risk management model will enable appropriate visibility of the risks once escalated as the local service will be able to retain local ownership and effective management of the risk.

The 3 tier risk management model requires that:

1. Risks scored 15 and above, are escalated for inclusion onto the CRR and approved are held as tier 1.
2. Risks scored 9-12 are managed at the Directorate Level and are held at Tier 2.
3. Risks scored 1-8 are managed at Area/Departmental, service/ward/Project etc levels, and are held at Tier 3

There are currently 1310 number of risks on the risk register as follows:

- 28 at Tier 1
- 102 at Tier 2
- 272 at Tier 3
- 491 at Tier 4
- 406 at Tier 5

Moving risks from a 5 to 3 tier risk management model, will be undertaken in five phases. Recognising that work has already commenced to review all current risks in the system, the Corporate Risk Team will further work with all Risk Leads and Handlers to:

1. Identify the current risks facing the organisation and score them based upon the current risk appetite and the impact/likelihood;
2. Consider the current controls in place to mitigate that risk and what further action is required to achieve the target risk score;
3. Refer to the previous risks as a check and record any cross reference within the Datix system for a clear audit trail, i.e. RM00201 archived on (*record date*) and replaced with RM02001;
4. Develop and implement an agreed standardised issues register at the same time to differentiate between issues the organisation is currently managing versus the risks that the organisations will need to manage

5. Develop and implement a quality assurance checking process to ensure a robust audit trail is in place and the revised register is complete.

However, there may be times when a risk could score high but when presented, discussed and agreed at the relevant governance/Q&S meeting and/or by the triumvirate, a decision is made to continue to mitigate and manage it at the current level. In all situations, approval to manage risk scoring >15 must be submitted to the Risk Management Group, with further exception reports provided to the Audit Committee on the appropriate management of risks. All evidence to support the management of the risk must be recorded and captured within the Datix Risk Module system.

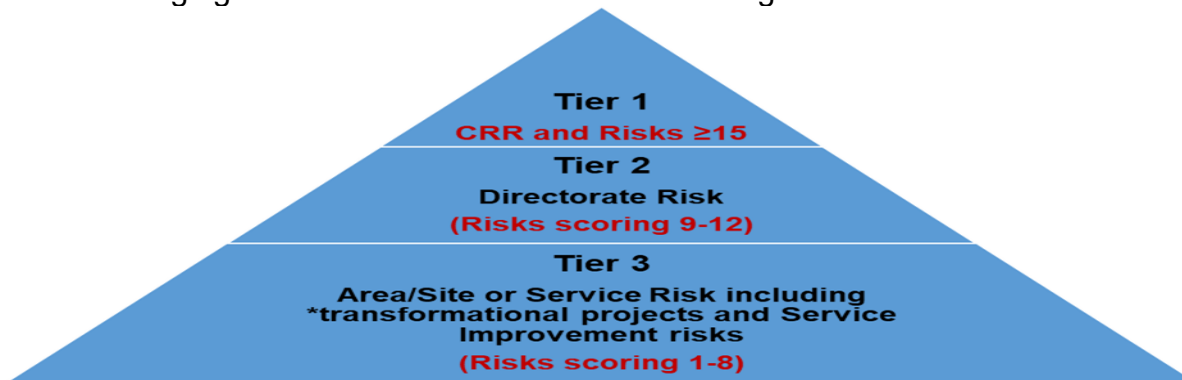
The rule of thumb is to always ensure that every risk is robustly and appropriately quantified/evaluated and presented at the relevant governance/Q&S meeting for approval for either escalation with clarity on the rationale and purpose of escalation or for it to be held on the risk register.

Approval process of re-evaluated risk registers and decision-making on which risk sits in which tier.

Once all the risks on the register have been reviewed by their owners/leads, the risk register will be presented at: -

- Tier 1 – This will be presented to the Board for full sign off and approval in line with the Risk Management Improvement Plan
- Tier 2 – This will be presented to the Risk Management Group for full sign off and approval in line with the Risk Management Improvement Plan
- Tier 3 – This will be presented to the updated Governance Group meetings in line with the revised emerging Governance Structure review.

The following figure illustrates the three tier risk management model.



How will we move risks from a 5 to 3 tier risk management model?

As stated above, our drive to move risks from the 5 to 3 tiers risk management model will be broken down into phases and the implementation of the improvement plan supports this development including the appropriate delivery and completion dates for each phase of the project.

A pilot exercise was undertaken with the Area East Division to test the movement to a 3 Tier approach and this has been successful. Further work is continuing as part of the process to scrutinise and challenge these Divisional Risk as part of the Area East Risk Meeting with assurance being provided through to the Corporate Risk Management Group.

This guideline will be supported with a full Standard Operating Procedure (SOP) which will provide diagrammatic illustrations of a step-by-step approach to moving risks from a 5 to 3 tier risk management model, including appropriate governance considerations to be taken and addressed so that risks are not inappropriately categorised and oversight at the right level is not lost.



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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> | Risk Management Strategy and Policy – RM01 -V4.5 |
| <u>Date form completed:</u> | 23 rd June 2020 |



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

| | | |
|----|--|--|
| 1. | What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking? | Risk Management Strategy and Policy - RM01 -V4.5 |
| 2. | Provide a brief description, including the aims and objectives of what you are assessing. | <p>Re-designing and crafting this new Risk Management Strategy and Policy for Betsi Cadwaladr University Health Board reflects its commitment to place and integrate effective risk management into everything it does including business/operational delivery, objective and priority setting, financial planning and budget setting. The Health Board emphasises the fact that effective risk management is everyone`s responsibility.</p> <p>The main objectives of this strategy and policy are:</p> <ul style="list-style-type: none">• To provide a framework including a clearly defined structure, consistency and standardisation in the effective management of strategic, operational and commissioning risks.• To set out the organisational governance arrangements and responsibilities for risk management.• To enable staff to understand our risk environment and to use the Health Board`s risk appetite statement to identify and assess risks which cannot be tolerated.• To facilitate the use of risk management as a tool for better decision-making, driving continuous improvements and linking these to organisational planning and performance reporting.• To foster an open, transparent and blame-free culture in driving and embedding an integrated approach to risk management that is intelligence-led, evidence-based and informed by continuous learning. |
| 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? | Gill Harris - Deputy Chief Executive and Executive Director of Nursing and Midwifery. |

Part A

Form 1: Preparation

| | | |
|----|--|--|
| 4. | Is the Policy related to, or influenced by, other Policies or areas of work? | <p>Yes,</p> <ul style="list-style-type: none"> • Board Assurance Framework • Health and Safety Policy (HS01) • Risk Assessment Guidance (HS03) • Concerns Policy and Procedure (PTR01 and PTR01A) • Datix Risk Register – Procedure and User Guide (RM02) Model Risk Management Procedure (RM04) |
| 5. | Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed? | <ul style="list-style-type: none"> • Employee's and workers • Patients and service users • The Public and visitors • Contractors • Any persons residing in BCUHB accommodation • Staff side and Trade Unions • All others entering BCUHB premises |
| 6. | What might help or hinder the success of whatever you are doing, for example communication, training etc.? | <p>To support the proposed implementation of the Strategy and Policy:</p> <ul style="list-style-type: none"> • A clear programme of communication and awareness raising of RM01 • Engagement from all BCUHB employees to implement and support the strategy and policy • A programme of training and training needs analysis to support staff with accessing and robustly utilising the RM01. <p>Potential barriers:</p> <ul style="list-style-type: none"> • Confidence to manage and comply with the Strategy and Policy • Poor communication or lack of engagement with staff/public • Lack of understanding around the Strategy and Policy requirements. |

Part A

Form 1: Preparation

| | | |
|----|---|--|
| 7. | Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage. | This Risk Management Strategy and Policy fosters equality and reduces inequality by emphasising the need for staff, contractors and everyone to ensure its appropriate application in embedding an organisation-wide culture of safety and the provision of high quality care to all patients irrespective of their age, sex, ethnicity etc. |
|----|---|--|

Part A

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

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. *(Please refer to the [Step by Step guidance](#) for more information)* 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

| 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)?" You can also visit their website here | How will you reduce or remove any negative Impacts that you have identified? |
|--|--|----|-------|-------|--|---|
| | Yes | No | (+ve) | (-ve) | | |
| Age (e.g. think about different age groups) | X | | (+ve) | | <ul style="list-style-type: none"> This Risk Management Strategy and Policy will prevent any potential discrimination, foster an organisational-wide culture of safety and offer the same level of support regardless of age. https://www.ons.gov.uk/atoz?az=a | Through regular review and audits of the Health Board`s risk management culture. |
| Disability (think about different types of impairment and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV) | X | | (+ve) | | <ul style="list-style-type: none"> This Risk Management Strategy and Policy ensures the same level of safety prioritisation and appropriate risk management for all staff, patients, visitors, contractors and everyone regardless of disability. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/ | Support will be provided to those with a disability as it is reasonably practicable in appropriately accessing and utilising the Risk Management Strategy and Policy including signposting them to relevant support services within the and outside the Health Board which can enhance and enable them to access and explore this strategy including those with |

Part A

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

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|---|---|--|-------|--|--|---|
| | | | | | | dyslexia. It also includes support for colour blindness for interpretation of the RAG ratings by the inclusion of the letters RAG in the column with the colour. |
| Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender) | X | | (+ve) | | <ul style="list-style-type: none"> This Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of gender reassignment. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/ | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their gender reassignment. |
| Pregnancy and maternity | x | | (+ve) | | <ul style="list-style-type: none"> This Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of their pregnancy and maternity status. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/ | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their pregnancy and maternity status. |
| Race (include different ethnic minorities, Gypsies and Travellers) | x | | (+ve) | | <ul style="list-style-type: none"> This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of their race and/or ethnicity. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/ | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their pregnancy and maternity status. |

Part A

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

| | | | | | | |
|---|---|--|-------|--|--|--|
| Consider how refugees and asylum-seekers may be affected. | | | | | | |
| Religion, belief and non-belief | x | | (+ve) | | <ul style="list-style-type: none"> This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of their religion, belief and non-belief. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/ | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their religion, belief and non-belief. |
| Sex (men and women) | x | | (+ve) | | <ul style="list-style-type: none"> This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of their sex. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/ | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their sex. |
| Sexual orientation (Lesbian, Gay and Bisexual) | x | | (+ve) | | <ul style="list-style-type: none"> This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff irrespective of their sexual orientation. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/ | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their sexual orientation. |

Part A

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

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|---|---|--|-------|--|--|--|
| Marriage and civil Partnership (Marital status) | x | | (+ve) | | <ul style="list-style-type: none">• This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff irrespective of their marriage and civil Partnership (marital status). | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their marriage and civil Partnership (marital status). |
| Low-income households | x | | (+ve) | | <ul style="list-style-type: none">• This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff irrespective of they being from low-income households. | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of they being from low-income households. |

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

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*

| 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) | | | |
| x | | (+ve) | | <ul style="list-style-type: none"> • Article 5 Right to liberty and security • Article 8 Right to respect for family & private life | The Strategy will support horizon scanning for emerging risks and their appropriate mitigation and management in providing high quality patient-centred responsive care. | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against. |

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

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 | X | | (+ve) | | The Strategy will support horizon scanning for any emerging risks which could negatively affect people who use the Welsh language and to appropriately mitigate and manage them. | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because they are a Welsh language speaker. |
| Treating the Welsh language no less favourably than the English language | X | | (+ve) | | The Strategy will support horizon scanning for any emerging risks which could negatively affect people who use the Welsh language and to appropriately mitigate and manage them as well as ensure that Welsh language is not less favourably treated than the English language. | Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because they are a Welsh language speaker. |

Part A Form 4: Record of Engagement and Consultation

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> | <ul style="list-style-type: none"> • Workshops have been held with all key stakeholders including staff of the Board and Audit Committee. • Risk management training has also been piloted around the main thrusts of the new strategy and feedback has been received. |
| <p>Have any themes emerged? Describe them here.</p> | <ul style="list-style-type: none"> • Collaborative and joined-up working in managing risks. • Risk appetite statement • Embedding risk management • Better and enhanced decision making |
| <p>If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?</p> | <p>Yes,</p> <ul style="list-style-type: none"> • The views of the various stakeholders who have been engaged in crafting this Strategy have shaped and influenced the final version as comments and feedback have been incorporated into the final version. |

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

| | |
|---|--|
| 1. What has been assessed? (Copy from Form 1) | Risk Management Strategy and Policy - RM01 -V4.5 |
|---|--|

| | |
|---|--|
| 2. Brief Aims and Objectives: (Copy from Form 1) | <p>Re-deigning and crafting this new Risk Management Strategy and Policy for Betsi Cadwaladr University Health Board reflects its commitment to place and integrate effective risk management into all what it does including business/operational delivery, objective and priority setting, financial planning and budget setting. The Health Board emphasises the fact that effective risk management is everyone`s responsibility.</p> <p>The main objectives of this strategy and policy are:</p> <ul style="list-style-type: none"> • To provide a framework including a clearly defined structure, consistency and standardisation in the effective management of strategic, operational and commissioning risks. • To set out the organisational governance arrangements and responsibilities for risk management. • To enable staff to understand our risk environment and to use the Health Board`s risk appetite statements to identify and assess risks which cannot be tolerated. • To facilitate the use of risk management as a tool for better decision-making, driving continuous improvements and linking these to organisational planning and performance reporting. • To foster an open, transparent and blame-free culture in driving and embedding an integrated approach to risk management that is intelligence-led, evidence-based and informed by continuous learning. |
|---|--|

From your assessment findings (Forms 2 and 3):

| | | |
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| 3a. Could any of the protected groups be negatively affected by your policy or proposal? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
|--|------------------------------|--|

Part B Form 5: Summary of Key Findings and Actions

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|--|------------------------------|--|
| 3b. Could the impact of your policy or proposal be discriminatory under equality legislation? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| <p>Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?</p> <p>The outcomes from the information provided in forms 2 and 3 indicate that the impact of the implementation of the Strategy will have a positive impact on the protected characteristic groups highlighted within this EqIA. The Strategy will be implemented equally across all protected characteristic groups.</p> | | |
| 5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Record Details: No Mitigating issues | | |
| 6. Are monitoring | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

Part B Form 5: Summary of Key Findings and Actions

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|--|--|---|
| arrangements in place so that you can measure what actually happens after you implement your policy or proposal? | How is it being monitored? | The Strategy will be monitored through local team engagement, senior management meetings, Risk Management Annual Health check and Audits. |
| | Who is responsible? | Gill Harris - Deputy Chief Executive and Executive Director of Nursing and Midwifery. |
| | What information is being used? | E.g. will you be using existing reports, data etc. or do you need to gather your own information? Feedback from the Board and Audit Committee and consultation with colleagues and risk reports generated for various Quality and Safety and/or Governance meetings. |
| | When will the EqIA be reviewed? (Usually the same date the policy is reviewed) | As appropriate and in line with the policy review date – July 2021 |

| | |
|--|---|
| 7. Where will your policy or proposal be forwarded for approval? | The Audit Committee and then ratification by the Board. |
|--|---|

| | | |
|---|-------------|-------------------------|
| 8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be | Name | Title/Role |
| | David Tita: | Head of Risk Management |

Part B Form 5: Summary of Key Findings and Actions

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|---|--|--|
| undertaken as a group activity Senior sign off prior to committee approval: | Justine Parry: Specialist support from the Equality and Inclusion Manager | Assistant Director of Information Governance & Risk. |
| | | |
| | | |
| Please Note: The Action Plan below forms an integral part of this Outcome Report | | |

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 | 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: | N/A | N/A | N/A |

Part B Form 5: Summary of Key Findings and Actions

| | Proposed Actions | Who is responsible for this action? | When will this be done by? |
|---|---|---|----------------------------|
| 2. What changes are you proposing to make to your policy or proposal as a result of the EqIA? | No significant change to procedure | N/A | N/A |
| 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? | Clear communication of the procedure across BCUHB Support for implementation | David Tita Head of Risk Management | 31 st Oct 2020 |
| 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 | N/A | N/A |
| 4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment. | Full implementation and engagement with the new Strategy. | David Tita Head of Risk Management | 31 st Oct 2020 |



| | | | | | | | |
|---|--|---|--|--|--|--------------------------------------|--|
| Cyfarfod a dyddiad: Meeting and date: | Audit Committee – June 2020 | | | | | | |
| Cyhoeddus neu Breifat: Public or Private: | Public | | | | | | |
| Teitl yr Adroddiad Report Title: | Schedule of Closed Liability Claims Over £50,000 - Quarter Four | | | | | | |
| Cyfarwyddwr Cyfrifol: Responsible Director: | Executive Director of Nursing and Midwifery/Deputy CEO Associate Director of Quality Assurance | | | | | | |
| Awdur yr Adroddiad Report Author: | Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience Claims Managers | | | | | | |
| Craffu blaenorol: Prior Scrutiny: | Review by the Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience | | | | | | |
| Atodiadau Appendices: | Schedule of closed claims and financial value for quarter four of 2019/20 (over £50,000) | | | | | | |
| Argymhelliad / Recommendation: | | | | | | | |
| The Audit Committee is asked to receive this report and approve payments in line with Standing Orders. | | | | | | | |
| Ar gyfer penderfyniad /cymradwyaeth 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 liability claims against the Health Board with a spend of over £50,000 closed during Quarter 4 (January - March) of the 2019/20 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> | | | | | | | |
| Cefndir / Background: | | | | | | | |
| <p>Claims Process (for assurance) All Health Boards in Wales contribute to a liability fund and have a risk share agreement, known as the Welsh Risk Pool (WRP).</p> | | | | | | | |

The Health Board employs a team of Claims Managers who sit within the Patient Safety and Experience Department. These legally trained staff were recruited to strengthen the management of claims. Clinical negligence and personal injury claims are managed by the Health Board on the basis of legal advice provided by the Legal and Risk Services Department of NHS Wales Shared Services Partnership. The Welsh Risk Pool will reimburse the Health Board for all losses incurred above an excess of £25,000 on a case by case basis.

To ensure that learning and improvement is commenced and implemented at the earliest possible stage the Welsh Risk Pool has amended its reimbursement procedures to bring the scrutiny of learning much earlier in the lifecycle of a case. These changes become effective from 1st October 2019. The new WRP procedures introduce a Learning from Events Report (LfER) and a Case Management Report (CMR). These are used by the Health Board to report the issues that have been identified from a claim and to determine how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event. The trigger for an LfER is related to the date of a decision to settle a case (even if the loss incurred is under £25,000) and the Health Board has sixty working days to submit a report from this date. A CMR is then submitted four months after the last payment on a claim is made, detailing how quantum was decided, if delegated authority was used and confirming that senior leaders have been advised of the claims. The LfER needs to provide a sufficient explanation of the circumstances and background to the events which have led to the case, in order for the WRP Committee to scrutinise and identify the links to the findings and learning outcomes. Supporting information, such as action plans, expert reports and review findings can be appended to the LfER to evidence the learning activity.

Should the Audit Committee require it, there is a learning document available for the cases listed within the schedule attached.

In all cases, claims have been managed by the Claims Managers within the Patient Safety and Experience Department who are all legally trained. All claims have been managed with the support and involvement of the Legal and Risk Services Department of NHS Wales Shared Services Partnership (NWSSP).

Asesiad / Assessment & Analysis

Please see the attached schedule. The data provided has been taken from the Datix software system through which claims are managed. The Audit Committee will be able to scrutinise spend of claims against geographical area throughout the Health Board and by speciality.

All claims have been managed in accordance with Health Board policy and standing orders.

| Ref | Type | Area | Specialty | Incident Date | Opened date | Closed Date | Description | Damages Authority Provided By | Damages Financial Payment Approval By | Costs Authority Provided By | Costs Financial Payment Approval By | Total (Payment summary) |
|----------|---------------------|---------|--------------------------------|---------------|-------------|-------------|---|--|---------------------------------------|--|--|-------------------------|
| W07-791 | Clinical Negligence | West | Nephrology / Renal (Secondary) | 01/07/2005 | 15/11/2007 | 04/02/2020 | Failure to appreciate blood test taken July 05 demonstrated mild impaired of renal function. Creatinine elevated @ 170. No further monitoring until test Jan 07, renal function deranged, urgent referral made to nephrology team, kidney biopsy not done, now ? transplant. | Gill Harris, Director of Nursing & Midwifery | Gary Doherty, Chief Executive | Gill Harris, Director of Nursing & Midwifery and Russ Favager, Director of Finance | Gary Doherty, Chief Executive | £238,568.71 |
| E11-98 | Clinical Negligence | East | Obstetrics (Secondary) | 16/02/1999 | 13/06/2011 | 03/02/2020 | Alleged that the child suffered shoulder dystocia at time of delivery and went on to be diagnosed with Erb's Palsy. | Gary Doherty, Chief Exec & Welsh Government | Gary Doherty, Chief Executive | Deborah Carter, Director of Quality Assurance | Head of Patient Safety | £1,112,720.48 |
| C13-1026 | Clinical Negligence | Central | Obstetrics (Secondary) | 27/10/2011 | 06/03/2013 | 27/03/2020 | Claimant rang delivery suite stating she was feeling unwell, advised to come in to be checked on delivery suite. On arrival claimant was very unwell; her Blood pressure was significantly raised and she was complaining of upper abdominal pain. Medical assistance was called immediately. Antihypertensive were drugs administered to reduce blood pressure, ranitidine was given intravenously, and an intravenous infusion was commenced. Claimant subsequently collapsed, cardiac arrest call put out, it was agreed to proceed to a code 1 caesarean section. All relevant teams arrived in a timely manner. Caesarean section performed under GA, live baby girl apgar score 5/10 at 1 minute and 8/10 at 5 minutes. Claimant transferred to ITU when a bed was available. Mother & Baby subsequently made a good recovery. Allegations relate to drugs given - may have been contra indicated with asthma | Claims Manager | Head of Complaints | Claims Manager | Head of Complaints | £76, 101.44. |
| E13-1058 | Clinical Negligence | East | Obstetrics (Secondary) | 06/01/2009 | 28/03/2013 | 27/02/2020 | Failure to carry out timely caesarean section as a result of which baby sustained foetal distress and hypoxic Ischaemic encephalopathy in the neonatal period. | Gary Doherty, Chief Exec & Welsh Government | Gary Doherty, Chief Executive | Deborah Carter, Director of Quality Assurance | Gill Harris, Director of Nursing & Midwifery and Russ Favager, Director of Finance | £2,759,364.54 |
| C13-1319 | Personal Injury | Central | Obstetrics (Secondary) | 12/02/2013 | 23/10/2013 | 26/03/2020 | Injuries sustained during course of duty - aggravation of a pre-existing condition in back which was asymptomatic before accident; injury to right knee. | Claims Manager | Head of Patient Experience | Claims Manager | Head of Patient Experience | £54,860.06 |

| Ref | Type | Area | Specialty | Incident Date | Opened date | Closed Date | Description | Damages Authority Provided By | Damages Financial Payment Approval By | Costs Authority Provided By | Costs Financial Payment Approval By | Total (Payment summary) |
|----------|---------------------|---------|----------------------------------|---------------|-------------|-------------|---|---|--|---|--|-------------------------|
| E13-1327 | Clinical Negligence | East | Community Hospital (Area) | 30/01/2013 | 31/10/2013 | 26/03/2020 | Patient suffered falls on three separate occasions as a result of which he sustained a gash to arm, cracked bone in wrist, bruising to back and a fracture to right hip. | Claims Manager | Barbara Jackson, Assistant Director Service User Experience | Claims Manager | Barbara Jackson, Assistant Director Service User Experience | £73,603.00 |
| E13-1361 | Clinical Negligence | East | Trauma/Orthopaedics (Secondary) | 19/07/2014 | 27/11/2013 | 26/03/2020 | It is alleged that there was a failure to carry out adequate tests and investigations; subsequently diagnosed with Cauda Equina Syndrome. | Deborah Carter, Director of Quality Assurance & Sue Hill, Director of Finance | Deborah Carter, Director of Quality Assurance | Sue Hill, Director of Finance | Gill Harris, Director of Nursing & Midwifery and Russ Favager, Director of Finance | £379,382.29 |
| E14-1570 | Clinical Negligence | East | Emergency Department (Secondary) | 01/01/2012 | 10/06/2014 | 03/02/2020 | Alleged clinical negligence in relation to treatment afforded to claimant from 2012 onwards. Related to attendance at ED and subsequent stroke. | Deborah Carter, Director of Quality Assurance | Gill Harris, Director of Nursing & Midwifery and Russ Favager, Director of Finance | Deborah Carter, Director of Quality Assurance | Head of Patient Safety | £436,253.55 |
| E14-1629 | Clinical Negligence | East | Emergency Department (Secondary) | 03/04/2013 | 25/07/2014 | 05/02/2020 | Patient died following a head injury. There was a failure to have a neuroradiologist review scans. It was found that Dexamethasone should not have been used in the presence of a brain contusion injury and the continued use of this caused material contribution in terms of side effects. | Claims Manager | Head of Patient Experience | Claims Manager | Head of Patient Safety | £58,458.71 |
| C14-1644 | Clinical Negligence | Central | Vascular Surgery (Secondary) | 10/11/2011 | 06/08/2014 | 27/03/2020 | Claimant underwent repair of AAA in November 2011. Allegation is that there was a failure to consider the source of an infection prior to surgery and thereafter recognise quickly that he was suffering from compartment syndrome and provide the appropriate treatment. | Claims Manger. | Kath Clarke, Interim Assistant Director of Service User Experience | Claims Manager | Deputy Head of Service User Experience | £169,192.97 |
| C15-1861 | Clinical Negligence | Central | Trauma/Orthopaedics (Secondary) | 01/11/2013 | 05/03/2015 | 27/03/2020 | Failure to be referred for an MRI scan by claimant's GP for an ongoing back problem thus resulting in spinal surgery in Nov 2013. Failure also by the Hospital to investigate back problem. | Deborah Carter, Director of Quality Assurance | Deborah Carter, Director of Quality Assurance | Deborah Carter, Director of Quality Assurance | Deborah Carter, Director of Quality Assurance | £286,537.29 |
| C15-1866 | Clinical Negligence | Central | Emergency Department (Secondary) | 11/09/2014 | 10/03/2015 | 18/03/2020 | Failure to properly report Radiology on 11.09.2014 | Claims Manager | Barbara Jackson, Assistant Director Service | Claims Manager | Barbara Jackson, Assistant Director Service | £93,088.87 |

| Ref | Type | Area | Specialty | Incident Date | Opened date | Closed Date | Description | Damages Authority Provided By | Damages Financial Payment Approval By | Costs Authority Provided By | Costs Financial Payment Approval By | Total (Payment summary) |
|------------|---------------------|---------|----------------------------------|---------------|-------------|-------------|---|---|--|---|--|-------------------------|
| | | | | | | | | | User Experience | | User Experience | |
| E15-1966 | Clinical Negligence | East | Trauma/Orthopaedics (Secondary) | 01/09/2013 | 01/07/2015 | 03/02/2020 | Alleged failure to appreciate the severity of a ligamentous injury and stabilise the right syndesmosis during ankle fracture surgery on 6 September 2013, causing the claimant to sustain a failed repair to the right ankle, damage to the superficial peroneal nerve, increased pain and inappropriate fixation of the ankle; plus additional pain and suffering. It is alleged that additional revision surgeries were required as a result. | Claims Manager | Barbara Jackson, Assistant Director Service User Experience | Claims Manager | Barbara Jackson, Assistant Director Service User Experience | £55,815.83 |
| C15-1987 | Clinical Negligence | Central | General Surgery (Secondary) | 01/12/2014 | 03/08/2015 | 03/02/2020 | Claimant was to be seen on an urgent basis this seemingly reclassified and arranged for December 2014, failure to perform a prompt colonoscopy to diagnose cancer sooner. Claimant was left with a permanent colostomy. Sadly claimant has since died | Claims Manager | Barbara Jackson, Assistant Director Service User Experience | Claims Manager | Deputy Head of Service User Experience | £107,402.25 |
| CLA16-2278 | Clinical Negligence | East | Ophthalmology (Secondary) | 01/05/2016 | 23/05/2016 | 26/03/2020 | The claimant underwent corneal surgery Wrexham Maelor Hospital to treat keratoconus. Following surgery, his sight deteriorated and he developed an infection, swelling and a cataract. He was referred to Abergele where a second surgery revealed that the lens had move due to not being sealed during the original procedure. It is the claimant's case that he is unlikely to recover the sight in his left eye. | Russ Favager, Director of Finance | Gill Harris, Director of Nursing & Midwifery and Russ Favager, Director of Finance | Russ Favager, Director of Finance | Gill Harris, Director of Nursing & Midwifery and Russ Favager, Director of Finance | £209,693.35 |
| CLA2304 | Clinical Negligence | Central | Emergency Department (Secondary) | 12/04/2016 | 13/06/2016 | 03/02/2020 | Claim relates to an over rapid correction of sodium levels following the claimant's development of chronic hyponatraemia in April 2016. The Claimant is diagnosed with permanent cerebral neuropathology (impaired brain function). | Deborah Carter, Director of Quality Assurance | Russ Favager, Executive Director of Finance | Claims Manager | Barbara Jackson, Assistant Director Service User Experience | £213,898.04 |
| CLA16-2426 | Clinical Negligence | East | General X-ray (Secondary) | 10/02/2014 | 21/09/2016 | 03/02/2020 | Treatment in relation to back pain - Alleged failure to identify signs suggestive of myeloma on x-ray of the lumbar spine taken, February 2014. | Deborah Carter, Director of Quality Assurance | Barbara Jackson, Assistant Director Service User Experience | Deborah Carter, Director of Quality Assurance | Barbara Jackson, Assistant Director Service User Experience | £167,174.08 |
| W17-2580 | Clinical Negligence | West | Emergency Department (Secondary) | 16/02/2011 | 23/01/2017 | 04/02/2020 | Failure to diagnose orbital fracture | Claims Manager | Barbara Jackson, Assistant Director Service | Claims Manager | Deputy Head of Complaints | £65,106.36 |

| Ref | Type | Area | Specialty | Incident Date | Opened date | Closed Date | Description | Damages Authority Provided By | Damages Financial Payment Approval By | Costs Authority Provided By | Costs Financial Payment Approval By | Total (Payment summary) |
|------------|---------------------|---------|----------------------------------|---------------|-------------|-------------|---|--|--|--|---|-------------------------|
| | | | | | | | | | User Experience | | | |
| CLA17-2734 | Clinical Negligence | Central | Emergency Department (Secondary) | 05/12/2013 | 18/04/2017 | 03/02/2020 | <p>Failure to provide the claimant with the standard of care to which he was reasonably entitled namely:</p> <p>Failure to request examination from a senior clinician</p> <p>Failure to refer the claimant for a CT brain scan</p> <p>Failure to carry out a thorough clinical assessment</p> <p>Failure to carry out a detailed neurological assessment</p> <p>Alleged that had all of the above been carried out, and the claimant admitted to hospital, his subsequent deterioration and death would not have occurred.</p> | Gill Harris, Director of Nursing & Midwifery | Gill Harris, Director of Nursing & Midwifery and Russ Favager, Director of Finance | Claims Manager | Deputy Head of Service User Experience | £99,651.97 |
| C17-2852 | Clinical Negligence | Central | General Surgery (Secondary) | 31/03/2016 | 23/06/2017 | 27/03/2020 | <p>Patient underwent a laparoscopic cholecystectomy in 2005 in the Countess of Chester.</p> <p>In 2016 the Claimant underwent a laparoscopic which was converted to an open remnant cholecystectomy. Claimant sustained a significant Strasberg E-type biliary injury. Claimant was transferred to specialist HPB Unit at Aintree</p> | Claims Manager | Kath Clarke, Interim Assistant Director of Service User Experience | Claims Manager | Deputy Head of Service User Experience | £86,019.86 |
| C17-2931 | Clinical Negligence | Central | Gynaecology (Secondary) | 11/05/2015 | 10/08/2017 | 03/02/2020 | Management of gynaecological symptoms from 2010 to December 2015 | Claims Manager | Kath Clarke, Interim Assistant Director of Service User Experience | Claims Manager | Deputy Head of Service User Experience | £59,107.54 |
| CLA17-3082 | Clinical Negligence | East | General Surgery (Secondary) | 08/07/2011 | 01/11/2017 | 26/03/2020 | Claim received following PTR. Patient contracted infection following surgical procedure | Gill Harris, Director of Nursing & Midwifery | Deborah Carter, Director of Quality Assurance | Gill Harris, Director of Nursing & Midwifery and Russ Favager, Director of Finance | Deborah Carter, Director of Quality Assurance | £188,641.20 |

It is important to note that payments are often made in stages and the chart therefore shows the latest authoriser in these cases. All payments have been authorised within delegated limits.

| | | | | | | | |
|--|---|---|--------------------------|--|--------------------------|--------------------------------------|--------------------------|
| Cyfarfod a dyddiad: Meeting and date: | Audit Committee 29th June 2020 | | | | | | |
| Cyhoeddus neu Breifat: Public or Private: | Public | | | | | | |
| Teitl yr Adroddiad Report Title: | Head of Internal Audit Opinion & Annual Report 2019/2020 Internal Audit Plan 2020/21 – Update for COVID-19 impact Reporting of Limited assurance reports in the period since the last Audit Committee | | | | | | |
| Cyfarwyddwr Cyfrifol: Responsible Director: | Dawn Sharp – Acting Board Secretary | | | | | | |
| Awdur yr Adroddiad Report Author: | Dave Harries – Head of Internal Audit | | | | | | |
| Craffu blaenorol: Prior Scrutiny: | The Head of Internal Audit opinion and annual report has been considered and approved by the Acting Board Secretary. The internal audit plan update due to the impact of COVID-19 has been approved by the Acting Board Secretary and shared with the Executive Team. | | | | | | |
| Atodiadau Appendices: | Appendix 1: Head of Internal Audit Opinion & Annual Report 2019/2020 Appendix 2: Internal Audit Plan 2020/21 – Update for COVID-19 impact Appendix 3: Limited assurance report – Deprivation of Liberty Safeguards (DoLS) | | | | | | |
| Argymhelliad / Recommendation: | | | | | | | |
| The Audit Committee is asked to: <ul style="list-style-type: none"> • Note and receive the Head of Internal Audit opinion and annual report for 2019/20. • Approve the revised internal audit plan for 2020/21. • Note and receive the Deprivation of Liberty Safeguards (DoLS) limited assurance 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 | <input checked="" type="checkbox"/> | Ar gyfer Trafodaeth For Discussion | <input type="checkbox"/> | Ar gyfer sicrwydd For Assurance | <input type="checkbox"/> | Er gwybodaeth For Information | <input type="checkbox"/> |
| Sefyllfa / Situation: | | | | | | | |
| In accordance with the Public Sector Internal Audit Standards, the head of internal audit (HIA) is required to provide an annual opinion, based upon and limited to the work | | | | | | | |

performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control).

The outcomes of these reviews have been shared with management, however at the time of the report, some of these are not yet finalised although the draft report opinion has been used to inform the HIA opinion.

The internal audit plan, approved by the Committee in March 2020 has been revised and updated to reflect the impact of COVID-19 on the Health Board and services provided. The timelines for completing these reviews have been revisited and the following reviews have been identified for deferral:

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

As part of the review and discussion with the Audit Committee Chair, the plan has been updated to include Mental Health & Learning Disabilities Division – Governance arrangements.

In accordance with reporting of limited/no assurance reports issued in the period since the last Committee meeting, the Deprivation of Liberty Safeguards (DoLS) report was agreed with management and approved for issue by the Executive Director of Nursing & Midwifery.

Cefndir / Background:

The head of internal audit opinion, annual report and updated plan have been developed in accordance with Public Sector Internal Audit Standards.

Asesiad / Assessment & Analysis

Strategy Implications

Changes to the Internal Audit plan for 2020/21 require approval by the Audit Committee to ensure it focuses on key risks that may undermine the Health Board delivering its corporate objectives.

Financial Implications

The plan focuses on areas that could have financial implications for the Health Board.

Risk Analysis

The Head of Internal Audit Opinion and annual report requires receiving and noting by the Committee, details of which will be included in the Annual Governance Statement for 2019/20. The report identifies areas of risk for the Health Board which management should actively address and provide assurance on progress.

The plan is risk based and focuses on areas identified through reviewing the corporate risk register and risk meetings with Executive Directors.

Legal and Compliance

The Head of Internal Audit Opinion and Annual Report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.6*

Reviewing the Head of Internal Audit's annual opinion.

The plan is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.3 Internal audit support to the Audit Committee* and *Section 4.4 Reviewing the internal audit plan*.

Impact Assessment

The Internal Audit plan recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk.

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

Betsi Cadwaladr University Local Health Board

Head of Internal Audit Opinion & Annual Report 2019/2020

April 2020

**NHS Wales Shared Services Partnership
Audit and Assurance Services**

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|-----------------------------|-----------------------------|
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| Draft report issued: | 28 th April 2020 |
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| Author: | Head of Internal Audit |
| Executive Clearance: | Acting Board Secretary |
| Audit Committee: | 29 th June 2020 |

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance in comparison to the plan and an assessment of conformance with the Public Sector Internal Audit Standards (these are the requirements of Standard 2450).

1.2 Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved internal audit plan is biased towards risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

The overall opinion has been formed by summarising audit outcomes across eight key assurance domains. The overall opinion is then based upon these grouped findings. In a change to previous year all domains now carry equal weighting.

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

1.3 Delivery of the Audit Plan

The internal audit plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee. Regular audit progress reports have been submitted to the Audit Committee during the year.

As a result of the COVID-19 pandemic and the response to it from the Health Board we have not been able to complete our audit programme in full. However, we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

We had anticipated, after adjustments to the original audit plan agreed with the Audit Committee, producing thirty-three (33) outputs at the year end. However, due to the impact of COVID-19 the final position at Betsi Cadwaladr University Local Health Board is: eighteen (18) Final reports, thirteen (13) Draft reports and two (2) work in progress. Where audits that are work in progress have been used to support the overall opinion (even though the work will not have been reported

to the Audit Committee in either Final or Draft form) this is set out in Section 2.4 of the Opinion.

For those audits that are either at the Draft report stage or are work in progress, we will agree an appropriate approach to complete and finalise those audits with the Health Board for formal submission to the Audit Committee at a later date.

There are, as in previous years, additional audits undertaken at NWSSP, NWIS, WHSSC and EASC that support the overall opinion for NHS Wales health bodies (see Section 3).

Our External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors, and our Quality Assurance and Improvement Programme have both confirmed that our internal audit work 'generally conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2019/2020. We are now able to state that our service 'conforms to the Institute of Internal Audit's (IIA's) professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

The report summarises the outcomes from the internal audit plan undertaken in the year and recognising audit provides a continuous flow of assurance includes the results of legacy audit work reported subsequent to the prior year opinion. The report also references assurances received through the internal audit of control systems operated by NWSSP for transaction processing on behalf of the Health Board.

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

In overall terms we can provide positive assurance to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the following assurance domains:

- Corporate governance, risk management and regulatory compliance;
- Financial governance and management;
- Information governance and security;
- Operational services and functional management; and
- Capital and estates management.

However, the significance of the matters identified in those areas where there are improvements to be made in governance, risk management and control impacts upon our overall audit assessment in the following assurance domains:

- Quality and safety;
- Strategic Planning, Performance Management & Reporting; and
- Workforce management.

Management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where appropriate.

Please note that our assessment across each of the domains has also taken into account, where appropriate, the number and significance of any audits that have been deferred during the course of the year (see also Sections 2.4.1 and 5.7).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives.
- The purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards.
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit Committee, will need to consider the Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Betsi Cadwaladr University Local Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement, and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Audit Wales in the context of their external audit.

The overall opinion by the Head of Internal Audit on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The assurance rating framework for expressing the overall audit opinion was refined in 2013/14 in consultation with key stakeholders across NHS Wales. In 2016/17, following further discussion with stakeholders, it was amended to remove the weighting given to three of the eight domains when judging the overall opinion. The framework applied in 2016/17 has been used again to guide the forming of the opinion for 2019/20.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions as clarified in 2012/13 has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix D**.

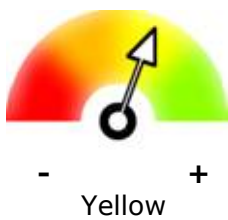
The individual conclusions arising from detailed audits undertaken during the year have been summarised by the eight assurance domains that were used to frame the internal audit plan at its outset. The aggregation of audit results by these domains gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the assurance domain ratings and overall opinion are consistent with the underlying audit evidence and in accordance with the criteria for judgement at **Appendix E**.

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

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

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any *limited* or *no-assurance* reports issued during the year and the significance of the recommendations made.

2.4.2 Basis for Forming the Opinion

In reaching the opinion the Head of Internal Audit has applied both professional judgement and the Audit & Assurance "*Supporting criteria for the overall opinion*" guidance produced by the Director of Audit & Assurance and shared with key stakeholders, see **Appendix E**.

The Head of Internal Audit has concluded *reasonable assurance* can be reported for the Corporate Governance, Risk Management and Regulatory Compliance; Financial Governance & Management; Information Governance & Security; Operational Service and Functional Management and Capital & Estates Management domains; but only *limited assurance* can be reported for the Strategic Planning, Performance Management & Reporting; Quality & Safety; and Workforce Management domains.

It should be noted that twelve reviews were deferred from the plan this year which could have a positive/negative impact on the specific domain assurance rating.

The audit work undertaken during 2019/20 and reported to the Audit Committee has been aggregated at **Appendix B**.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements;
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module; and

- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3 – Other Work for details).

As stated above these detailed results have been aggregated to build a picture of assurance across the eight key assurance domains around which the risk-based Internal Audit plan is framed. Where there is insufficient evidence to draw a firm conclusion the assurance domain is not rated.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited or no assurance was reported. Further, a number of audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. Where changes were made to the audit plan then the reasons were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings in each of the domains is set out below. Each domain heading has been colour coded to show the overall assurance for that domain.

Corporate Governance, Risk Management and Regulatory Compliance (Yellow)

- Our reviews relating to Welsh Risk Pool Claims Management Standard, Health and Safety, Compliance with Standing Financial Instructions – Procuring goods and services: Estates – GRAMMS and Compliance with Standing Financial Instructions – Procuring goods and services: Therapies – Therapy Manager recorded reasonable assurance, where some compliance issues with expected controls were identified.
- Adroddiad Archwilio Mewnol Terfynol - Mesur y Gymraeg (Cymru) 2011/Welsh Language (Wales) Measure 2011 - Nid yw strategaeth sgiliau dwyieithog y Bwrdd Iechyd yn cydymffurfio a swyddi hynny a nodir fel Cymraeg hanfodol/ The Health Board Bi-lingual skills strategy is not being complied with for those posts stipulated as Welsh essential – limited assurance.

Strategic Planning, Performance Management & Reporting (Amber)

- The review of Partnership governance - Section 33 Agreements identified a lack of assurance reported through the management and Committee structure regarding the performance of each Section 33 agreement. In addition, the Health Board was not compliant with the Statutory Instrument where it is the host partner – limited assurance.
- Performance measure reporting to the Board – Accuracy of information review was deferred from the plan, following agreement of the scope with the Audit Committee to analyse the accuracy of RTT activity reporting to the Board.

Financial Governance and Management (Yellow)

- The review of Budget setting - Ysbyty Wrexham Maelor Hospital identified that the Health Board had robust governance arrangements in place for the setting of the 2019/20 budgets, however in reviewing the costing of

vacancies, backing documentation had not been retained and was not available for review, therefore we could not confirm that the budget strategy requirements had been met – reasonable assurance.

- Salary overpayments – We identified that the implemented procedure has not been consulted upon and that overpayments were increasing due, in part, to late submission of staff leavers forms for processing – limited assurance.
- Our work on the Delivery of savings against identified schemes at Ysbyty Glan Clwyd is currently in progress but we have not been able to conclude this audit at the date of issuing this opinion. We will issue our report and findings as part of the 2020/21 audit programme.
- Audit work had been planned to look at Health Board-wide management of delivery savings plans however the scope of the Internal Audit work would have covered similar ground to that being undertaken by Price Waterhouse Coopers (PwC) and as such was deferred to avoid potential duplication. PwC commenced work at the Health Board on the 1st April 2019 and continued supporting the Health Board savings programme up to the 5th July 2019. PwC issued two reports, the *Review of Expenditure (Grip and Control)* on the 26th April 2019 [twenty-two recommendations] and *Financial Baseline Review* issued on 15th May 2019 [32 recommendations].

Quality & Safety (Amber)

- Our review of Safeguarding Follow-up recorded substantial assurance where all recommendations, at the time of our review, had been implemented.
- The review of the Annual Quality Statement and HASCAS & Ockenden external reports – Recommendation progress and reporting (based upon the review of three recommendations received to date) both recorded reasonable assurance.
- Quality Impact Assessment review identified that some Project Initiation Documents (PIDs) had not been completed in accordance with the procedure made available to us and we could not identify effective reporting with subsequent scrutiny possible Improvement Groups over PIDs for assurance reporting to the Finance Recovery Group – limited assurance.
- Decontamination review identified a lack of reporting of issues of significance for escalation from the Local Infection Prevention Groups (LIPGs) as well as identifying several meetings have been cancelled within the governance and reporting arrangements. The Decontamination Department demonstrated a planned approach with the self-audit tool, however we found the self-audit tools were not routinely discussed at the LIPGs; evidence of self-audit tool being completed within two departments was not provided and no questions within the self-audit tool ascertaining whether the chemicals have been assessed correctly – limited assurance.
- Deprivation of Liberty Safeguards (DoLS) – The review identified a lack of local operational procedure clarifying expectations of wards/departments as the Managing Authority; there is insufficient Best Interest Assessors exposing the Health Board to risk of financial penalties from non-compliance with the requirements of DoLS Legislation. In addition DoLS applications

were sometimes incomplete and the reporting of breaches was not evident – limited assurance.

- Quality Improvement Strategy - We were unable to confirm that the Strategy has delivered its intended actions over the three years as there was no underpinning plan stating what the Health Board intended to do. Limited reporting on progress was evident and Welcome Boards across some wards are not being maintained – limited assurance.

Information Governance & Security (Yellow)

- GDPR – Follow-up of the Information Commissioners Office (ICO) review identified robust control over the action plan with clear timelines for implementation – limited evidence of regular reporting to Committee on progress – reasonable assurance.
- Cyber security review identified a draft cyber security policy requires approval and a lack of evidenced assurance reporting through the Committee structure to the Board - reasonable assurance.

Operational Service and Functional Management (Yellow)

- Non-emergency patient transport service (NEPTS) review identified there was a lack of performance management in relation to contract monitoring of NEPTS. In addition, the introduction of an all-Wales NEPTS contract, by WAST, had slipped – reasonable assurance.
- Managed General Practitioner Practices review identified opportunities to enhance the governance and performance scrutiny arrangements around managed practices, recognising the Health Board is planning to manage all practices under a managed practice unit – reasonable assurance.
- Joint follow-up with Conwy County Borough Council Internal Audit Service: Conwy Community Mental Health Team (CMHT) – this review was limited to solely reviewing the evidence provided by officers in the Mental Health and Learning Disabilities Services Division to address specific findings/recommendations made by Conwy Internal Audit Services report on Conwy CMHT. We noted progress had been made across all recommendations bar one. We believe that the only way to address the original recommendations by the Council auditors is to develop a formal Section 33 agreement between both partners – assurance not applicable.
- Ysbyty Gwynedd Emergency Department Patient Monitors – The review identified that governance arrangements and transparency in recording decisions require improvement at Ysbyty Gwynedd – assurance not applicable.

Workforce Management (Amber)

- NHS Wales staff survey – delivering the findings review identified that there was no overarching scrutiny of divisional delivery plans as reported to Committee and a lack of evidence in Mental Health & Learning Disabilities (MHL) and Secondary Care Ysbyty Gwynedd that respective governance arrangements routinely reviewed the staff survey. It has not been possible to definitively state that the progress reported against each delivery plan, for some, address the actions due to limited specific/measurable actions – limited assurance.

- Recruitment – Medical and Dental staff review identified data quality and completion of set fields is poor; this needs addressing for the Health Board to have meaningful data. The length of time taken from submission of an establishment control request to completion of pre-employment checks takes an average of 104 days; the ability of services/divisions to provide services is undermined by the lengthy recruitment process and could impact efforts to reduce locum/agency costs. The review of TRAC data notes the period between advert closing and shortlisting dates can add significant delay; it is unclear why closing date and shortlisting stage takes this amount of time as recruiting managers will know in advance the closing date and have adequate time to arrange to shortlist - limited assurance.
- Roster management – Our work on roster management is currently in progress but we have not been able to conclude this audit at the date of issuing this opinion. We will issue our report and findings as part of the 2020/21 audit programme.

Capital & Estates Management (Yellow)

- The review of the Carbon Reduction Commitment Order received substantial assurance and noted full compliance with expected controls.
- The environmental sustainability review noted that the Health Board's overarching sustainability strategy requires developing and that relevant and accurate information is included in the report – reasonable assurance.
- Statutory Compliance: Fire Safety review identified that the Strategic Occupational Health & Safety Group has been re-established coupled with the pro-active steps taken to re-energise the health and safety agenda within and across the Health Board. Reporting and assurance from directorates/ divisions must however improve to provide assurance to the Executive and Board – reasonable assurance.
- Ysbyty Gwynedd Emergency Department review identified regular reporting of project progress was evident however the project was delayed and issues around snagging were identified – reasonable assurance.
- North Denbighshire Community Hospital review identified that project board meetings have not met monthly and contracts require sign-off – reasonable assurance.
- Substance Misuse Action Funds review identified some issues around Project Board compliance and timeliness of one planning application - reasonable assurance.
- Ysbyty Glan Clwyd Redevelopment - Operation of the Pain/Gain Mechanism and Ysbyty Glan Clwyd Open Book Pain/Gain reviews identified some control issues for management consideration – both reviews were reasonable assurance.

2.4.3 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based

Internal Audit plan. In accordance with auditing standards and with the agreement of senior management and the Board Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.4.4 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and subject to the key financials and other mandated items being completed in-year the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board and Board Secretary, audit work reported to draft stage has been included in the overall assessment, all other work in progress will be rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2019/20 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment. Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide limited scope update on the current condition of control and a measure of direction of travel.

There are also some specific assurance reviews which remain relevant to the reporting of the Annual Report. These specific assurance requirements relate to the following two public disclosure statements:

- Annual Quality Statement; and
- Environmental Sustainability Report.

The specified assurance work on these statements has been aligned with the timeline for production of the Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit opinion. However, the Head of Internal Audit's assessment of arrangements in these areas is legitimately informed by drawing on the assurance work completed as part of this current year's plan albeit relating to the 2018/19 Annual Report and Quality Statement, together with the preliminary results of any audit work already undertaken in relation to the 2019/20 Annual Report and Quality Statement.

2.5 Required Work

There are a number of pieces of work that Welsh Government has required previously that Internal Audit should review each year, where applicable. These pieces cover aspects of:

- Health & Care Standards - Governance, Leadership and Accountability

Module;

- Annual Governance Statement;
- Annual Quality Statement;
- Environmental Sustainability Report;
- Carbon Reduction Commitment Order; and
- Welsh Risk Pool Claims Management Standard.

Health & Care Standards

As the Health Board was placed in Special Measures in June 2015, evidence of progress against the Governance, Leadership and Accountability Module is focussed and monitored as an integral part of the Special Measures Improvement Framework – As such, no separate assessment has been completed.

Where appropriate, our work is reported in Section 5 – Risk based Audit Assignments and at **Appendix B**.

Please note that there are discussions ongoing with Welsh Government as to whether this work will be required in 2020/21 and future years.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of internal audit is also subject to an annual assessment by the Wales Audit Office. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at Betsi Cadwaladr University Local Health Board in conformance with the Public Sector Internal Audit Standards for 2019/20.

Our conformance statement for 2019/20 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2019/20 which will be reported formally in the Summer of 2020;
- the results of the work completed by Wales Audit Office; and
- the results of the External Quality Assessment undertaken by the IIA.

We have set out, in Appendix A, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2019/20 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- Direct assurances from management on the operation of internal controls through the upward chain of accountability;
- Internally assessed performance against the Health & Care Standards;
- Results of internal compliance functions including Health & Safety, Local Counter-Fraud, Post Payment Verification, and Risk Management;
- Reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- Reviews completed by external regulation and inspection bodies including the Wales Audit Office, Healthcare Inspectorate Wales and Health and Safety Executive.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. The Head of Internal Audit has had regard to these audits, which are listed below.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

- Accounts Payable - Reasonable
- Payroll – Reasonable (draft report)
- Primary Care Services – General Medical Services - Substantial
- Primary Care Services – General Pharmaceutical Services - Substantial
- Primary Care Services – General Dental Services – Substantial
- Primary Care Services – General Ophthalmic Services – Substantial.
- Primary Care Services – Post Payment Verification - Substantial

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme.

The overall Head of Internal Audit Opinion for NWSSP has given an overall rating of Reasonable Assurance.

Six of the seven reports noted above (with the exclusion of the Post Payments Verification Audit) are also included in the table at Appendix B as they are

undertaken annually to ensure coverage of the main financial systems and include transactions processed on behalf of the Health Board.

In addition, as part of the internal audit programme at Cwm Taf Morgannwg UHB a number of audits were undertaken in relation to both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). These audits are listed below and derived the following opinion ratings:

Welsh Health Specialised Services Committee

- Cardiac review – Reasonable
- Information governance - Reasonable

Emergency Ambulance Services Committee

- Non-emergency patient transport service - N/A

NHS Wales Informatics Service (NWIS)

We have also undertaken six audits relating to the processes and operations of NWIS.

- Infrastructure / Network Management – Reasonable
- Service provision – Reasonable
- Supplier management – Limited (draft report)
- Follow up change control – Substantial
- GDPR – Limited
- Pharmacy project – Reasonable (draft report)

While these audits do not form part of the annual plan for Betsi Cadwaladr University Local Health Board, they are listed here for completeness as they do impact on the Health Board's activities, and the Head of Internal Audit does consider if any issues raised in the audits could impact on the content of our annual report.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre University NHS Trust Head of Internal Audit Opinion and Annual Report, along with the NWIS Audits; the WHSSC and EASC audits are detailed in the Cwm Taf Morgannwg UHB Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits which remain to be reported and reflected within this Annual Report will be reported alongside audits from the 2019/20 operational audit plan.

The assignment status summary is reported at section 5 and **Appendix B**.

In addition, throughout the year we have responded to requests for advice and/or assistance across a variety of business areas. This advisory work undertaken in addition to the assurance plan is permitted under the standards to assist management in improving governance, risk management and control. This activity has been reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

In order to be able to demonstrate the quality of the service delivered by Internal Audit, a range of service performance indicators supported by monitoring systems have been developed. These have become part of the routine reporting to the Audit Committee during 2019/20. The key performance indicators are summarised in the **Appendix C**.

Delivering against the performance indicators has, overall, been positive; whilst the timeline for responding to a draft internal audit report is twenty working days, we continue to experience delays in obtaining management response to some draft reports as well as agreement of audit briefs prior to commencement of reviews.

In accordance with the internal audit charter, we have seen in 2019/20 a further increase in obtaining the support of the Board Secretary to progress management response and closure of the review on a number of occasions.

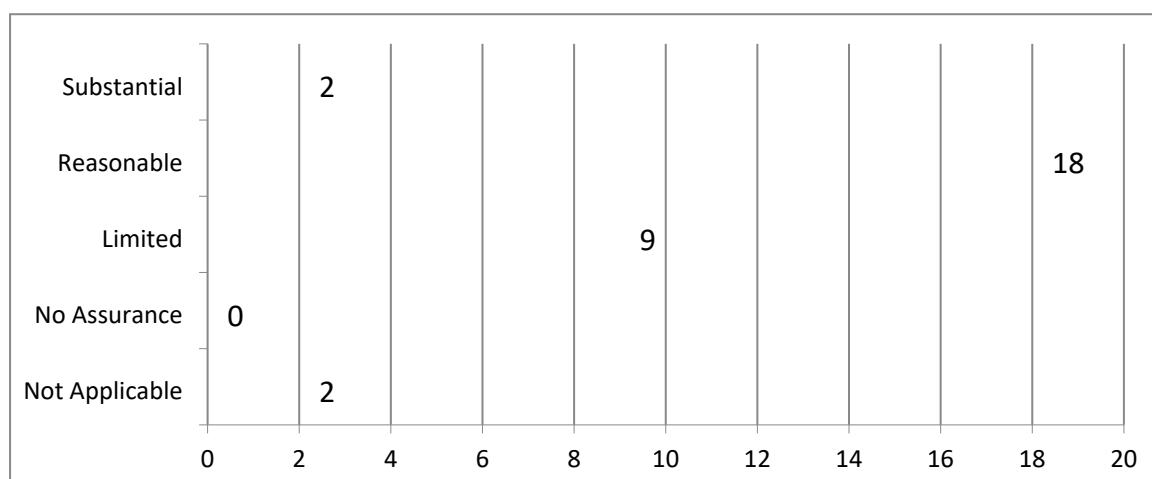
5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total thirty-seven audit reviews were reported during the year. Figure 1 below presents the assurance ratings and the number of audits derived for each.

Figure 1 Summary of audit ratings



The assurance ratings and definitions used for reporting audit assignments are included in **Appendix D**.

In addition to the above, there were twelve reviews which did not proceed following preliminary planning and agreement with management, as it was recognised that there was action required to address issues/risks already known to management and an audit review at that time would not add additional value.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)



In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

| Review Title | Objective |
|-----------------------------------|---|
| Carbon Reduction Commitment Order | To confirm compliance of the Energy Team with CRC guidance. |
| Safeguarding Follow-up | To provide assurance that the actions undertaken by management in delivering the agreed recommendations [within internal Audit's previous review] have been completed/advanced. |

5.3 Reasonable Assurance (Yellow)



In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

| Review Title | Objective |
|--|---|
| Welsh Risk Pool Claims Management Standard (Draft) | To establish whether there is a robust control environment in place within the Health Board to manage and support claims reimbursements from the Welsh Risk Pool. |

| Review Title | Objective |
|--|---|
| Health and Safety | To provide assurance that the gap analysis has been undertaken and completed within the time frame. We also sought to ensure the gap analysis was robust; consistently administered and the outputs of the analysis were accurately recorded - We also considered documentation provided to the Health & Safety Advisors as part of the gap analysis. |
| Compliance with Standing Financial Instructions – Procuring goods and services: Estates - GRAMMS | To review compliance with Standing Financial Instructions and operational procedure in procuring items locally. |
| Compliance with Standing Financial Instructions – Procuring goods and services: Therapies – Therapy Manager | To review compliance with Standing Financial Instructions and operational procedure in procuring items locally. |
| Budget Setting - Ysbyty Wrexham Maelor Hospital (Draft) | To establish whether there is a robust control environment in place within the Health Board to manage and support the budget setting process. |
| Annual Quality Statement | To review the consistency of information published within the AQS with organisational data previously reported to the Board and its Committees. |
| HASCAS & Ockenden external reports – Recommendation progress and reporting (Draft – <i>based upon the review of three recommendations received to date</i>) | To review the evidence supporting the eleven recommendations noted as completed to the Health Board at its meeting of the 5th September 2019. |
| GDPR – Follow-up of the Information Commissioners Office (ICO) review | To establish the controls in place and provide assurance that ICO recommendations were being implemented. |
| Cyber security (Draft) | To establish if the mechanisms in place for ensuring cyber-security are appropriately designed, and procedures and controls have been implemented within the previously agreed timeframes as outlined in the SIP derived from the recent external review of cyber-security. |
| Managed General Practitioner Practices (Draft) | To identify what the Health Board has developed, through its Area management teams, to hold the Managed GP Practices to |

| Review Title | Objective |
|--|--|
| | account on performance and how the outcome is reported for assurance. |
| Non-Emergency Patient Transport Service (NEPTS) | To assess the adequacy of management controls for the management of the Non-Emergency Patient Transport Service. |
| Environmental sustainability report | To assess the adequacy of management arrangements for the production of the Sustainability Report within the Annual Report. |
| Statutory Compliance: Fire Safety | To review the adequacy of, and operational compliance with, the systems and procedures of the Health Board, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate. |
| Ysbyty Gwynedd Emergency Department | To evaluate the delivery of the project and ensure compliance with the systems and procedures of the UHB, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate. |
| North Denbighshire Community Hospital (Draft) | To evaluate the delivery of the project and ensure compliance with the systems and procedures of the UHB, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate. |
| Substance Misuse Action Funds (Draft) | To determine the adequacy of, and operational compliance with, the systems and procedures of the Health Board, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate. |
| Ysbyty Glan Clwyd Redevelopment - Operation of the Pain/Gain Mechanism (Draft) | To obtain assurance that the pain/gain mechanism was being appropriately applied in accordance with the contract. |
| Ysbyty Glan Clwyd - Open Book Audit (Draft) | To provide assurance that amounts recovered by the Supply Chain Partner were in accordance with the terms of the Designed for Life: Building for Wales framework agreement. |

5.4 Limited Assurance (Amber)



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

| Review Title | Objective |
|--|---|
| Welsh Language (Wales) Measure 2011 | To establish whether there is a robust control environment in place within the Health Board to action the requirements of the Bilingual Skills Strategy and ensure compliance with the Welsh Language Measure (Wales) 2011. |
| Partnership governance - Section 33 Agreements | To provide assurance over the governance arrangements in place to support the various Section 33 Agreements. |
| Salary overpayments (Draft) | To review the adequacy of arrangements to ensure identified Overpayments are repaid to the Health Board in an acceptable and timely manner and in accordance with the operational procedure F14 Salary Overpayments / Underpayments Procedure. |
| Quality Improvement Strategy | To review the launch and regular reporting of progress in implementing the Strategy across the Health Board. |
| Quality Impact Assessment (Draft) | To provide the Health Board with assurances that recommendation 2a of the Ockenden Report (June 2018) 'Review of the Governance Arrangements...' whereby it seeks evidence that 'Quality Impact Assessments' are reviewed and the clinical implication of financial savings plans are assessed. |
| Decontamination (Draft) | Working in partnership with the Health Board Decontamination Advisor, ensure the requirements set out in IPC17 Decontamination of Medical Devices Procedure (Version 3.0) are being complied with. |
| Deprivation of Liberty Safeguards (DoLS) | To review the process for DoLS applications to ensure that these are managed in accordance with the Deprivation of Liberty Safeguards Code |

| Review Title | Objective |
|--|---|
| | of Practice, Welsh Government guidance and Health Board procedures. Additionally noting the recommendations of the HASCAS and Ockenden reports we reviewed progress where this directly relates to those areas that are the subject of our testing. |
| NHS Wales staff survey – delivering the findings (Draft) | To obtain evidence that underpins reported progress against the divisional improvement plans. |
| Recruitment– Medical and Dental staff (Draft) | To identify the timescale between establishment control submission, approval and TRAC request to advertise and shortlist for the vacancy and if there are any delays in the process. |

5.5 No Assurance (Red)



No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Blue)



The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

| Review Title | Objective |
|---|--|
| Joint follow-up with Conwy County Borough Council Internal Audit Service: Conwy Community Mental Health Team (CMHT) | To identify progress made in implementing agreed recommendations that have passed the original implementation date. |
| Ysbyty Gwynedd Emergency Department Patient Monitors | To identify where the final decision was made to award the contract to Phillips and whether the final decision was within the scope of the |

| | |
|--|--|
| | operational scheme of delegation taking into account the overall contract value. |
|--|--|

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

| Review Title | Reason for deferment |
|---|---|
| Compliance with Standing Financial Instructions – Procuring goods and services: Community Dental Services | The review of source data for this review has identified no individual transaction of £5,000 or more which required competitive quotation in accordance with the Standing Financial Instructions and was recommended for removal from the plan. |
| Compliance with Standing Financial Instructions – Procuring goods and services: Pharmacy EDS | The review of source data for this review has identified no individual transaction of £5,000 or more which required competitive quotation in accordance with the Standing Financial Instructions and was recommended for removal from the plan. |
| Health Board governance arrangements – Quality & Safety | We discussed this review with the Performance Auditor, Wales Audit Office and identified that the planned scope of our review would duplicate the mandatory review undertaken by the Wales Audit Office. |
| Cluster governance arrangements | Following development of the draft brief and issued for management consideration, we were advised of proposals being considered to develop integrated health & social care localities which potentially will have significant delegated responsibilities for planning and providing for the population. The localities are the same footprint as current clusters. We were told that it is unclear, currently, whether they incorporate the current primary care clusters, or run parallel. |
| Continuing Healthcare | Following issue of the draft brief, we were advised that the National Commissioning Collaborative (NCC) had been commissioned to begin a programme of work to review and improve CHC governance processes and contracting. As part of the first 30 days in the 90 day plan, the NCC was to observe every CHC panel and feedback the opportunities for improvement. Consequently the review was recommended for removal from the plan. |

| Review Title | Reason for deferment |
|--|---|
| Caldicott – Principles into Practice (CPiP) self-assessment | We were advised that the CPiP self-assessment was being replaced with planned changes in the reporting tool and migration to a new process in 2019/20, consequently the review was recommended for removal from the plan. |
| Welsh Community Care Information System (WCCIS) | We have been unable to commence this review following the restrictions due to the COVID-19 pandemic - The Audit Committee has, through Chair’s Action approved the removal of this review from the plan. |
| Capital Systems: Primary Care benefits realisation | Management had previously requested we defer the commencement of the Primary Care (2018/19) review (i.e. systems in place to ensure benefits are realised and that appropriate lessons are identified and applied at any future procurement exercises), until Quarter 1, 2019/20. However, noting the proposed scope of the Gateway 5 exercise (scheduled for September 2019), it was recommended that the audit assignment be removed from the audit plan. |
| Ysbyty Wrexham Maelor Hospital – Backlog maintenance risk management | Following recent planning discussions, management requested that the commencement of this review be deferred until Q1 of 2020/21 as funding from Welsh Government was not to be released until April 2020 with management establishing governance arrangements for the scheme and appointing their key advisers. |
| Performance measure reporting to the Board – Accuracy of information | In agreeing the scope with Audit Committee Members, the Committee approved delay to 2020/21 (quarter 1) with the review focusing on RTT activity and reporting for March 2020 data – This review will form part of the 2020/21 audit programme. |
| Delivery of savings against identified schemes at Ysbyty Glan Clwyd | The review is progressing but delayed due to the impact of COVID-19 and still have testing to complete and further information is still required - Our work on the delivery of savings against identified schemes is currently in progress but we have not been able to conclude this audit at the date of issuing this opinion. We will issue our report and findings as part of the 2020/21 audit programme. |

| Review Title | Reason for deferment |
|-------------------|---|
| Roster Management | <p>The Audit Committee confirmed they require this review to be undertaken, however testing cannot be fulfilled by visiting wards due to the COVID-19 restrictions but rather on the return of timesheets from the agencies to Internal Audit for review.</p> <p>Requests for timesheets were sent by management on the 17th April 2020 and we have not yet received them all – Our work on roster management is currently in progress but we have not been able to conclude this audit at the date of issuing this opinion. We will issue our report and findings as part of the 2020/21 audit programme.</p> |

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2019/20 plan.

Dave Harries CMIIA QiCA

Pennaeth yr Archwiliad Mewnol/Head of Internal Audit

Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services

Partneriaeth Cydwasaethau GIG Cymru/NHS Wales Shared Services Partnership





April 2020

| ATTRIBUTE STANDARDS | |
|---|---|
| 1000 Purpose, authority and responsibility | Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis. |
| 1100 Independence and objectivity | Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair. |
| 1200 Proficiency and due professional care | Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified. |
| 1300 Quality assurance and improvement programme | Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018. |
| PERFORMANCE STANDARDS | |
| 2000 Managing the internal audit activity | The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk |

| | |
|--|--|
| | <p>based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee.</p> <p>Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.</p> |
| 2100 Nature of work | The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach. |
| 2200 Engagement planning | The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation. |
| 23000 Performing the engagement | The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue. |
| 2400 Communicating results | <p>Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee.</p> <p>An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's</p> |

| | |
|---|--|
| | framework of governance, risk management and control. |
| 2500 Monitoring progress | An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan. |
| 2600 Communicating the acceptance of risks | If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution. |

AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN

| Assurance domain | Audit Count | Overall rating | Not rated | No assurance | Limited assurance | Reasonable assurance | Substantial assurance |
|--|--------------------|---|------------------|---------------------|--------------------------|-----------------------------|------------------------------|
| Quality and Safety | 7 |  | | | ☺☺☺☺ | ☺☺ | ☺ |
| Corporate Governance, Risk and Regulatory Compliance | 5 |  | | | ☺ | ☺☺☺☺☺ | |
| Financial Governance and Management* | 8 |  | | | ☺ | ☺○○ | ○○○○ |
| Strategic Planning, Performance Management and Reporting | 1 |  | | | ☺ | | |
| Information Governance and Security | 2 |  | | | | ☺☺ | |
| Operational Service and Functional Management | 4 |  | ☺☺ | | | ☺☺ | |
| Workforce Management | 2 |  | | | ☺☺ | | |
| Capital and Estates Management | 8 |  | | | | ☺☺☺☺☺☺☺☺ ☺ | ☺ |

Key to symbols:






- ☺ Audit undertaken within the annual Internal Audit plan including those issued as draft.
- * This domain outcome also includes the six financial system audits undertaken through the audit of NWSSP as they include transactions processed on behalf of the Health Board (please see section 3 for details).

PERFORMANCE INDICATORS

| Indicator Reported to NWSSP Audit Committee | Status | Actual | Target | Red | Amber | Green |
|---|---------------|---------------|---------------|------------|--------------|--------------|
| Operational Audit Plan agreed for 2019/20 | G | March 2019 | By 30 June | Not agreed | Draft plan | Final plan |
| Total assignments reported against adjusted plan for 2019/20 | G | 94% | 100% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time from fieldwork completion to draft reporting [10 working days] | G | 100% | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time taken for management response to draft report [20 working days] | G | 73% | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time from management response to issue of final report [10 working days] | G | 100% | 80% | v>20% | 10%<v<20% | v<10% |

Key: v = percentage variance from target performance
 Please note the actual performance indicators for the three report turnaround measures are at 29th February 2020 due to the impact of COVID-19.

Audit Assurance Ratings

| RATING | INDICATOR | DEFINITION |
|--------------------------|---|---|
| Substantial assurance |  - Green + | The Board can take substantial assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure. |
| Reasonable assurance |  - Yellow + | The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved. |
| Limited assurance |  - Amber + | The Board can take limited assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved. |
| No assurance |  - Red + | The Board has no assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved. |
| Assurance not applicable |  - Blue + | Reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed. |

| Criteria | Substantial Assurance | Reasonable Assurance | Limited assurance | No assurance |
|--------------------------------|---------------------------|---------------------------------|----------------------------------|-----------------------------|
| Audit results consideration | | | | |
| Overall results | | | | |
| Assurance domains rated green | ≥5 green; and | | | |
| Assurance domains rated yellow | ≤3 yellow; and | ≥5 yellow; and | | |
| Assurance domains rated amber | No amber; and | ≤ 3 amber; and | ≥5 amber; and | |
| Assurance domains rated red | No red | No red | ≤3 red | ≥4 red |
| Audit scope consideration | | | | |
| Audit spread domain coverage | All domains must be rated | No more than 1 domain not rated | No more than 2 domains not rated | 3 or more domains not rated |

Note: The overall opinion (see section 2.4.2) is subject ultimately to professional judgement notwithstanding the criteria above.

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and Internal Auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, Internal Audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Betsi Cadwaladr University Local Health Board

Internal Audit Plan 2020/21 – Update for COVID-19 impact

February 2020

**NHS Wales Shared Services Partnership
Audit and Assurance Services**

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Appendix A Internal Audit Plan 2020/21

Appendix B Key Performance Indicators

1. Introduction

This document sets out the Internal Audit Plan for 2020/21 ('the Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

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

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

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

Accordingly this document sets out the risk based approach and the Plan for 2020/21. The Plan will be delivered in accordance with the Internal Audit Charter. All internal audit activity will be provided by Audit & Assurance Services, a division of NHS Wales Shared Services Partnership.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

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

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

and risks;

- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- quantification of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the 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;
- coverage of the audit domains;
- previous years' internal audit activities; and
- audit resources required to provide a balanced and comprehensive view.

Our planning also takes into account the NHS Wales Planning Framework 2020/23 and is also mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the 3 year plan and/or Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

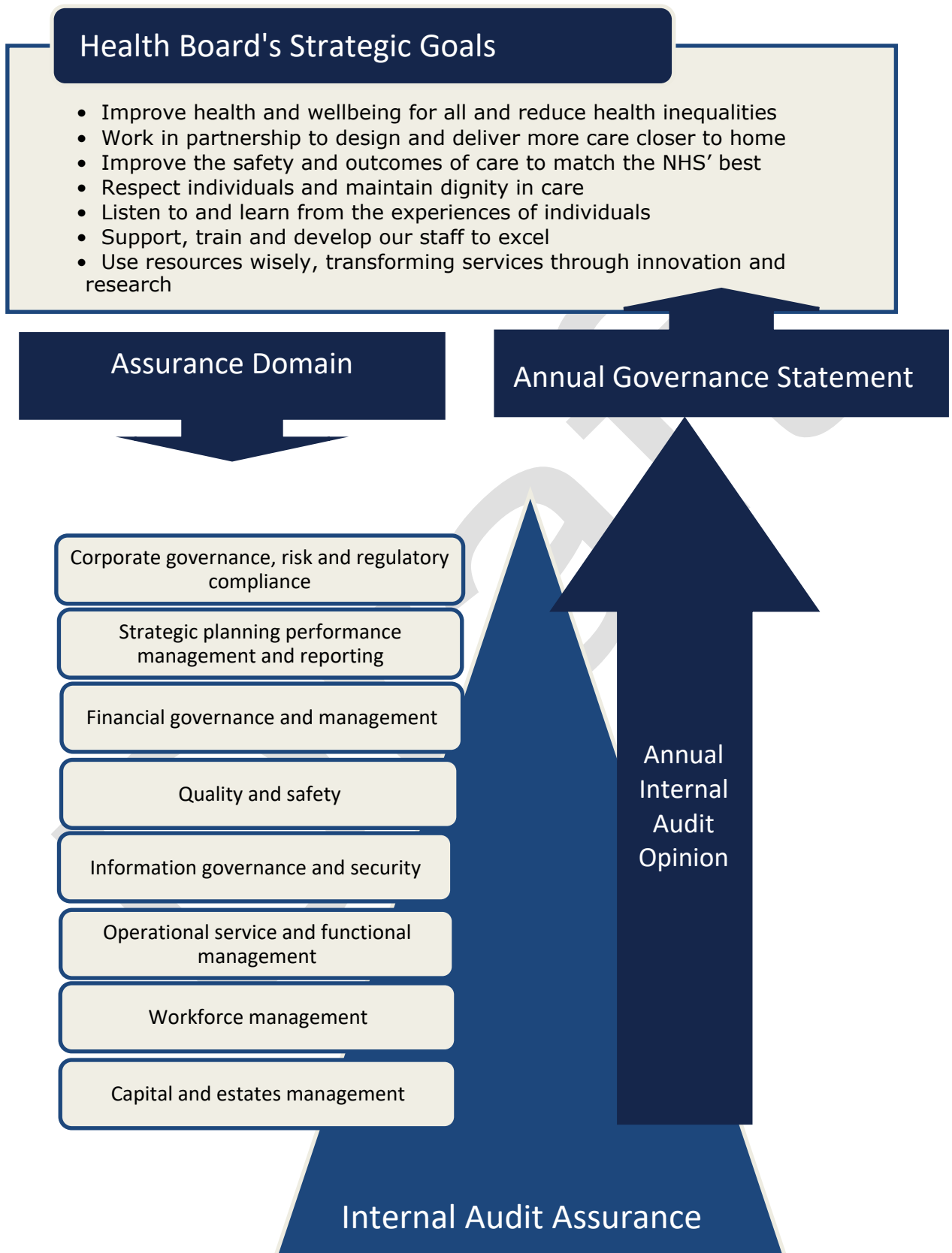
We will ensure that the Plan remains fit for purpose by reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control require annual review, and some work is mandated by Welsh Government, 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), categorised into eight assurance domains. The risk associated with each domain is assessed and this determines the appropriate frequency for review.

The eight audit domains are shown in figure 1 which also shows how the cumulative internal audit coverage of them contributes to the Annual Internal Audit Opinion which in turn feeds into the Annual Governance Statement and the achievement of the key objectives for the organisation.

The mapping of the Plan to the eight assurance domains is designed to give balance to the overall annual audit opinion which supports the Annual Governance Statement.

Figure 1 Internal Audit assurance on the domains



2.3 Link to the Health Board's systems of assurance

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

- a review of the Board's vision, values and forward priorities as outlined in the draft three year plan;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and 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;
- other assurance processes including planned audit coverage of systems and processes now provided through NHS Wales Shared Services Partnership (NWSSP) and, where appropriate, WHSSC, EASC and NWIS;
- work undertaken by other assurance bodies including the Health Board's Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV);
- work undertaken by other bodies including Wales Audit Office (WAO); Healthcare Inspection Wales (HIW); Health and Safety Executive (HSE); Public Services Ombudsman for Wales (PSOW); and
- coverage necessary to provide reasonable assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit, working in partnership with the Wales Audit Office Performance Audit Lead, sought to meet with a number of Health Board Executives and Independent Members to discuss current areas of risk and related assurance needs. We have contacted/met with the following key individuals during the planning process:

- Chair of the Audit Committee;
- Deputy Chief Executive/Director of Nursing & Midwifery;
- Director of Finance;
- Director of Planning and Performance;
- Director of Primary & Community Care;
- Director of Workforce & OD;
- Director of Public Health;
- Medical Director;
- Acting Director of Mental Health & LDS;

- Area Directors; and
- Recovery Director.

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

3. Audit risk assessment

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

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2020/21

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

Where appropriate the Plan makes cross reference to key strategic risks identified within the 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 WAO 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.

Audit coverage in terms of capital audit and estates assurance will be delivered locally through our Specialist Services Unit. Given the specialist nature of this work and the assurance link with the all-Wales capital programme we will need to refine with management the scope and coverage on specific schemes. The Plan will then be updated accordingly to integrate this tailored coverage.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above. We will review and update the risk assessment and rolling three year audit plan annually giving definition to the upcoming operational year and extending the strategic view outward.

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. Hence, the plan will be kept under review and may be subject to change to ensure it remains fit for purpose. In particular the Plan will need to be periodically reviewed to ensure alignment with the developing systems of assurance.

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

5. Resource needs assessment

The plan indicates an indicative resource requirement of 1,000 days to provide balanced assurance reports to the Chief Executive as Accountable Officer in accordance with the Public Sector Internal Audit Standards.

This assessment is based upon an estimate of the audit resource required to review the design and operation of controls in review areas for the purpose of sizing the overall resource needs for the Plan. Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

This total resource allocation covers the servicing of the local audit plan plus some of the earmarked estates assurance audit coverage. These numbers are consistent with previous years.

The top-slice funding passed to NWSSP together with the recharge of £12,592.16 agreed by management for capital audit assurance work is sufficient to meet these audit resource needs. The recharge sum for 2020/21 reflects a reduction of £20,002 compared to the originally agreed 2019/20 audit plan (and a reduction of £41,926 compared to 2018/19).

However, this further reduction is predicated upon agreement of integrated audit and assurance plans for the major capital developments at North Denbigh, Ablett Unit and Wrexham Maelor Hospital – Redevelopment/Backlog Requirements to be funded through business case submissions [see page 13 for details]. The above will need to be reviewed in future in the event that adequate audit provisions are not provided within respective integrated audit and assurance plans.

No resources are taken from this plan to support the national audits undertaken at NWSSP; NWIS; WHSSC and EASC.

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

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2020/21 and:

- Approve the Internal Audit Plan for 2020/21;
- Approve the Internal Audit Charter; and
- Note the associated internal audit resource requirements and key performance indicators.

Dave Harries CMIIA QiCA

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

Draft

Appendix A: Internal Audit Plan 2020/2021

| Planned output | CRR/ Mandatory | Outline Scope | Executive Lead | Outline timing |
|--|-------------------|--|--|---|
| Corporate governance, risk and regulatory compliance | | | | |
| Annual Governance Statement | Mandatory | To provide an Opinion on key aspects of Board governance to underpin the completion of the Statement. | Board Secretary | Q1 |
| Welsh Risk Pool Claims Management Standard | Mandatory | In accordance with the Welsh Risk Pool Standards, we will review a sample of completed files to ensure the required process has been complied with. In addition, we will report on themes/trends, by hospital/area, identified during the review. | Director of Nursing & Midwifery | Q4 |
| Risk Management | | We will review the implementation of the new Risk Management Strategy across the Health Board. | Deputy Chief Executive | Revised to Q4 |
| Health and Safety | CRR21 | We will review health and safety governance and accountability arrangements to ensure divisions/directorates are actively managing health and safety progress taken by the Health Board for the management and scrutiny of health and safety arrangements. This will include implementation of actions as a result of the recent comprehensive assessment. | Director of Workforce & Organisational Development | Revised to Q2 |
| Security | CRR20 | Working in partnership with the Associate Director of Health, Safety & Equality, we will identify key risk areas as well as reviewing compliance with the Welsh Government published Security Management Framework. | Director of Workforce & Organisational Development | Q2 |
| Violence and Aggression – Obligatory responses to violence in healthcare | CRR20 | We will review the Health Board's implementation of its responsibilities to the all Wales agreement which took effect on the 21 st November 2018. | Director of Workforce & Organisational Development | Revised Q3 |
| Engagement of interim appointments | | We will review the Health Board's compliance with Standing Financial Instructions and procurement arrangements. | Director of Finance | Q2 review by HIA but aiming late June start |
| Temporary Hospitals | | We will review the establishment, management and financial control surrounding the Temporary Hospitals. | Director of Finance | Q2 |
| Decision making during COVID-19 | | We will assess the adequacy and effectiveness of internal controls in operation during the Covid-19 outbreak, with particular regard to the Principles set out by the Welsh | Director of Finance | Q1-2 |

| Planned output | CRR/ Mandatory | Outline Scope | Executive Lead | Outline timing |
|--|-------------------|--|---|---|
| | | Government. The review will focus on the following Principles: <ul style="list-style-type: none"> • governance and risk management; • delegation and escalation; and • departures from existing policies and processes. | | |
| Mental Health & Learning Disabilities Division – Governance arrangements | Audit Committee | We will review the governance arrangements within the Division following previous internal audit reviews. | Acting Director of Mental Health & Learning Disabilities | Q2-3 |
| Strategic planning performance management and reporting | | | | |
| Performance measure reporting to the Board – Accuracy of information | Audit Committee | In discussion with the Audit Committee, we will validate the reporting of a sample of performance measure(s) back to source data to confirm the integrity, accuracy and controls in place. | Director of Planning and Performance | Q2 focus was accuracy of RTT data per Audit Committee |
| Improvement Groups | | We will review the governance and effectiveness of the Improvement Groups against established governing documentation coupled with reporting arrangements and assurance to the Board. We will also review the linkage of projects to the reporting of progress against key actions in the annual plan and the use of Post project business benefits reviews. | Director of Workforce & Organisational Development | Revised Q3 |
| Financial Governance and management | | | | |
| Delivery of savings against identified schemes | CRR06 | We will review areas that have consistently not delivered against their savings plans to understand why this is the case; what support they have received; and how they plan to remedy the non-delivery of savings. | Interim Director of Recovery/ Director of Workforce & OD | The 19/20 review was delayed due to receipt of evidence; to be issued as a 20/21 report |
| Budgetary Control & Financial Reporting | CRR06 | To review key financial controls and compliance in accordance with Finance policies/procedures. | Director of Finance | Q2-3 Focus on financial reporting |
| Travel & Expenses | CRR06 | Using Travel Bureau and E-Expenses data, we will review compliance with the Health Board's travel and subsistence related procedures; We will analyse the data using CAATTs (computer assisted audit tools and techniques). | Director of Finance | Defer to-2021/22- due to- home-working- and- forecast- |

| Planned output | CRR/ Mandatory | Outline Scope | Executive Lead | Outline timing |
|--|--------------------------|--|--|---|
| | | | | reduction in travel-related expenditure |
| Financial Governance Cell - Consultancy | Director of Finance | The Head of Internal Audit is supporting the Finance Directorate, in line with the consulting protocol, following agreement between the Director of Finance and Director of Audit & Assurance. | Director of Finance/ NWSSP Director of Audit & Assurance | Q1 onwards |
| Quality & safety | | | | |
| Annual Quality Statement | Mandatory | The Board must assure itself that the information published is both accurate and representative. To provide an opinion on the process that has been adopted and the evidence recorded supports data sources. | Director of Nursing & Midwifery | Revised to Q2 due to revised annual report timeline |
| HASCAS & Ockenden external reports – Recommendation progress and reporting | Special Measures & CRR13 | We will review the reporting of progress against the agreed management actions for those recommendations formally accepted by the Health Board. | Director of Nursing & Midwifery | Revised to Q2-4 |
| Clinical Audit | CRR05 | Following adoption of the Clinical Audit Policy, we will review the clinical audit process, with particular focus on the management of recommendations and follow-up. | Medical Director | Revised to Q4 or defer to 2020/21 |
| Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices | CRR05 | We will review the process operated in the Health Board for the receipt of a sample of notices; circulation; and receipt of assurance that they have been actioned, where applicable. | Deputy Chief Executive | Revised to Q2 |
| Follow up of previous Healthcare Inspectorate Wales reports | | We will conduct follow-up reviews throughout the year to provide the Audit and Quality, Safety and Experience Committees with assurance regarding management's implementation of agreed actions. | Board Secretary/ Deputy Chief Executive | Q1-4 |
| Information Governance and Security | | | | |
| IM&T Control and risk assessment | CRR10A & CRR10C | To review and assess the control environment for the management of IM&T within the organisation. | Medical Director | Q2 |
| Information Governance Toolkit | | Following submission of the IG toolkit self-assessment, we will review the evidence underpinning the submission. | Deputy Chief Executive | Revised to Q2 |
| Disaster Recovery/Business Continuity Plan | CRR10C | We will review the Informatics Department recovery/continuity plan | Medical Director | Q2-3 |

| Planned output | CRR/ Mandatory | Outline Scope | Executive Lead | Outline timing |
|--|-------------------|---|--------------------------------------|--|
| | | and seek evidence of regular testing and learning from each test. | | |
| Digital Strategy | CRR10C | We will review progress against the timelines set out in the plan to understand if the Health Board is achieving its expected goals. | Medical Director | Revised to Q3 |
| Operational service and functional management | | | | |
| Health and Social Care Localities governance and accountability | CRR09 | We will review a sample of Localities governance and accountability arrangements and assess in accordance with Welsh Government issued <i>Primary Care Cluster Governance – A Good Practice Guide</i> . | Director of Primary & Community Care | Q2-3 |
| Community Mental Health Team partnership arrangements – Denbighshire | CRR13 | We will review the partnership governance arrangements in place to deliver this service in Denbighshire. | Director of Mental Health & LDS | Revised to Q2-3 will require partnership work with Council IA but impact of C-19 on service not known. |
| Community Mental Health Team partnership arrangements – Ynys Môn | CRR13 | We will review the partnership governance arrangements in place to deliver this service in Ynys Môn. | Director of Mental Health & LDS | Revised to Q2-3 will require partnership work with Council IA but impact of C-19 on service not known. |
| Programme Management Office (PMO) | CRR06 | We will review the process adopted by the PMO to ensure due diligence of scheme project initiation documents (PIDs). | Director of Workforce & OD | Revised to Q2 |
| Workforce management | | | | |
| Roster Management | | We will review a sample of nurse agency payments and verify supporting evidence to corroborate that the shift was undertaken, ensuring the Health Board does not pay for agency services it had not received due to a lack of internal control at ward level. | Director of Workforce & OD | Carry over review issued as draft in May 20/21 however ward based testing now required as gap in evidence from agencies contacted. |

| Planned output | CRR/ Mandatory | Outline Scope | Executive Lead | Outline timing |
|---|-------------------|--|---|--|
| Recruitment – Employment of staff including interim posts and locum doctors | CRR15 | In accordance with standard operating procedure MD01 <i>Medical Agency Locum Appointments</i> and other operating procedures, we will review the process in place for ensuring pre-employment checks are undertaken of seeking references from the most recent employer. | Director of Workforce & OD | Revised to Q2 |
| Sickness management – Recording reason for the sickness episode | | For a sample of sickness reasons recorded as S99 – Unknown Causes/Not Specified, we will review to source documentation and discuss with local managers why the reason has not been updated. | Director of Workforce & OD | Q3 |
| Establishment control – Leaver management | | We will review the submission of employee leaver forms for timeliness. | Director of Workforce & OD | Revised to Q2-3 |
| On-Call arrangements | | We will review the on-call arrangements in operation across the Health Board. | Deputy Chief Executive/ Director of Workforce & OD | Q2 |
| Capital and Estates | | | | |
| Environmental sustainability report | Mandatory | To provide an opinion that the Health Board has robust systems in place to record and report minimum sustainability requirements as required by Welsh Government. | Director of Planning & Performance | Brief agreed Q2 to meet Annual Report timeline |
| Control of Contractors | CRR21 | The Health & Safety Executive (HSE) has produced a range of guidance on the safe management of contractors, including “Managing Contractors” (HSG 159) and the “Using Contractors – a Brief Guide”. We will assess compliance with the requirements of this guidance. | Director of Planning & Performance | Q2 |
| Statutory Compliance: Water Safety | CRR12 | To determine the adequacy of, and operational compliance with, the systems and procedures of the Health Board, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate. | Director of Planning & Performance | Q2 |
| Follow Up (capital and Estates) | | To ensure appropriate management action/ closure is demonstrated for agreed audit recommendations incorporated on the TeamCentral Tracker system. | Director of Planning & Performance | Q1-4 |
| Capital Systems | CRR12 | The audit coverage reviews a key stage within the Procedure Manual for Managing Capital Projects – Stage 2: Design. | Director of Planning & Performance | Revised to Q2 |

| Planned output | CRR/ Mandatory | Outline Scope | Executive Lead | Outline timing |
|--|-------------------|--|------------------------------------|--|
| <p>Integrated Audit and Assurance Plans:</p> <ul style="list-style-type: none"> • North Denbighshire • Ablett Unit • Wrexham Maelor Hospital - Backlog maintenance requirements | CRR12 | <p>NHS Wales Infrastructure Investment Guidance (updated guidance issued by Welsh Government in October 2018) requires an Integrated Assurance and Approval Plan (IAAP), which sets out assurance and approval points for each stage of the Business Case process. Accordingly, the organisation is required to outline the various formalised assurance mechanisms proposed (e.g. internal audit, Gateway reviews, functional reviews etc.) and the timing of each. The Integrated Audit Plans proposed include a combination of programme-level, functional and consultancy assurance that, when combined, provide a balanced programme for the client to achieve the desired level of assurance required by Welsh Government. These plans have been agreed by the Director of Planning & Performance subject to Audit Committee approval.</p> | Director of Planning & Performance | Q1-4 but dependent on WG approving each stage for IA review. |
| Compliance with the Public Sector Internal Audit Standards | | | | |
| Contingency | | <p>This element of the plan allows the flexibility to respond to management requests in order to meet specific Health Board needs throughout the course of the financial year.</p> <p>The Head of Internal audit, working with the Deputy Chief Executive, will provide support and scrutiny in the implementation of the revised governance structure.</p> | Board Secretary | Q1-4 |
| Audit Management and Reporting | | <p>An allocation of time is required for management:-</p> <ul style="list-style-type: none"> • Planning liaison and management – Incorporating preparation and attendance at Audit Committee; completion of risk assessment and planning; liaison with WAO; HIW; PSOW; HSE and organisation of the audit reviews; and • Reporting and meetings – Key reports will be provided to support this, including preparation of the annual plan and progress reports to the Audit Committee. | Board Secretary | Q1-4 |

| Planned output | CRR/ Mandatory | Outline Scope | Executive Lead | Outline timing |
|-------------------------------------|---------------------------|--|---------------------------|---------------------------|
| Follow up of previous audit reports | | We will conduct follow-up reviews throughout the year to provide the Audit Committee with assurance regarding management's implementation of agreed actions – reviews that received limited or no assurance. | Board Secretary | Q1-4 |

Draft

Appendix B: Key performance indicators (KPI)

The KPIs reported monthly for Internal Audit are:

| KPI | SLA required | Target 2020/21 |
|---|---------------------|-----------------------|
| Audit plan 2020/21 agreed/in draft by 30 April | R | 100% |
| Audit opinion 2019/20 delivered by 31 May | R | 100% |
| Audits reported vs. total planned audits | 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 days minimum] | R | 80% |
| Report turnaround draft response to final reporting [10 days] | R | 80% |

Betsi Cadwaladr University Health Board

Deprivation of Liberty Safeguards (DoLS)

Final Internal Audit Report

March 2020

BCU-1920-20

NHS Wales Shared Services Partnership



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| Review reference: | BCU-1920-20 |
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| Auditor/s: | Audit Manager (Capital) Head of Internal Audit |
| Executive sign off: | Executive Director of Nursing & Midwifery |
| Distribution: | Associate Director of Safeguarding Safeguarding Specialist Practitioner/DoLS Manager Acting Board Secretary Statutory Compliance, Governance and Policy Manager |
| Committee: | Audit Committee |



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

ACKNOWLEDGEMENT

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

Disclaimer notice - Please note:

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

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

1. Introduction and Background

In accordance with the 2019/20 Internal Audit Plan a review of the Deprivation of Liberty Safeguards (DoLS) process has been undertaken.

The Mental Capacity Act Deprivation of Liberty Safeguards provides protection for vulnerable people in NHS hospitals (includes registered independent hospitals and hospices) who lack capacity to agree to be accommodated for their care or treatment.

A DoLS Code of Practice, issued by the Lord Chancellor in 2008, outlines key requirements. Since 2014 the number of DoLS applications has increased significantly due to a the Supreme Court creating a new case law test (the 'acid test') which has resulted in a higher number of patients being subject to a deprivation of liberty in a registered hospital.

The governance of DoLS within the Health Board has been the subject of recommendations made as part of two reviews undertaken in response to the investigation of the Tawel Fan Ward.

"Both the HASCAS and Donna Ockenden reviews identified the DoLS work plan as a high-risk area, which required a full review. This remains a high priority in the Corporate Safeguarding work plan for 2019-20 as the demand, complexity and challenging nature of this specialist area requires a sound infrastructure to meet the needs of the client group and organisation. Consultation on the revised DoLS Structure is due to commence in June 2019" (Source: BCUHB Corporate Safeguarding Team-Safeguarding and Protection of People at Risk of Harm Annual Report 2018-19).

The law has changed with an amended Mental Capacity Act (MCA) 2019 which received Royal Assent in May 2019. The MC(amendment) Act 2019 also puts in place new legislation, the publication of a new statutory Code of Practice and statutory Regulations under Liberty Protection Safeguards (LPS) which will replace DoLS legislation and procedures from an expected date of 1st October 2020. While DoLS is to be replaced by LPS, there will be a period of transition for those individuals who are granted a DoLS and the expiry date will occur after the implementation date. This means until the expiry date existing DoLS authorizations will continue until their expiry date. Any new authorisations for LPS will be under that legal regime. Any policy and procedures will therefore need to be updated prior to the implementation of LPS. Existing DoLS policy and procedures need to be updated to reflect its continuation for individuals subject to DoLS after the implementation date prior to its expiry and also other related policies and procedures which take account of DoLS or MCA 2005.

DoLS has two key frameworks, the Supervisory Body, which is the Corporate Safeguarding Team and the Managing Authority, which is the responsibility of the ward manager who is responsible for the care of patients.

A number of report have been produced and shared at key forums evidencing activity and demands and strategic activities, QSG, QSE, Mental Health Act

Committee, HASCAS Improvement Group and the Safeguarding Governance and Performance Group.

2. Scope and Objectives

The overall objective of this audit was to review the process for DoLS applications to ensure that these are managed in accordance with the Deprivation of Liberty Safeguards Code of Practice, Welsh Government guidance and Health Board procedures. Additionally noting the recommendations of the HASCAS and Ockenden reports we reviewed progress where this directly relates to those areas that are the subject of our testing.

The review has evaluated arrangements in place to ensure that:

- There are clear policies, procedures and responsibilities for the process of the management of DoLS;
- DoLS applications are logged and actioned in a timely manner;
- Information maintained to monitor DoLS is up to date, accurate and complete;
- Documentation is completed fully by appropriate people;
- Issues identified are being actively managed as reported within the Quality & Safety Dashboard.

3. Associated Risks

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


- Policies, procedures and responsibilities relating to DoLS are not clear;
- DoLS applications are not logged and actioned promptly;
- Information used for monitoring DoLS applications is not up to date, accurate and complete;
- Documentation is not completed by appropriate persons; or
- Issues identified with the process are not being actively managed.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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





The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Deprivation of Liberty Safeguards (DoLS) process is **Limited** Assurance.

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

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

5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|-------------------|---|---|--|---|---|
| 1 | Policies, Procedures and Responsibilities | | | ✓ | |
| 2 | DoLS Applications and completeness of documentation | | ✓ | | |
| 3 | DoLS Monitoring | | | ✓ | |
| 4 | Issues and actions identified | | | ✓ | |

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Deprivation of Liberty Safeguards.

Operation of System/Controls

The findings from the review have highlighted 5 issues that are classified as weakness in the operation of the designed system/control for Deprivation of Liberty Safeguards.

Please note: We have not reviewed records held on wards focusing instead on the process followed once a DoLS application has been submitted; similarly the review has sought to test new applications and we have not reviewed submissions for extensions to existing DoLS.

Policies, Procedures and Responsibilities

There is a DoLS Code of Practice, published by the Ministry of Justice, which details the DoLS process that must be followed. This code supplements the Mental Capacity Act 2005 Code of Practice. The statutory responsibilities of Managing Authorities [MA] and Supervisory Bodies [SB] is detailed within the Code, and there is also separate guidance for each.

Wards within the Health Board acute and Community Hospitals along with Mental Health acute facilities are Managing Authorities. The DoLS Team co-ordinate and manage the DoLS assessments, undertaking the statutory function of Supervisory Body for the Health Board, processing the DoLS applications (receipt, arrangement of assessors and authorisation).

We were sighted on a locally produced policy document (SCH018) that was produced in 2014, however we understand that this is not published online for staff to refer to [as it contains a range of appendices which are no longer applicable]. The Welsh Government (WG) revised all the forms in 2015 and whilst the Health Board have since put in place revised forms, the policy document has not been revised to reflect this.

The Safeguarding Specialist Practitioner/DoLS Manager advised us that this is currently under review, with a revised version to be submitted to the Safeguarding Governance and Performance Group for approval, but with changes under Liberty Protection Safeguards (LPS) due in 2020, this had been placed on hold and is to be developed from a LPS perspective.

There is a flow chart showing the DoLS process and standard forms; however as noted earlier there is no current local Health Board policy or operational procedure detailing the process and responsibilities for staff.

Information relating to DoLS is available to staff via the intranet and included and reiterated during both the DoLS and Safeguarding mandatory Training. Within the Safeguarding Web page there is a specific section for Mental Capacity Act (MCA)/DoLS. This provides members of staff with:

- ❖ A flowchart showing the process.
- ❖ MCA code of practice and guidance for MA & SBs.
- ❖ Relevant forms.
- ❖ Contact information.
- ❖ Training information.
- ❖ Care plan templates.
- ❖ Reports.
- ❖ Guidance for families.

DoLS applications and completeness of documentation

The joint Care Inspectorate Wales (CSSIW) and Healthcare Inspectorate Wales (HIW) Deprivation of Liberty Safeguards Annual Monitoring Report for 2017-18 noted that there was a continuing annual increase in DoLS applications across Wales [up by 8% from 2016/17] and that resource required to manage the DoLS

process often exceeds the resource available. It reported that the average number of applications for Health Boards in Wales was 201 per 100,000 population. The Health Board fell below this with 153 applications per 100,000.

However, the Deprivation of Liberty Safeguards Update report as presented to the Mental Health Act Committee meeting of the 27th September 2019 records that for Quarter 1 of 2019/20 *"there has been a significantly high level of applications from all areas across the Health Board. In the West a 77% increase; the East 53% increase and Central remains the same trend"*.

The logging and processing of DoLS applications is undertaken by the DoLS Team based at Preswylfa. The database is managed by two staff.

We have reviewed a sample of records to determine where/if any delays may be occurring within the current process for DoLS applications and if this is captured for review by management. We confirmed that the date an application is received by email is recorded.

For each DoLS application, two assessors need to be commissioned and appointed:

- Section 12(2) assessor (mental health and eligibility criteria).
- Best Interest Assessors (best interests, mental capacity, No refusals and age assessments).

The Section 12(2) assessors are doctors, who get paid a fee for each assessment, (the exception being those who work within a Health Board Mental Health setting) Accountability for this function sits within the Office of the Medical Director however, the DoLS Team manager provides guidance and support and the administration team manages the process and data collection. The Best Interest Assessors (BIA) are nurses or social workers, employed by the Health Board in the BIA role with specific approved qualifications/training appropriate to the post. The Health Board does however on occasions utilise an external BIA Assessor where work load dictates.

We reviewed a sample of ten DoLS applications for each of the three respective acute sites (Managing Authority). The sample was selected from submissions made between April and the end of June 2019 (Qtr1). Whilst we were able to identify and choose a sample of ten DoLS applications for the East (Wrexham Maelor), we were only able to choose seven submitted from the West Area (Ysbyty Gwynedd) with only five to choose from Central Area (Ysbyty Glan Clwyd).

To assist with our testing we were provided with access to the database maintained by the DoLS Team and the folders in which all copies of forms and correspondence were held. The testing focused solely on the completeness of information submitted and the process followed once a DoLS application had been submitted to the Supervisory Body.

Completeness of documentation

- 9/22 of the DoLS applications submitted did not appear to have been accompanied by a copy of the MCA

- Only 1/22 DoLS applications submitted appeared to have included a copy of the care plan. Form 1 (P2) specifies that "A *RELEVANT CARE PLAN SHOULD BE ATTACHED*".

These findings echo those reported by the Safeguarding Specialist Practitioner/DoLS Manager in the September 2019 (Qtr1) Deprivation of Liberty Safeguards (DoLS) update report where issues with individual applications varied between 35-50% depending on the area submitting them. It is noted that the DoLS Team are challenging the respective services when these occur, however the issue remains relevant and in need of further mitigation.

Process for submission of applications

The document 'Guidance for Managing Authorities working within the Mental Capacity Act Deprivation of Liberty Safeguards' notes the following:

"Wherever there is the possibility that a relevant person may need to be detained the managing authority should plan ahead. If the detention is likely to be unavoidable, then, if possible, the managing authority should make a request for a standard authorisation in advance so that the standard authorisation is in place at the beginning of the detention. If this is not possible and the relevant person needs to be detained as a matter of urgency then the managing authority can give itself an urgent authorisation for up to 7 days which will enable it to lawfully detain the person while the standard authorisation is pending".

The DoLS applications that made up our sample were exclusively classified as Urgent, it is understood that the majority of DoLS applications within BCUBH take this form.

The first element of the process we analysed was the appointment of Best Interest Assessors, to determine the timescale between the application being received and the booking of a BIA assessment and following this the time period before the findings of the assessment have been formally recorded (please see Table 1).

The second part of the process we reviewed surrounds the request for a Section 12 (S12) assessment to be completed. Again we sought to identify the timescale between the application being received, the booking of the S12 assessment and following this the time period before the findings of the assessment have been formally recorded (please see Table 2).

The third part of the process we focused on is where following a review of completed assessments and where authorisation is granted, "Form 5" should be fully completed and signed by the Supervisory Body (to confirm that assessments have been considered as part of the review process), then sent to the Managing Authority. We reviewed the timescale between completed assessments and authorisation by the Supervisory Board signatory. It should be noted that the sample had been reduced by half at this stage due to a number of factors, including applications being withdrawn or being declined following assessment by the BIAs (please see Table 3).

Table 1: Best Interest assessments

| Days | <8 | 8-14 | 15-21 | 22-28 | >28 |
|---|----|------|-------|-------|-----|
| Timescale between DoLS application and booking of assessor Average = 16 days | 4 | 8 | 4 | 1 | 3 |
| Timescale between booking of assessor and completed assessment Average = 8 days | 13 | 2 | 3 | 0 | 0 |

Table 2: Section 12 assessments

| Days | <8 | 8-14 | 15-21 | 22-28 | >28 |
|---|----|------|-------|-------|-----|
| Timescale between DoLS application and booking of assessor Average = 10 days | 12 | 4 | 1 | 1 | 1 |
| Timescale between booking of assessor and completed assessment Average = 6 days | 13 | 4 | 1 | | |

Table 3: Authorisation of application

| Days | <8 | 8-14 | 15-21 | 22-28 | >28 |
|---|----|------|-------|-------|-----|
| Timescale between completed assessments and authorisation by SB (10 applications tested as above) Average = 11 days | 2 | 6 | 2 | 0 | 0 |

In the final table (Table 4) we sought to identify the overall timescale between a DoLS application being submitted and authorisation being granted. The sample was reduced for this element by virtue of the fact that half of the sample as selected did not reach this stage for a number of reasons, alluded to earlier.

Table 4: Overall period of time elapsed between applications being initially received and authorisation being granted.

| Days | <8 | 8-14 | 15-21 | 22-28 | >28 |
|--|----|------|-------|-------|-----|
| Timescale between application being made and authorisation by SB (10 applications tested as above) | 1 | 0 | 0 | 4 | 5 |
| Average = 29 days | | | | | |

Analysis of delays & risks

The findings as detailed in tables 1 to 4 above highlight delays in all elements of the process that combined mean that the average Urgent DoLS application [as per our sample] took twenty nine (29) days to be authorised which is in breach of the Code of Practice.

Our testing revealed a variety of compounding factors that contribute to this.

Firstly, DoLS application documents are not being completed correctly which means that the DoLS Team have to go back to the originating Ward/Department to request that the forms, as submitted, be completed fully/signed. 30% of our initial sample were found to have been initially submitted in an incomplete manner. This will be detailed further under completeness of documentation.

The figures show a high average number of days between the booking of the Best Interest Assessments and the eventual completion and reporting of the assessment. The figures above also show the majority of applications being authorised over seven days following receipt of the last assessment. This adds to the delay already experienced in booking and receiving assessments.

The DoLS update report provided to the Mental Health Act Committee Meeting of the 29th March 2019 noted under 3.4 (P4) that *"In order to continue to meet capacity demands the DoLS team will retain the services of a Sessional BIA to undertake assessments until the full integration of qualified BIA staff is complete"*.

We understand that although an establishment figure of six BIAs was identified with two in each of the three areas across North Wales, the West area still relies on one BIA. We were advised that the lack of recruitment to this post is attributed to budgetary constraints, although we have not corroborated this assertion. However noting this, we requested the cost of paid additional sessions utilising bank and External Assessors for January to October 2019 and the figure came to £10,880. We understand that the bank assessors are largely Health Board BIA team members who are paid a sessional fee of £360 per assessment, but that they are limited on how many they are allowed to undertake in any given month.

With the delays identified in getting the BIA assessments, there is a risk to the Health Board that they could be exposed to financial penalties from non-compliance with the requirements of DoLS legislation and that these costs could significantly exceed the costs currently being saved by having a reduced establishment of BIAs. We acknowledge however that the impending introduction of LPS should be factored in and future workforce requirements take account of potential changes in working practices.

The majority of S12(2) assessments were undertaken in less than six days from

the point of being booked to the assessment being conducted and reported back to the DoLS Team, however for an urgent seven day DoLS application this still leaves little time to complete the process and comply with the requirements of the Act. In addition the average time taken from a DoLS application being submitted and a Doctor being contacted to undertake the S12(2) assessment was found to be 10 days. It is not immediately clear why this is the case, but when this is factored in with the average six day lead time, before an assessment can be undertaken, the delays are added to.

The DoLS Team have made great strides in increasing the number of authorised signatories over the course of the past twelve months with the Health Board having a total number of forty four signatories at the time of this review, with a further thirty two nominated as signatories by their line managers but still to complete training.

We noted that the DoLS Manager reported in the DoLS update report to the Mental Health Act Committee meeting of the 27th September 2019 under s4.1 (P6) that, *"A concern remains regarding a delayed response to requests to complete the task of agreeing a standard authorisation with some signatories not responding to emails"*.

We sought to quantify the level of engagement by the signatories and requested a list of all the applications authorised since April 2019 and noted the following:

- 137 DoLS applications were authorised between April and October 2019.
- 19 different signatories were found to have authorised these 137 applications, these 19 represent 43% of the total signatories who could have potentially provided authorisation.
- However, we further identified that of the 137 of the DoLS applications authorised since April 2019, 108 (79%) were signed/authorised by 7 individuals. The remaining 12 individuals authorised an average of 2.4 each.

DoLS Monitoring & Reporting

The coversheet that accompanies the quarterly Deprivation of Liberty Safeguards (DoLS) update report notes that *"DoLS activity and issue of risks and mitigating factors are addressed within the Safeguarding Governance Framework which includes the Safeguarding Governance and Performance Group, Area/Secondary Care Safeguarding Forums: MH/LD Safeguarding Forum: Consent, Capacity Strategic Working Group; Safeguarding Performance and Governance Group; Quality, Safety and Experience (QSE) and Quality Safety Group(QSG) .*

It adds that the *"Mental Health Act Committee Report on DoLS is shared with these groups"*. It is this report that we have focused on when reviewing DoLS Monitoring and Reporting. In conjunction with this, we also reviewed update reports provided to the Quality, Safety and Experience Committee in relation to HASCAS/Ockenden recommendations, where these pertained to areas covered by this review and were presented by the Associate Director of Safeguarding.

The quarterly report produced by the Safeguarding Specialist Practitioner/DoLS Manager is comprehensive with details both on DoLS applications received but

also on challenges to Health Board in meeting its obligations.

The Health Board reports data for DoLS applications to the Care Inspectorate Wales (CIW) on an annual basis. We have had sight of the correspondence demonstrating that the return was made in line with the expected due date.

Issues and actions taken

As noted earlier a comprehensive quarterly report is produced by the Safeguarding Specialist Practitioner/DoLS Manager and is presented at the Mental Health Act Committee (MHAC).

We also had sight of an update report which is produced quarterly and presented at the four individual Safeguarding Forums, these being: East, Central, West and Mental Health & Learning Disabilities. We note minutes of these meetings along with that of the MHAC demonstrate discussions arising from the content of the reports presented which reflect the performance and challenges being faced by the DoLS Team.

Whilst conducting the review we also observed that the Health Board Corporate Safeguarding Team produce a quarterly report which is presented at the Quality Safety Group and to the Quality, Safety and Experience Committee (QSE) on a bi-annual basis. This report includes a section dedicated to DoLS and includes details of the number of applications, along with details of cases referred to Court of Protection; further details are provided about work undertaken by the DoLS Team in their capacity representing the Supervisory Body. The significant increase in Court of Protection activity both referencing complexity and demand place a greater demand upon the Supervisory Body. The requirement for legal advice and attendance also places a cost pressure to the service.

The latest copy of this report as presented to the QSE meeting held on the 19th November 2019 also includes a section detailing the monitoring undertaken by the HASCAS Improvement Group. In particular we note the progress against HASCAS12/Ockenden 9, which relates to DoLS are detailed, this includes narrative showing that the implementation date for the recommended actions has been moved back from 2018/19 to March 2020.

We noted that an overarching Safeguarding risk (CRR16) is included in the Corporate Risk Register and that this does detail a list of actions which include a number in relation to DoLS; this includes narrative which records that "A review of the DoLS Structure and service provision is a priority activity for 2019-20 and a key requirement from HASCAS. An options paper which sets out options for the DoLS team will be presented to QSG in December 2019". This references risk no 2548 which is included at tier 2 – Directorate risk within the Executive Director of Nursing and Midwifery portfolio.

We were able to review the tier 2 risk in relation to DoLS as included in Datix and note risk 2548 which is specific to DoLS and in addition risk 2780 which has been raised in relation to the impending introduction of LPS and the transition from DoLS and the risks surrounding this.

Whilst acknowledging that these risks have been identified and included in the associated risk registers, it is apparent that there is no mention of the ongoing

compliance risk concerning the submission and processing of DoLS applications within the required timeframe. In addition, it is our understanding that where breaches are occurring these are not being recorded in Datix or subject to reporting.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

| Priority | H | M | L | Total |
|----------------------------------|----------|----------|----------|--------------|
| Number of recommendations | 3 | 2 | - | 5 |

| Finding 1 - Lack of local Policy in respect of DoLS (Operating effectiveness) | Risk |
|--|---|
| <p>There is no published up-to date operational procedure clarifying expectations of departments/wards in their capacity as Managing Authorities. Staff would also benefit from further guidance on timescales / escalation and reporting breaches to ensure ward staff are taking appropriate action.</p> | <p>Staff may be unclear on their responsibilities.</p> |
| Recommendation | Priority level |
| <p>Supervisory Body. An up to date procedure should be produced and consideration given to short guidance for staff on wards that identifies action they should be taking and clarifies timescales. Staff should then be made aware of new policies / guidance and all published on intranet.</p> | <p>Medium</p> |
| Management Response | Responsible Officer/ Deadline |
| <p>The DoLS Manager will lead and be supported to produce a Standard Operating Procedure (SOP) which will provide additional guidance for staff across the Health Board. Actions, timescales and a rationale for responding to an actual or potential deprivation of a patient.</p> <p>Ratification will take place through the Safeguarding Governance and Reporting Framework; which is the, Safeguarding Performance and Governance Group; Quality, Safety and Experience (QSE) and Quality Safety Group (QSG).</p> | <p>DoLS Team Manager 30th April 2020.</p> <p>Associate Director of safeguarding Full ratification 31st May 2020</p> |

| Finding 2- Shortage of Best Interest Assessors (BIAs) (Operating effectiveness) | Risk |
|--|---|
| <p>The lack of BIAs is impacting upon the timescales for DoLS applications. We understand that although an establishment figure of six BIAs was identified with two in each of the three areas across North Wales, the West area still relies on one BIA. With the delays identified from our testing in relation to getting the BIA assessments completed there is a risk to the Health Board that they could be exposed to financial penalties from non-compliance with the requirements of DoLS legislation and that these costs could significantly exceed the costs currently being saved by having a reduced establishment. We do acknowledge however that the impending introduction of LPS should be factored in and future workforce requirements take account of potential changes in working practices.</p> | <p>Health Board could face financial penalties due to DoLS assessments breaching timescales</p> |
| Recommendation | Priority level |
| <p>Supervisory Body. The funded establishment of BIA is reviewed as a matter of urgency to address the current delay in undertaking DoLS assessments and the pending introduction of the Liberty Protection Safeguards (LPS). The risk of financial penalties arising due to the delays in undertaking DoLS assessments be included, with action planned, in the corporate risk register.</p> | <p>High</p> |
| Management Response | Responsible Officer/ Deadline |
| <p>In the immediate, the DoLS Manager will complete an Establishment Control Form to process the vacant post to be advertised. The post is currently on hold due to the Health Board’s budget pressures, however as a result of the recent papers to QSG additional consideration must be given, as all current and new</p> | <p>DoLS Manager 31ST March 2020.</p> |

| | |
|---|--|
| <p>post holders will require new LPS training which has yet to be developed by the universities.</p> <p>The pending development of LPS being implemented in England and Wales has delayed some progress relating to the development of procedures and additional guidance due to the uncertainty and the delay of the publication of guidance. However after receiving training and information in February the DoLS Manager with support has produced a further report to the Quality Safety Group (QSG) to highlight the current demands and organisational risks with current DoLS service provision and the potential impact of LPS cross the Health Board and impact of LPS for the whole workforce and organisation.</p> <p>A further business case highlighting the financial requirements to support the service delivery will be developed as a result of the report and presented to the Finance and Performance Group.</p> | <p>Associate Director, Corporate Safeguarding. 13th March 2020.</p> <p>Associate Director of Safeguarding 31st May 2020</p> |
|---|--|

| <p>Finding 3 Completion of DoLS paperwork (Operating effectiveness)</p> | <p>Risk</p> |
|--|---|
| <p>We were provided with access to the database maintained by the DoLS Team and the folders in which all copies of forms and correspondence were held. From our testing we noted the following:</p> <ul style="list-style-type: none"> 9/22 of the DoLS applications submitted did not appear to have been accompanied by a copy of the Mental Capacity Assessment. | <p>Issues with completion of DoLS application by wards leading to delays in the DoLS process.</p> |

| | |
|--|--|
| <ul style="list-style-type: none"> Only 1/22 DoLS applications submitted appeared to have included a copy of the care plan. Form 1 (P2) specifies that "A <i>RELEVANT CARE PLAN SHOULD BE ATTACHED</i>". <p>These findings echo those reported by the Safeguarding Specialist Practitioner/DoLS Manager in the September 2019 (Qtr1) Deprivation of Liberty Safeguards (DoLS) update report where issues with individual applications varied between 35-50% depending on the area submitting them. It is noted that the DoLS Team are challenging the respective services when these occur, however the issue remains relevant and in need of further mitigation.</p> | |
| <p>Recommendation</p> | <p>Priority level</p> |
| <p>Managing Authority. All wards are reminded of the need to complete DoLS paperwork in an accurate and comprehensive manner in keeping with the stipulated requirements.</p> | <p style="text-align: center;">High</p> |
| <p>Management Response</p> | <p>Responsible Officer/ Deadline</p> |
| <p>A Safeguarding Bulletin specifically assigned to DoLS will be produced and disseminated. The Safeguarding Ambassadors will also ensure the bulletin is disseminated within their areas and teams.</p> <p>The Managing Authority will develop an audit and assurance process to ensure all DoLS applications are completed accurately and correctly.</p> | <p>DoLS Manager 30th April 2020. Safeguarding Business Unit/ Safeguarding Team Managers May 2020 Directors of Nursing 31st May 2020</p> |

| | |
|--|---|
| <p>The development of a SOP for DoLS should further strengthen the process and to support staff and enhance their awareness of their responsibilities and the actions to be taken to safeguard patients when a deprivation is occurring. (Finding 1)</p> <p>The SOP will be agreed through the existing Safeguarding Governance Framework. The dissemination will include all relevant communication processes used by the Corporate Safeguarding Team. This action directly links to Finding 1 management response above.</p> | <p>DoLS Manager 30th April 2020</p> <p>Associate Director of Safeguarding 30th April 2020</p> |
|--|---|

| | |
|--|---|
| <p>Finding 4 Lack of engagement from DoLS signatories (Operating effectiveness)</p> | <p>Risk</p> |
| <p>Whilst there has been significant progress on the part of the DoLS Team in increasing the number of signatories and providing training to these, we noted issues in respect of engagement on the part of those nominated who are yet to be trained and that the majority of DoLS applications authorised in the current year have been signed off by a small number of the pool of potential signatories.</p> | <p>Health Board increasingly reliant on a small number of signatories with the risk that delays will occur.</p> |
| <p>Recommendation</p> | <p>Priority level</p> |
| <p>Managing Authority. Management should ensure that all nominated signatories attend training and are reminded of their obligations in respect of the DoLS</p> | <p>Medium</p> |

| | |
|---|--|
| process. | |
| Management Response | Responsible Officer/ Deadline |
| <p>The Managing Authority will ensure Authorisers (Signatories) are reminded of their role and responsibilities through the PADR and supervision processes available to them.</p> <p>The DoLS Manager will include guidance reinforcing their role and responsibilities as authorisers within the Safeguarding Bulletin which is to focus specifically upon DoLS, (as above).</p> <p>A SOP document will be devised setting out the responsibilities for those who have been approved to authorise a DoLS. This will be signed off through Corporate Safeguarding Governance and Reporting arrangements.(linked to Finding 1)</p> | <p>Directors of Nursing 31st May 2020</p> <p>DoLS Manager 30th April 2020</p> <p>DoLS Manager 30th April 2020 Ratified May 2020</p> |
| Finding 5 – Reporting of Breaches through Datix (Operating effectiveness) | Risk |
| <p>We were provided with reports produced from Datix but were unable to identify any specific reporting of breaches by individual wards/departments, within the period under review.</p> | <p>Under reporting of breaches within individual wards/departments.</p> |
| Recommendation | Priority level |

| | |
|--|--|
| <p>Managing Authority. Wards/Departments should undertake a check of DoLS cases and monitoring records within their areas to establish whether breaches are being reported promptly.</p> <p>Managing Authority. Staff should be reminded that all breaches are to be reported via Datix (with appropriate CCS code.)</p> | <p>High</p> |
| <p>Management Response</p> | <p>Responsible Officer/ Deadline</p> |
| <p>The Managing Authority will undertake a random sample of Datix incidents within their responsibility to determine if breeches have been reported.</p> | <p>Directors of Nursing 30st April 2020</p> |
| <p>The Managing Authority are to develop and to include an audit of DoLS paperwork and DoLS activities within the current Audit of records and develop a process to cross reference Datix incidents to determine whether breeches have been reported promptly.</p> | <p>Directors of Nursing 31th May 2020</p> |
| <p>The management response of developing a SOP identified in Finding 1 and 3 authority are fully aware of their responsibilities and the consequences of breaches of Article 5 (a deprivation of liberty, Human Rights Act '98) and expectations to have in place Datix reporting and notification to the DoLS Team.</p> | <p>DoLS Manager, Associate Director of Safeguarding 30th April 2020</p> |

Appendix B - Assurance opinion and action plan risk rating **Audit Assurance Ratings**



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



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



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



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



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

Prioritisation of Recommendations

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

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

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



| | | | | | | |
|---|--|---|---|--|--|--------------------------------------|
| Cyfarfod a dyddiad: Meeting and date: | 29 June 2020 | | | | | |
| Cyhoeddus neu Breifat: Public or Private: | All Wales Audit Office (WAO) papers will be in the public agenda of the committee | | | | | |
| Teitl yr Adroddiad Report Title: | <ul style="list-style-type: none"> Review of Audited Accounts and Financial Statement Latest letters on Covid-19 impact Wales's First "Future Generations Report" by the Future Generations Commissioner for Wales. | | | | | |
| Cyfarwyddwr Cyfrifol: Responsible Director: | Board Secretary, on behalf of the executive team | | | | | |
| Awdur yr Adroddiad Report Author: | Andrew Doughton and Amanda Hughes | | | | | |
| Craffu blaenorol: Prior Scrutiny: | All final Wales Audit Office reports on Betsi Cadwaladr University Health have passed through a clearance process with the lead Executive Director. | | | | | |
| Atodiadau Appendices: | | | | | | |
| Argymhelliad / Recommendation: | | | | | | |
| The Audit Committee is requested to: <ul style="list-style-type: none"> Receive the report on the annual accounts. Receive and note the letters on the impact of covid on the external audit work programme. Receive and discuss the All-Wales report on Wellbeing or future generations progress. | | | | | | |
| Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category) | | | | | | |
| Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval | | Ar gyfer Trafodaeth For Discussion | ✓ | Ar gyfer sicrwydd For Assurance | | Er gwybodaeth For Information |
| Sefyllfa / Situation: | | | | | | |
| The documents for audit committee include the annual review of audited accounts and letter of representation. Covid 19 has impacted the delivery of the performance audit programme and is under a process of regular review. This is set out in the letters to the Health Board. | | | | | | |
| Cefndir / Background: | | | | | | |
| Asesiad / Assessment & Analysis | | | | | | |
| Strategy Implications | | | | | | |
| The Wellbeing of Future Generations Act provides the opportunity to change and improve ways of working both operationally and to support longer term recovery. | | | | | | |
| Financial Implications | | | | | | |
| External audit of the annual accounts is a statutory requirement. | | | | | | |
| Risk Analysis | | | | | | |

Any risks identified as part of a specific review should be used to inform the Health Board's risk management arrangements.

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Impact Assessment

Audit of Accounts Report – Betsi Cadwaladr University Health Board

Audit year: 2019-20

Date issued: June 2020

Document reference: 1909A2020-21

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention

is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000.

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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.

Contents

We intend to issue an unqualified 'true and fair' audit opinion on your financial statements, together with a qualified opinion on regularity and a narrative Report providing further detail about the financial position and planning arrangements of the Health Board.

There are some issues to report to you prior to their approval.

Audit of Accounts Report

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Audit of Accounts Report

Introduction

- 1 We summarise the main findings from our audit of your 2019-20 financial statements in this report.
- 2 We have already discussed these issues with the Executive Director of Finance and her team.
- 3 Auditors can never give complete assurance that accounts are correctly stated. Instead, we work to a level of 'materiality'. This level of materiality is set to try to identify and correct misstatements that might otherwise cause a user of the accounts into being misled.
- 4 We set this level at £18.04 million for this year's audit.
- 5 There are some areas of the accounts that may be of more importance to the reader and we have set a lower materiality level for these, as follows:
 - Remuneration report / senior pay disclosure and exit packages
 - Related parties (to executive and non-executive directors)
 - Ministerial directions
- 6 We have now substantially completed this year's audit.
- 7 In our professional view, we have complied with the ethical standards that apply to our work; remain independent of yourselves; and, our objectivity has not been compromised in any way. There are no relationships between ourselves and yourselves that we believe could undermine our objectivity and independence.

Impact of COVID-19 on this year's audit

- 8 The COVID-19 pandemic has had a significant impact on all aspects of our society and continues to do so. You are required by statute to prepare accounts and it is of considerable testament to the commitment of your accounts team that you have succeeded in doing so this year in the face of the challenges posed by this pandemic. We are extremely grateful to the professionalism of the team in supporting us to complete our audit in such difficult circumstances.
- 9 The pandemic has unsurprisingly affected our audit and we summarise in **Exhibit 1** the main impacts. Other than where we specifically make recommendations, the detail in **Exhibit 1** is provided for information purposes only to help you understand the impact of the COVID-19 pandemic on this year's audit process.

Exhibit 1 – impact of COVID-19 on this year’s audit

| | |
|------------------------------|---|
| Timetable | <ul style="list-style-type: none"> • The deadline for completing your accounts was changed by Welsh Government from 28 April 2020 to 22 May 2020. • We received the draft accounts on 7 May 2020. • Our deadline for completing our audit was changed from 29 May 2020 to 29 June 2020. • We expect your audit report to be signed on 2 July 2020. |
| Electronic signatures | <p>If still necessary at the time of approval and signing, we will accept electronic signatures and electronic transfer of files.</p> |
| Audit evidence | <p>As in previous years we received most of the audit evidence in electronic format. We have used various techniques to ensure its validity. Where we have been unable to obtain access to paper documents because of COVID-19 restrictions we have devised alternative audit methodologies to obtain sufficient audit evidence. Specifically:</p> <ul style="list-style-type: none"> • BCU officers provided electronic working papers in accordance with our agreed Audit Deliverables Report • BCU officers provided audit evidence to the audit team via a Secure File Sharing Portal • BCU officers were available by Skype for discussions and also for the sharing of on-screen information/evidence • Audit Wales also secured remote read only access to the BCU Oracle ledger. • For testing of existence and ownership of assets we have used a combination of visual identification (where this was practical) access to our land registry tool and photographic evidence. |
| Other | <ul style="list-style-type: none"> • Video conferencing has enabled the audit team to correspond effectively with BCU officers throughout the audit. • Video conference based BCU Audit Committee meetings have enabled us to proficiently discharge our responsibility for reporting to those charged with governance. |

- 10 We will be reviewing what we have learned for our audit process from the COVID-19 pandemic and whether there are innovative practices that we might adopt in the future to enhance that process.

Proposed audit opinion

- 11 We intend to issue a an unqualified 'true and fair' audit opinion on your accounts, together with a qualified opinion on regularity once you have provided us with a Letter of Representation based on that set out in **Appendix 1**.
- 12 We issue a 'qualified' audit opinion where we have material concerns about some aspects of your accounts; otherwise we issue an unqualified opinion.
- 13 Our proposed audit report is set out in **Appendix 2**. This includes, as in previous years, a qualified opinion on regularity along with a substantive report explaining the reasons for that qualification.
- 14 The audit report also includes as Emphasis of Matter which draws attention to Note 21 of the accounts, which describes the impact of a Ministerial Direction to fund NHS Clinicians' pension tax liabilities in respect of the 2019-20 financial year. My opinion is not modified in respect of this matter.
- 15 The Letter of Representation contains certain confirmations we are required to obtain from you under auditing standards along with confirmation of other specific information you have provided to us during our audit.

Significant issues arising from the audit

Uncorrected misstatements

- 16 There are no misstatements identified in the accounts, which remain uncorrected.

Corrected misstatements

- 17 There were initially misstatements in the accounts that have now been corrected by management. However, we believe that these should be drawn to your attention and they are set out with explanations in **Appendix 3**.

Other significant issues arising from the audit

- 18 In the course of the audit, we consider a number of matters relating to the accounts and report any significant issues arising to you. There was an issue arising in these areas this year as shown in **Exhibit 2**:

Exhibit 2 – significant issues arising from the audit

| Significant issues arising from the audit | | |
|---|---|---|
| Contingent liability arising from a ministerial direction to fund NHS clinicians' pension tax liabilities | I have requested that the Board sets out in Note 21 - Contingent liabilities – additional narrative to disclose the potential liability resulting a ministerial direction to fund pensions tax liabilities above the pension savings annual allowance threshold in 2019-20. | The Board has included the additional contingent liability. I have also drawn the reader's attention to this disclosure in an emphasis of matter paragraph in my audit report. My opinion is not modified in respect of this matter. |

Recommendations

19 There are no recommendations arising from our audit.

Appendix 1

Final Letter of Representation

Betsi Cadwaladr University Health Board letterhead

Auditor General for Wales

Wales Audit Office

24 Cathedral Road

Cardiff

CF11 9LJ

29 June 2020

Representations regarding the 2019-20 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Betsi Cadwaladr University Health Board for the year ended 31 March 2020 for the purpose of expressing an opinion on their truth and, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
 - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
 - make judgements and estimates on a reasonable basis;
 - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and

- prepare them on a going concern basis on the presumption that the services of Betsi Cadwaladr University Health Board will continue in operation.
- ensuring the regularity of any expenditure and other transactions incurred.
- the design, implementation and maintenance of internal control to prevent and detect error.

We have provided you with:

- full access to:
 - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
 - additional information that you have requested from us for the purpose of the audit; and
 - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- Our knowledge of fraud or suspected fraud that we are aware of and that affects Betsi Cadwaladr University Health Board and involves:
 - management;
 - employees who have significant roles in internal control; or
 - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.
- Our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

Significant assumptions used in making accounting estimates, including those measured at fair value, are reasonable.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by Betsi Cadwaladr University Health Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Betsi Cadwaladr University Health Board on 29 June 2020.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:

Chief Executive

Date:

Signed by:

Board Chair

Date:

Appendix 2

Proposed Audit Report

The Certificate and independent auditor's report of the Auditor General for Wales to the Senedd

Report on the audit of the financial statements

Opinion

I certify that I have audited the financial statements of Betsi Cadwaladr University Health Board for the year ended 31 March 2020 under Section 61 of the Public Audit (Wales) Act 2004. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Taxpayers' Equity and related notes, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and HM Treasury's Financial Reporting Manual based on International Financial Reporting Standards (IFRSs).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Betsi Cadwaladr University Health Board as at 31 March 2020 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)). My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I am independent of the board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Emphasis of matter

I draw attention to Note 21 of the financial statements, which describes the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government, instructing her to fund NHS Clinicians' pension tax liabilities incurred by NHS Wales bodies in respect of the 2019-20 financial year. The Health Board

has disclosed the existence of a contingent liability at 31 March 2020, and my opinion is not modified in respect of this matter.

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Chief Executive has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the board's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Chief Executive is responsible for the other information in the annual report and accounts. The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies, I consider the implications for my report.

Qualified opinion on regularity

In my opinion, except for the irregular expenditure of £118.813 million explained in the paragraph below, in all material respects, the expenditure and income have been applied to the purposes intended by the Senedd and the financial transactions conform to the authorities which govern them.

Basis for qualified opinion on regularity

The Health Board has breached its resource limit by spending £118.813 million over the £4,566 million that it was authorised to spend in the three-year period 2017-18 to 2019-20. This spend constitutes irregular expenditure. Further detail is set out in the attached Report.

Report on other requirements

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and the Annual Governance Statement has been prepared in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the board and its environment obtained in the course of the audit, I have not identified material misstatements in the Annual Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- proper accounting records have not been kept;
- the financial statements are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed; or
- I have not received all the information and explanations I require for my audit.

Report

Please see my Report below.

Responsibilities

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for the preparation of financial statements which give a true and fair view and for such internal control as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors and Chief Executive are responsible for assessing the board's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Responsibilities for regularity

The Chief Executive is responsible for ensuring the regularity of financial transactions.

I am required to obtain sufficient evidence to give reasonable assurance that the expenditure and income have been applied to the purposes intended by the Senedd and the financial transactions conform to the authorities which govern them.

Adrian Crompton
Auditor General for Wales
2 July 2020

24 Cathedral Road
Cardiff
CF11 9LJ

Report of the Auditor General to the Senedd

Introduction

Local Health Board (LHBs) are required to meet two statutory financial duties – known as the first and second financial duties.

For 2019-20 Betsi Cadwaladr University Health Board (the LHB) failed to meet both the first and the second financial duty and so I have decided to issue a narrative report to explain the position.

Failure of the first financial duty

The **first financial duty** gives additional flexibility to LHBs by allowing them to balance their income with their expenditure over a three-year rolling period. The fourth three-year period under this duty is 2017-18 to 2019-20, and so it is measured this year for the fourth time.

As shown in Note 2.1 to the Financial Statements, the LHB did not manage its revenue expenditure within its resource allocation over this three-year period, exceeding its cumulative revenue resource limit of £4,566 million by £118.813 million.

Where an LHB does not balance its books over a rolling three-year period, any expenditure over the resource allocation (i.e. spending limit) for those three years exceeds the LHB's authority to spend and is therefore 'irregular'. In such circumstances, I am required to qualify my 'regularity opinion' irrespective of the value of the excess spend.

Failure of the second financial duty

The **second financial duty** requires LHBs to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-term plan. This duty is an essential foundation to the delivery of sustainable quality health services. An LHB will be deemed to have met this duty for 2019-20 if it submitted a 2019-20 to 2021-22 plan approved by its Board to the Welsh Ministers who then approved it by the 30th June 2019.

As shown in Note 2.3 to the Financial Statements, the LHB did not meet its second financial duty to have an approved three-year integrated medium-term plan in place for the period 2019-20 to 2021-22.

Following the LHB being placed in Special Measures in June 2015, the LHB were not in a position to submit a three-year integrated medium-term plan for 2019-2022. Instead the LHB has operated, in agreement with the Welsh Government, under annual planning arrangements. The LHB's Annual Operating Plan for 2019-20, which identified a planned

annual deficit of £35 million, was approved by its Board in March 2019. However, the LHB's eventual deficit for 2019-20 was £38.7 million.

Adrian Crompton
Auditor General for Wales
2 July 2020

Appendix 3

Summary of corrections made

During our audit we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention due to their relevance to your responsibilities over the financial reporting process.

Exhibit 3: summary of corrections made

| Value of correction | Nature of correction | Reason for correction |
|--|---|--|
| £1,474,000 | <p>Note 2.1 Revenue Resource Performance Additional funding from Welsh Government increased the Revenue Resource Allocation by £1,474,000 and reduced the overspend against the allocation by £537,000.</p> <p>Note 3.1 Expenditure on Primary Healthcare Services Total expenditure increased by £937,000.</p> <p>Note 18 Trade and Other Payables Analysis of the actual March data identified a requirement to increase the year-end prescribing accrual by a further £937,000.</p> | To account for additional resource only allocation of £1,474,000 for 2019-20 due to increases in March 2020 prescribing costs due to Covid-19. |
| Amended analysis of the table within the disclosure note - Nil impact on overall position. | <p>Note 20 Provisions Reclassification of the analysis of movements in provisions within Note 20 between current and non-current.</p> | To correctly reflect the timing of when amounts provided for are expected to be utilised. |

| | | |
|--|--|---|
| Additional narrative disclosure | <p>Note 21 Contingent Liabilities</p> <p>Additional disclosure added to describe the potential impact of a Ministerial Direction to fund NHS Clinicians’ pension tax liabilities.</p> | To disclose a contingent liability which could be material by nature. |
| Narrative disclosure | <p>Note 34 Other Information</p> <p>Additional disclosure added to explain the deferral of the implementation of Accounting Standard IFRS16 Leases.</p> | To provide relevant information to the reader on the anticipated future impact. |
| Narrative disclosure | <p>Remuneration Report</p> <p>Additional disclosure added to the ‘off payroll engagements’ section of the Remuneration Report to reflect the nature and costs associated with the Interim Recovery Director position.</p> | To ensure that disclosures are in accordance with the Manual for Accounts. |
| Various amendments to figures and additional narrative disclosures | <p>Remuneration Report</p> <p>There have been various amendments to figures, additional footnotes and other narrative amendments to ensure that the remuneration report correctly reflects the relevant details.</p> | To ensure that disclosures are in accordance with the Manual for Accounts. |

There have been some other amendments and disclosure updates as a result of our work.



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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Reference: AC/190/caf

Date issued: 30 April 2020

Dear Colleague

Audit Wales work programme

I am writing to update you on some important aspects of the work that my office will be undertaking over the coming weeks and months. Firstly though, I would like to pay tribute to all the public servants who are working so hard to see our country through this crisis. As the organisation responsible for scrutinising so many of these public bodies, we have a privileged insight into how vital they are to everyone's lives, every day – and even more so at a time like this. As Auditor General, on behalf of everyone at Audit Wales, and simply as a member of the public - thank you.

As you know, last month I decided to pull back from all on-site audit work as the public service focused on the pandemic. We have continued to make progress on other activity whilst working and engaging with you remotely. I remain committed to ensuring that our audit work does not have a detrimental impact on the efforts of severely stretched public bodies to deal with the national emergency. That is not to say, however, that I want us to be entirely passive. Well targeted and well delivered public audit has a vital part to play at this time in ensuring value for money, good governance and accountability. This letter explains how we will be approaching our work over the coming months.

Well-being of Future Generations report

In line with statutory requirements, we have published our Annual Plan for 2020-21, recognising that much of the performance audit work programme described in it will now need to be re-shaped or deferred.

One important exception to this is my national report under the Well-Being of Future Generations (Wales) Act 2015, which I am required by statute to lay by 5 May 2020. I have decided to lay my report 'without fanfare' before the Senedd on 5 May, and to defer any significant engagement with public service leaders and others regarding the key report messages until later in the year. I consider this to be a pragmatic way of discharging my statutory duty under the 2015 Act, whilst minimising any unnecessary distractions for the wider public sector at this difficult time. I hope the delay in engagement will also help to ensure that the impact of this important report in supporting constructive change is not significantly diminished.

Real-time audit work in respect of COVID-19

It is already apparent to my audit teams that people and organisations right across the Welsh public services are developing novel and innovative ways of working in response to COVID-19. The crisis is forcing us all to innovate and address long-standing issues with urgency. Both opportunities and risks will doubtless emerge during this period which, if acted upon sooner rather than later, can generate real-time benefits and help to mitigate other risks.

To that end, I want to deploy the capability and capacity of Audit Wales for the good of the wider public sector. Specifically, I propose to undertake work providing real-time capture and sharing of learning and experience across our audited bodies. This will involve our staff in gathering novel and other practice as it emerges and analysing it rapidly to draw out relevant points of learning. We are developing a software tool to assist us in gathering and processing this information. We will share the resulting insights swiftly to our key contacts across the Welsh public service.

I am acutely conscious that we will need to conduct any activity in a manner that doesn't impede the very important work that is happening across Wales, and which can add substantial value in informing that work. My intention is therefore to work closely with audited bodies to support them to improve their evolving responses to COVID-19, whilst preserving my objectivity and independence as Auditor General.

I am pleased to say that we have received support for this proposal from the Permanent Secretary and other senior officials at Welsh Government, the WLGA and the NHS Wales Confederation. As soon as we are able, my staff will be in touch to discuss practicalities which, as I say, will be designed to be as least intrusive as possible.

I attach a short summary of the project for your information. If you have any queries or concerns with this approach, or if you can suggest particular areas where it could be usefully directed, please let me or a member of my team know.

Other audit work in respect of Wales' response to COVID-19

Given the impact of COVID-19, I will be re-shaping my previously planned programmes of audit work. You won't be surprised, for example, that I am tracking the various COVID-19 funding flows from both UK and Welsh Governments and considering how best I can assure the people of Wales that those funds are well managed and that there is appropriate governance and accountability for the use of public money. Looking a little further ahead, I envisage a focus on what the impact of the current crisis means both in terms of the resilience and the future shape of public services in Wales. Of course, timing is everything, and I will ensure that our work does not prejudice the efforts of the public sector to tackle the crisis, whilst still reporting sufficiently thoroughly and promptly to support both scrutiny and learning.

Audit of accounts

My Engagement Directors have written to each of you about the impact of the COVID-19 emergency on your audit plan. This includes specific audit risks, as well as

revisions to the audit timetable and accounting requirements (where relevant). My staff will continue our close engagement with you and your senior team over the coming weeks and months to ensure that we deliver a high quality audit of your accounts in these changed circumstances.

Other matters

As well as considering how best to deploy Audit Wales resources to support the COVID-19 effort through our audit work, I am very aware that staff resources across public services are being stretched as never before. I want to let you know that, subject to availability and provided that the future independence of our work is not compromised, I am very willing to consider how my staff can assist wherever their skills and expertise may be required. Please let me (or a member of my team) know if there is anything specific that we can do to assist.

And finally, you will have noticed the identity and name change in this letter. Such a secondary issue in the current climate, I know, but in response to feedback on how we communicate and engage, we took the decision last year to bring together the various strands of our work under a new, clearer umbrella identity – Audit Wales. While not affecting our formal legal status, we will operate as Audit Wales henceforth in the vast majority of our public facing work. It is just one part of a wider programme of change for our audit reports; our website; our communications style and the way we engage more generally, that I hope you will recognise and value.

In closing, I would like to pay tribute once again to my colleagues across the Welsh public service and the phenomenal work they are doing for the people of Wales.

Yours sincerely



ADRIAN CROMPTON
Auditor General for Wales

Title

Project Briefing note:

The Auditor General for Wales plans to support the rapid collection, analysis and sharing of knowledge and insights during COVID-19

Novel Practice Emerges During a Crisis.

During any emergency or crisis people will develop solutions and work in ways that are novel. Practices will emerge that are outside the range of what could be described as business as usual.

The prolonged duration of COVID-19 provides the opportunity to capture and consider this novel practice from three perspectives:

1. The identification of opportunities to improve the current response to the situation, in as close to real time as possible;
2. The identification of emerging risks (for example widespread fraud attempts) that can then be mitigated before they develop to a large scale; and
3. The recording and consolidation of novel practice, that could be shared more widely in real time and also incorporated as good practice into 'business as usual' once COVID-19 has subsided.

Collecting and Recording Novel Practice

Organisations that are experienced in emergency and crisis situations often deploy observers / information gatherers alongside their recovery teams, to identify the novel practice as it emerges. This role is recognised as a vital part of learning from what has happened and facilitates being better prepared to face the future.

The collection of information can be achieved through a range of approaches that include impartial observation, conversations and document review. It is supported by rapid analysis to draw out key insights and feedback learning. This 'closes the loop' and supports a process of real time learning and improvement.

The role of Audit Wales in supporting the Welsh Public Services response to COVID-19

The Auditor General's statutory remit places Audit Wales in a unique position to observe activity wherever public resources are being used. Our staff have strong networks and trusted relationships with people across the Welsh public services. Consistent with preserving his independence, the Auditor General plans to deploy Audit Wales staff in the three areas identified above, in support of the 'team Wales' efforts to respond to COVID-19.

Importantly, the approach taken will not impose an additional burden upon public bodies and will be predicated upon sharing useful information and analysis in real time alongside collecting what might be useful insights and learning for others.

Specifically, this will involve:

- Audit Wales staff collecting information through methods including reviews of documents and published materials, discussions with individuals and groups and observations of meetings (generally via remote working);
- The collation of this material within and across our audit teams, using our SenseMaker data tool, to provide rapid analysis; and
- The rapid dissemination of insights, additional knowledge and potential shared learning points to their original data sources, and more widely across Welsh public services where appropriate.

We anticipate that this will be an ongoing process of 'collect, analyse, share and repeat'. Greater value will potentially be generated over time as more information is gathered and shared with the people who can use it to support their response to COVID-19. We will also keep the process itself under close review and adjust it as needed in response to feedback and changing circumstances.

The overall approach taken will be consistent with how our Good Practice work has been developed over the last decade - working with public services to support them to improve, whilst maintaining the objectivity and independence that is required of the Auditor General.

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To: Chief Executives, NHS bodies
Cc: Chairs
Audit Committee Chairs
Board Secretaries

Reference: PA288/DT/hcj

Date issued: 11 June 2020

Dear all

Update on the AGW's programme of NHS Performance Audit work

I trust this letter finds you all well as the service continues to navigate its way through the next phases of the COVID-19 outbreak. It truly has been an unprecedented challenge for the NHS and its partners, and I'd just like to echo the sentiments expressed by the Auditor General in his letter of 30 April to public sector Chief Executives (attached again here in case you missed first time around), thanking public servants for the phenomenal work they are doing for the people of Wales. More specifically, myself and colleagues at Audit Wales are really grateful to NHS bodies for the way they've maintained engagement with us throughout the crisis. It has helped us stay connected to developments and also to appreciate the tremendous amount of work that has been undertaken in such a short space of time to respond to the challenges presented by COVID-19.

In his letter, the Auditor General provided some information on how we were adapting our work in response to COVID-19 and I'd like to use this opportunity to provide a further specific update on our programme of NHS performance audit work. As you know we took the early decision to suspend on-site performance audit work at all NHS bodies and to progress our work remotely as far as we can. That continues to be the situation and as part of our own business continuity planning, we've been looking afresh at our current programme of work to assess how it gets taken forward in the context of COVID-19. The Annex attached to this letter provides an update on our current plans for each of the main strands of work in our programme.

In addition to re-shaping the existing elements of our work programme as set out in the Annex, we are keen to ensure that we focus our attention on issues that are specific to the current situation. We're currently reviewing the information in the Welsh Government's supplementary budget and accompanying explanatory memorandum as we consider those areas that merit some specific work. At a more local level, our 2020 structured assessment work will allow us to understand how NHS bodies are maintaining their corporate and financial governance arrangements in the context of COVID-19, as well as the progress being made on recovery planning. Further information on our 2020 structured assessment work is provided in the attached project specification, which has recently been shared with Board Secretaries.

As referenced in the Auditor General's letter, we have also started work on a "COVID-19 learning project" that will seek to identify and share examples of new ways of working that have been introduced as a result of the pandemic, and wider learning points that can help with the plans to continue to control the virus and rebuild a stronger and better NHS. We are aware that there is already quite a lot of activity in this area within the NHS, so we are working closely with the NHS Confederation and Welsh Government to ensure that what we do in this space complements and adds value to existing activities.

The information I've set out in this letter represents the current position and our latest thinking but we'll continue to adopt an agile approach and where necessary adjust the content and focus of our work to ensure we are deploying our resources to areas where outputs from ourselves will add most value in the current environment. We'll continue to keep you informed of any further developments to our programme through our local engagement channels and communications such as this.

Whilst this update primarily concerns our performance audit work, I thought it would also be useful to provide a brief update on our accounts work. Our teams have continued to liaise with Directors of Finance and the wider Finance teams as we are drawing our work to a close. The Auditor General is planning to sign off the opinions on the financial statements of NHS bodies on the 2nd July 2020.

I trust this update is helpful and my thanks once again for your positive on-going engagement with our audit teams, and for all the hard work that is being done by yourselves and your organisations in response to the current situation. If you had any queries about the any aspect of this update, then please don't hesitate to contact me.

Your sincerely



David Thomas
Audit Director

ANNEX: NHS PERFORMANCE AUDIT WORK PROGRAMME UPDATE

A: Work included in local audit plans

| Review | Update |
|-----------------------------------|---|
| Structured Assessment 2020 | <p>Our annual structured assessments are one of main ways in which the AGW discharges his statutory requirement to examine the arrangements NHS bodies have in place to secure efficiency, effectiveness and economy in the use of their resources. In the context of COVID-19, we have designed an approach which allows us to undertake structured assessment work remotely and with minimal impact on NHS bodies in terms of time and resource to support the work. Our lines of enquiry will be based on the same broad areas as previous years' work but our audit questions in this year's work will have a COVID-19 context, taking note of Welsh Government guidance and frameworks issued in response to the pandemic, and including a focus on recovery planning. We are aware that the internal audit service has been asked to undertake some early work on aspects of governance related to COVID-19. We've had a constructive dialogue with internal audit colleagues and we are devising approaches at each NHS body to ensure our respective programmes of work are co-ordinated and mutually informed.</p> |

| Review | Update |
|---|--|
| <p>Reviews of quality governance arrangements at NHS bodies</p> | <p>Following the Joint Review of quality governance arrangements at Cwm Taf Morgannwg UHB, we had been developing a programme of work to examine these arrangements at all relevant NHS bodies. The cessation of on-site fieldwork as a result of COVID-19 has meant that we've had to put this work on hold. In the interim will use this year's structured assessment to get an overview of quality governance arrangements at NHS bodies and how they have been maintained during the pandemic. Subject to how the COVID-19 situation pans out, we hope to be in a situation where we can resume some form of on-site work later in the year. However, if that is not possible, we will look to design an alternative approach to capturing information we require, collaborating with Healthcare Inspectorate Wales, and other stakeholders as necessary in the design of that work.</p> |
| <p>Follow up work on orthopaedic services (and the national AGW follow up study on elective NHS waiting times)</p> | <p>At the point the pandemic hit we were preparing local and national reports to summarise the progress made in response to the recommendations we made in 2015. However, in the context of the Minister's decision to suspend routine elective NHS work to create capacity to deal with the expected surge in COVID-19, it seemed inappropriate to issue these reports in the format which they had been drafted. We are therefore looking to reshape these outputs so that they inform the recovery planning discussions that are starting to take place locally and nationally, and to help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.</p> |

| Review | Update |
|--|--|
| <p>Governance review of Welsh Health Specialised Services Committee</p> | <p>We had made good progress with this review up to March of this year, but we do still need to gather in views on the current arrangements for specialised services commissioning from leaders in NHS bodies. We hope to be able to do this remotely over the coming month, potentially through the use of survey software, although we will take soundings from some key contacts in the service to test our thinking and inform our approach before we progress this. Subject to being able to collect this additional information, we would envisage having a draft output to share for comment by the end of the summer.</p> |
| <p>Whole system review of unscheduled care</p> | <p>We have split this work into two phases. The first phase has involved collection of data across the unscheduled care pathway with the aim of creating an interactive database that can be shared with external stakeholders and used to inform the focus of audit work in the second phase. Our ability to undertake more focused audit work in the second phase will largely be shaped by the restrictions associated with COVID-19 and stakeholders' ability to engage with the audit work. In the short term, i.e. through to the end of July, we will focus on preparing the database and discussing the most productive ways of sharing this information with external stakeholders. We have continued to take this work forward in close collaboration with Healthcare Inspectorate Wales</p> |

| Review | Update |
|---|---|
| Locally specific performance audit reviews | <p>In several NHS bodies, our work programme had included reviews that were specific to local circumstances in those organisations. These reviews were at various stages of completion at the point the COVID-19 restrictions were introduced. Where we can, we have continued to progress these pieces of work remotely and our performance audit leads at each site will continue to liaise with Board Secretaries to keep them up to speed with individual reviews and check on the NHS body's ability to support the remainder of the work required, including the ability to provide comments on the factual accuracy of products at the draft report stage.</p> |

B: Other AGW NHS Performance Audit Work

| Review | Update |
|--|--|
| Counter Fraud Services | The AGW has undertaken a public sector wide review of counter fraud services and is due to publish his findings on 14 July. That national report will be supported by summaries of our local findings at individual NHS bodies. We'll shortly be issuing those local reports for final factual accuracy checks ahead of them being ready to be shared with Audit Committees at their autumn meetings alongside the national output |
| Clinical Coding | We are currently preparing a short publication that aims to share some key messages from our recent local follow up work on clinical coding. We plan on publishing this work towards the end of July and think it will be a timely aid to discussion on the importance of clinical coding in ensuring good information flows to support decision making in response to COVID-19. |
| Welsh Community Care Information System (WCCIS) | We will shortly be commencing the clearance process through the WCCIS Leadership Board and the Welsh Government and, where relevant, with individual NHS bodies. This will be with a view to report publication in early autumn. |
| Follow up: Local public health team collaborative working | Comments on the factual accuracy of our draft report have been received and reviewed. A finalised output is in preparation with a view to publication later this summer. |
| Other cross sector work | Scoping work is currently underway on several pieces of work which are not NHS-specific but which are likely to involve some evidence gathering from NHS bodies. These topics include digital resilience in the public sector, collaborative working across emergency services and work on the General Equality Duty. |

So, what's different?

Findings from the Auditor General's Sustainable
Development Principle Examinations

May 2020



I have prepared this report under section 15 of the Well-being of Future Generations (Wales) Act 2015.

My examination team was led by Catryn Holzinger and directed by Mike Usher.

Adrian Crompton
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The Auditor General is independent of the Senedd and government. As well as auditing the accounts of Welsh public bodies, the Auditor General undertakes examinations of the extent to which public bodies have applied the sustainable development principle when setting and pursuing well-being objectives. The Well-being of Future Generations (Wales) Act 2015 requires the Auditor General to report such examinations to the Senedd.

The Auditor General has a wide range of audit and related functions. These include auditing the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies, and reporting to the Senedd on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General also audits and reports on local government bodies in Wales. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Auditor General's Foreword

When we began the work that underpins this report, none of us imagined that we would today be engaged in an effort to tackle the biggest crisis in most our lifetimes.

For all of us – as individuals, communities and public bodies – the world is suddenly a very different place. The global pandemic has affected and is affecting all of us. The last few months have been frightening, stressful, pressured and distressing. But every day we have been comforted and uplifted by the stories of ingenuity, commitment and bravery of public sector workers. We are all proud and eternally grateful for their efforts.

For some time to come, the focus will be on responding to the crisis. Further down the line, there will be an opportunity to pause and reflect. Innovation is often born out of crisis and I am sure there will be much that public bodies will have learned in their response to Covid-19. I am determined that Audit Wales supports that learning process and that we work with public bodies to capture and draw out those lessons.

The evidence for this report was gathered in a different time. It does not cover emergency planning or the response to Covid-19. This report summarises the findings from our examinations of 44 public bodies under the Well-being of Future Generations (Wales) Act 2015 in the first reporting period, from 2015-2020.

It would be tempting to dismiss the Act as irrelevant in the face of such a crisis. But the best public sector leaders will recognise that the ways of working it sets out – planning for the long term, preventing problems, working with and listening to others and taking a broader perspective – are sound principles for dealing with whatever challenges the future might hold. On that basis, I hope this report provides some insights that can help public bodies develop their foresight and resilience.

In these early years, our main objective has been to add value by helping public bodies learn and improve. We worked with public bodies, the Future Generations Commissioner and other stakeholders to understand how we could best do that. We co-designed a methodology that focuses on ways of working and on behaviours. It promotes self-reflection. It aims to help bodies learn and develop their own actions in response to our findings. The sustainable development principle is not something that can be uniformly applied or audited. So, we have listened, tried to understand context and to appreciate differences. We have learned so much that we can carry forward into our future work.

Overall, we have found that public bodies can demonstrate that they are applying the sustainable development principle. But it is also clear that they must improve how they apply each of the five ways of working if they are going to affect genuine cultural change – the very essence of the Act. In the next five-year reporting period, public bodies across Wales will need to work together in taking a more system-wide approach to improving well-being if they are to take their work to the next level.

I understand it may be some time before all of the 44 bodies are able to consider and respond to these findings. It may also be some time before Members of the Senedd, civic society and others can be part of a conversation about what we have found. When appropriate, the Commissioner and I will create the time and space to explore the findings and recommendations.



Adrian Crompton

Auditor General for Wales



What you'll find in this report

- 1 This report sets out the main findings from the Auditor General for Wales's (the Auditor General) sustainable development principle examinations, carried out under the Well-being of Future Generations (Wales) Act 2015 (the Act).
- 2 During 2018-19 and 2019-20, we carried out 71 examinations across the 44 Welsh public bodies named under the Act.¹ We published reports on each examination, which can be viewed on our [website](#).²
- 3 This report provides an overview of what we looked for, what we found and what we will expect to see in future. It also draws on other relevant findings across the breadth of our audit work.
- 4 The Future Generations Commissioner for Wales (the Commissioner) has also published a report today, the **Future Generations Report**. Together, these reports describe how public bodies in Wales are applying the Act and improving well-being across Wales.³

-
- 1 The 44 public bodies named under the Act are Welsh Ministers (the Welsh Government), Local Authorities, Local Health Boards, Public Health Wales NHS Trust, Velindre NHS Trust, National Park Authorities, Fire and Rescue Authorities, Natural Resources Wales, the Higher Education Funding Council for Wales, the Arts Council of Wales, Sport Wales, the National Library of Wales and the National Museums and Galleries of Wales.
 - 2 The Auditor General must examine each public body at least once in a five-year period and report on the examinations to the Senedd before each Senedd election.
 - 3 The Commissioner must publish a Future Generations Report 12 months before a Senedd election giving her assessment of the improvements public bodies should make to set and meet well-being objectives in accordance with the sustainable development principle.

Exhibit 1 – key concepts for this report⁴

The Well-being Duty requires...

...public bodies to carry out sustainable development. As part of this, they must set well-being objectives and take all reasonable steps to meet them.

Sustainable development is...

‘...the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.’






Well-being goals

| | | | |
|-----------------------------|--|-----------------------------|-------------------|
| More Equal | Healthier | Resilient | Prosperous |
| Globally Responsible | Vibrant Culture and Thriving Welsh Language | Cohesive Communities | |

The sustainable development principle is defined as acting in a manner...

‘...which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.’

To do this, they must take account of the ‘**five ways of working**’.

| | | | | |
|---|---|---|--|---|
|  |  |  |  |  |
| Long-term | Prevention | Integration | Collaboration | Involvement |

The **Auditor General** must examine public bodies and assess the extent to which they have acted in accordance with the sustainable development principle when a) setting well-being objectives, and b) taking steps to meet those objectives.

The **Future Generation’s Commissioner** must promote the sustainable development principle.

This includes monitoring and assessing the extent to which public bodies are meeting their well-being objectives.

⁴ For more information see **Well-being of Future Generations (Wales) Act 2015** and **Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (2016)**.

◀ What we've done and why

Exhibit 2 – audit for future generations: What we've done and why

The duty 1

We must assess the extent to which 44 public bodies have acted in accordance with the sustainable development principle when **setting well-being objectives** and **taking steps to meet them**



The conversation 3

We ran a consultation with the public sector and wider stakeholders

We ran engagement sessions with staff and stakeholders

We worked closely with the Commissioner and her team

We ran a programme of nine pilots to help us co-create and test audit methods



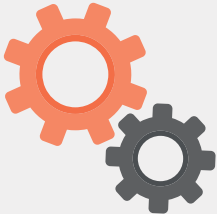
The challenge 2

Assessing 'ways of working'

44 bodies, that are very different!

Understanding how the sustainable development principle fits with value for money

Coordinating with and complementing the Commissioner's work



The ask from stakeholders 4


'You need to look beyond strategic planning and corporate arrangements and include a focus on more operational issues'

'You need to focus ways of working and take account of behaviours, rather than focusing on processes and arrangements'

'You should engage with a range of people – including partners and citizens'

'You need to work with the Commissioner so that you set consistent expectations and coordinate your activity'

'You need to avoid a focus on compliance and consistency'



Our commitment

5

Focus on the ‘five ways of working’

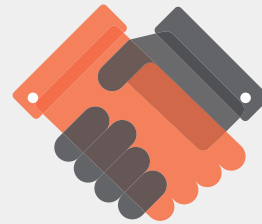
Focus on ‘how’ organisations are working, as well as ‘what’ they are doing

Help public bodies to self-reflect and explore what they could do differently

Capture narrative and seek the views of a cross-section of staff and stakeholders

Give early feedback

Encourage public bodies to develop their own actions in response to our findings



The delivery

6

We conducted 71 examinations in 2018-19 and 2019-20 at all 44 bodies

We looked at steps they were taking to meeting their well-being objectives

We looked at a diverse range of steps, including health and social care, economy and regeneration, healthy lifestyles, waste management, employment and skills

We published reports, which included actions the bodies committed to take in response to our findings

We have summarised the findings in this report, to be laid before the Senedd



The future

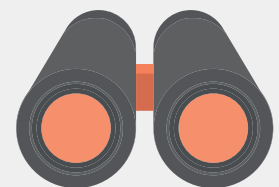
7

We are asking for and will respond to feedback from public bodies

We will integrate our sustainable development principle and value for money work

We will do more joint working with the Commissioner

We will continue to apply the sustainable development principle in the way we carry out our work



Our focus for the first reporting period, 2015-2020

- 5 This first reporting period under the 2015 Act has been unique. Public bodies (excluding Welsh Ministers) were required to publish their first well-being objectives part way through, by April 2017.⁵ They then needed some time and space to start delivering against those objectives. This meant that the time available for carrying out our examinations was shorter than it will be in future reporting periods.
- 6 We appreciate that applying the Act well, and doing that consistently, is difficult. Public bodies are still learning, and so we have aimed to strike a careful balance between support and constructive challenge in this first reporting period.
- 7 We have made sure that we covered the elements required by law, while being mindful of the total amount of audit work and the load this could place on public bodies. We therefore built our picture of how public bodies are applying the Act by carrying out some specific examinations, as well as gathering useful information from other audit work. In the first reporting period we have:
 - published an initial [report](#) **Reflecting on year one: How Have Public Bodies Responded to the Well-being of Future Generations (Wales) Act 2015?** which explored how public bodies were beginning to apply the Act and how they developed their first set of well-being objectives;
 - asked public bodies how they are embedding the Act more generally to help inform our overall understanding and the planning of future work;
 - gathered relevant information through our local and national studies; and
 - undertaken detailed examinations of how the sustainable development principle has been applied in relation to specific activities ('steps').
- 8 Our detailed examinations covered a variety of themes including health and social care, economy and regeneration, healthy lifestyles, waste management, employment and skills. **Exhibit 3** provides an overview of these themes. This has meant we have been able to report practical findings that provide insight and support service improvements.
- 9 This report gives an overview of the diverse findings, important themes and main learning points from those examinations, each of which contained our conclusions on how public bodies were applying the sustainable development principle.

5 Welsh Ministers were required to publish their well-being objectives six months after the Assembly election

Exhibit 3 – themes we examined across the 44 public bodies

| The steps we examined covered... | | |
|----------------------------------|------------------------|--------------------------|
| Digital | Natural environment | Schools & Youth Services |
| Public involvement | Health & social care | Leisure services |
| Antisocial behaviour | Service transformation | Healthy lifestyles |
| Partnership working | Housing | Arts & culture |
| Waste and recycling | Tackling poverty | Employment & skills |
| Strategic planning | Children & families | Economy & regeneration |

Working with the Future Generations Commissioner

- 10 The Commissioner must (among other things) ‘monitor and assess’ the extent to which public bodies are meeting their well-being objectives. This is closely related to what the Auditor General must do. In broad terms, the Auditor General must look at the way public bodies have **planned and carried out** their work, while the Commissioner must look at what they have **achieved**.
- 11 The Commissioner’s **Future Generations Report** must summarise the work she has undertaken and set out the improvements that public bodies need to make so that they can better apply the sustainable development principle.
- 12 We have worked closely with the Commissioner’s office while developing our two statutory reports. The findings in this report have helped to inform the recommendations the Commissioner has made in her report.
- 13 This report contains two recommendations; one to the Welsh Government and one to the Senedd (see **page 50**), but does not include a separate set of recommendations to the 44 public bodies. Our individual reports to each body identified areas for improvement, which they developed an action plan in response to. Setting another set of recommendations in this report would risk ‘recommendation overload’. As the Commissioner has set recommendations in her report, this means there is a single set of national recommendations for public bodies to focus on. This fits with the Auditor General’s and Commissioner’s previous commitments to set clear and consistent expectations of public bodies.



The implementation challenge: Is it getting easier?

- 14 Our year one report **Reflecting on year one: How Have Public Bodies Responded to the Well-being of Future Generations (Wales) Act 2015?** highlighted several constraints that make it difficult for public bodies to fully embed the Act and maximise its potential across their work. These included short-term funding, legislative and governance complexity and performance reporting (see **Exhibit 4**). These constraints provide important context to our findings on how public bodies are applying the sustainable development principle.
- 15 It is also reasonable to assume that if the constraints set out in **Exhibit 4** can be addressed, public bodies are likely to make more rapid progress in applying the Act. This is perhaps even more important, in the context of the major, complex challenges they will face in the next reporting period (see **page 48**). **If we want to see a greater rate of progress and increase public bodies' capacity to deal with the prevailing challenges, then these barriers need to be addressed.** The Welsh Government, the Commissioner and the Auditor General all need to play their part in helping to create the conditions for change.

- 16 The Welsh Government itself has multiple roles to play. Clearly, it is responsible for the legislation, issuing guidance and supporting its implementation. It is also itself bound by the legislation as one of the 44 bodies. In addition, it has a wider leadership role, which would include modelling the behaviours it expects from others, demonstrating how the Act can be applied and communicating that clearly. This means that the Welsh Government has a responsibility not only to address the barriers that are in its direct control, but also to help other public bodies implement the Act. This is particularly challenging for the Welsh Government, as it requires a comprehensive approach to applying the Act so that new policy, legislation and funding reflect the sustainable development principle (see **Exhibit 4**), and to do all of this ahead of other bodies. The leadership role should also include considering how it interacts with other public bodies and how it can best support the changes it wants to see.⁷ However, the Commissioner has criticised the resourcing and support the Welsh Government has put in place. In essence, to help other bodies to get it right, the Welsh Government must itself get it right.
- 17 The Commissioner and Auditor General can help by focusing on the right things, setting consistent expectations and not over-burdening public bodies with monitoring requirements. Both also have a role in promoting good practice and supporting learning and improvement. Our two offices have worked together closely to try to achieve this, but we recognise more can be done. We will continue to strengthen the co-ordination of our work in the next period.
- 18 Audit Wales' examination methodology was designed to respond to the concerns and requests from public bodies and other stakeholders. We restate our own commitment to ensuring our approach helps drive the right behaviours and supports, rather than impedes, progress.

“ The Welsh Government has not sufficiently resourced the implementation of the Well-being of Future Generations (Wales) Act in terms of leadership development, support for transformational change and delivering the infrastructure required by the Act; both within their own organisation and the organisations they sponsor.

Future Generations
Commissioner for Wales⁶

6 Future Generations Commissioner for Wales, **Progress towards the Well-being of Future Generations Act**, October 2019

7 See also our summary and supplementary reports on **The Well-being of Young People**, September 2019.

Exhibit 4 – barriers to progress, as identified by public bodies in 2017 and how things have changed since

| Then... | ...Now |
|---|--|
| <p>Public bodies were clear that short term funding hampers their ability to plan effectively over the long term. Some sponsored bodies stated that the annual remit letter poses the same challenge. Linked to this, public bodies cited a lack of flexibility over how grant funding can be spent and disproportionate monitoring requirements as inhibiting long term planning and a focus on outcomes.</p> | <p>Short term funding and late notifications remain a reality. There are some examples of grants being merged and flexibility being increased. The Commissioner is recommending that, starting with Welsh Government, financial planning should move to a model of well-being budgets and remit letters to national bodies should be reformed so that they are set in a longer-term context.⁸</p> |
| <p>Some bodies described the challenge of legislative complexity and the difficulty of joining-up statutory requirements in practice. Specifically, they referred to the need to find a practical means of meeting the requirements of the Act whilst also meeting the requirements of the Social Services and Well-being (Wales) Act 2014, the Environment (Wales) Act 2016 or planning policy and legislation.</p> | <p>This remains a practical challenge. Our national studies have identified references to and consideration of the Well-being of Future Generations Act as part of the development of national policy. However, we have seen examples of policy, guidance and legislation making only marginal or unclear references to the Act.</p> |
| <p>There were some concerns about existing national reporting requirements and a focus on indicators, which were considered to detract from a focus on long term outcomes and preventative benefits. A few bodies expressed concerns that audit and regulatory requirements could drive a focus on compliance with a process, rather than promoting the spirit of the Act.</p> | <p>There have been some changes in national reporting requirements for local authorities, who are no longer required to report on national performance measures. However, national performance measures in health are based on the performance of acute services. The Commissioner is considering undertaking a review to explore this.</p> |
| <p>Public bodies highlighted some challenges that need to be overcome if Public Services Boards are to be as effective as intended. These included; the complexity of the partnership governance environment, some potentially influential partners not being engaged, different levels of commitment and different ways of working.</p> | <p>The debate on partnership governance in Wales continues, informed by various published reviews since devolution in 1999. The Local Government and Elections (Wales) Bill potentially adds to an already complex and crowded partnership environment by creating statutory Joint Committees.</p> |

What we found

This section covers

- **Setting the first well-being objectives:** Our findings on how public bodies set their first well-being objectives, taken from our 2018 [report **Reflecting on year one: How Have Public Bodies Responded to the Well-being of Future Generations \(Wales\) Act 2015?**](#)
- **Taking steps to meet well-being objectives:** An overview of our findings on how public bodies have taken steps to meet their well-being objectives, based on the examinations we undertook in 2018-19 and 2019-20.

Setting the first well-being objectives: Findings from our 2018 report

- 19 We explored how public bodies had set their first well-being objectives in our 2018 report. We found that most public bodies had set their first objectives in 2017 and were able to provide some examples of how they applied the five ways of working as part of that process.

Challenges

- 20 We reported in 2018 that publishing well-being objectives had posed some difficulties for public bodies. The Act prescribed a challenging planning timetable and, of course, none of the 44 bodies was starting with a blank sheet. Some were required to publish their first well-being objectives mid-way through an existing planning cycle. Local authorities, fire and rescue authorities and national park authorities had to meet the requirements of the Local Government (Wales) Measure 2009, but the Act also required them to publish well-being objectives shortly before the local elections. Individual bodies were required to publish their objectives before Public Services Boards (PSBs) and this was also highlighted as a barrier to integration by some.

- 21 Public bodies took different approaches to aligning or integrating their well-being objectives with existing strategies and corporate objectives. Our 2018 report identified that in 2017 most public bodies had developed well-being objectives that either added to or replaced their previous corporate objectives. A few chose not to set well-being objectives by the statutory deadline and others said that they intended to revise them soon after setting them.
- 22 Where public bodies had not integrated their well-being and corporate objectives, it was sometimes unclear how their various objectives related to each other, or fitted with their corporate planning processes, performance measures and budget setting. This was despite clear guidance that corporate planning (and corporate plans where relevant) should be the mechanism for setting well-being objectives.⁹

Applying the sustainable development principle

- 23 For our 2018 report, we asked public bodies how their process for setting well-being objectives had differed from how they had set corporate objectives in the past. Most told us it had been different, but often failed to give a detailed explanation of ‘how’ or give examples of how they had used all of the five ways of working. Where they did give examples, these tended to relate to collaboration, involvement or integration.
- 24 Most local authorities said that they had drawn on work they had done in **collaboration** through the PSBs to help them develop their well-being objectives. They described how they had used the PSBs’ well-being assessment as part of their evidence base, as did some health bodies.¹⁰
- 25 Most local authorities made reference to how they had engaged the public in developing their well-being objectives. It was not always clear how this differed from engagement and consultation they had undertaken in the past and made the shift to **‘involvement’**. Some described how they had drawn on the engagement undertaken by the PSB as part of the development of the well-being assessment. However, our recent **Review of Public Services Boards** [report](#) found that:

‘Whilst engagement activity has been time consuming and extensive it has nonetheless tended to follow traditional approaches focused on informing rather than involving people and consequently falls short of meeting the new expectations of the Act.’¹¹

9 Welsh Government **‘Shared Purpose: Shared Future’ – statutory guidance on the Well-being of Future Generations (Wales) Act 2015**, 2016

10 PSBs are required to prepare and publish an assessment of well-being under section 37 of the Act.

11 Auditor General for Wales, [Review of Public Services Boards](#), October 2019

- 26 Most health bodies said they had engaged internal and external stakeholders as part of the process of developing their well-being objectives, though few referred to engaging the public (beyond drawing on the results of any engagement included in the well-being assessment). A few said they intended to undertake greater involvement when they revised their well-being objectives.
- 27 Similarly, the Welsh Government and sponsored bodies tended to involve staff and stakeholders in the development of their well-being objectives and some stated that they had involved a wider circle than they had in previous years. However, only a few of these bodies directly involved the public in developing their well-being objectives, though others went on to launch large-scale public engagement processes.
- 28 Some public bodies said that they had taken a more **'integrated'** approach by involving people from different backgrounds and disciplines, who had helped them think more broadly about their work. While public bodies may feel that they have improved the process, this did not necessarily result in objectives that reflected all the aspects of well-being. The Commissioner found that:
- 'Overwhelmingly, objectives have a focus on improving the economic and social well-being of localities, with little emphasis on the environment or culture.'¹²
- 29 We received limited information on how public bodies had considered the **long term** when setting their well-being objectives. There was even less information on **prevention**. Some of this had been drawn from well-being assessments, though the Commissioner also highlighted weaknesses in the information those assessments included on long-term trends. There were, however, references to preventative activities in plans. These included references to delivering the Social Services and Well-being (Wales) Act 2014. Notably, fire and rescue authorities emphasised that prevention is a well-established and successful way of working for them and gave examples, such as work with health and police partners on falls prevention and home fire safety.

12 Future Generations Commissioner for Wales, **Well-being in Wales: The journey so far**, May 2018.

-
- 30 While public bodies may have felt they applied the five ways of working, it was not always clear how the process was different or what changed as a result. The Commissioner's analysis also highlighted that:
- 'At the moment, public bodies are committing to well-being objectives that largely resemble the corporate objectives they would have set prior to 2017.'¹³
- 31 In our recent work, we identified the need for a few public bodies to clarify how they were going to deliver and monitor progress towards their well-being objectives. This included two public bodies that had set well-being objectives without setting out the steps they would take to meet them. As this is necessary for them to meet their statutory obligations, we reported it to those bodies.
- 32 We will conduct further work on the setting of well-being objectives in the next reporting period and we will be looking to see full and meaningful consideration of all five ways of working.

Taking steps to meet well-being objectives

The following sections set out findings from our examinations of specific steps that public bodies are taking to meet their well-being objectives, and how they applied the five ways of working. They also include some references to our other published reports. There are some case studies from Wales which are designed to illustrate effective application of the five ways of working. There are also some case studies from beyond Wales, which we hope are helpful resources.

Long-term



Why it's important: Planning for the long term is at the heart of the Act. If public bodies do not look ahead and balance what they need to achieve today with what they and future generations need to achieve in the future, they risk reducing well-being and increasing costs over the long term.

The expectation¹⁴

Public bodies must...

Take account of balancing short-term needs with the need to safeguard the ability to meet long-term needs, especially where things done to meet short-term needs may have detrimental long-term effect.

Public bodies could demonstrate this by...¹⁵

- Having a clear understanding of 'long term', in the context of the Act.
- Designing actions to deliver well-being objectives and contributing to long-term vision.
- Designing actions to deliver short or medium-term benefits, balanced with long-term impact.
- Designing actions based on a deep understanding of current and future needs, trends and pressures.
- Having a comprehensive understanding of current and future risks and opportunities.
- Allocating resources to ensure long-term, as well as short-term, benefits.
- Focusing on delivering outcomes and, where this is long term, identifying milestone steps.
- Being open to new ways of doing things which could help deliver benefits over the longer term.
- Valuing intelligence and pursuing evidence-based approaches.

¹⁴ Expectations are set out in section 5 of the Act and associated statutory guidance.

¹⁵ These 'positive indicators' were developed through our pilot work with public bodies.

What we found: Our work identified many examples where public bodies had thought about what they want to achieve over the long term. In the next reporting period, public bodies will need to undertake more sophisticated planning for the future, informed by a rounded understanding of both current needs and future trends and supported by appropriate measures of progress and impact.

Understanding the present and the future

- 33 Clearly, public bodies can't predict the future with complete certainty. But we do expect to see them thinking about the future and engaging with uncertainty. That means better understanding needs, risks and opportunities as they are now and exploring how they could play out over the long term. It means being clearer about what they want the future to look like and what they can do to get there. There are a number of tools that can help them do this.
- 34 Linked to this, the definition of long term under the Act goes beyond simply 'thinking about the future'. It requires public bodies to think about balancing what they want and need to achieve now, with what they or future generations will want or need to achieve over the long term.
- 35 We found that many public bodies had a reasonable understanding of current needs and demand pressures. Some were also able to describe how demand and other pressures were likely to change over time. They were using performance data, the results of consultations and local research, such as population needs assessments and well-being assessments, to help them understand the needs of people and places.¹⁶
- 36 While some public bodies could describe some of the likely changes in demand and the factors that might affect it, we found limited examples of forecasting and scenario planning. We identified opportunities for public bodies to think about how wider intelligence and trends might impact on what they were seeking to achieve. They need to think about the connections between social, economic, environmental and cultural trends, rather than focusing only on those that are most obviously and directly related. They also need to ensure they update their trend analyses, as appropriate.¹⁷

¹⁶ Regional Partnership Boards are required to produce a Population Needs Assessment under the Social Services and Well-being Act.

¹⁷ See also Future Generations Commissioner for Wales, **Progress towards the Well-being of Future Generations Act**, October 2019.

37 The Commissioner previously highlighted weaknesses in well-being assessments because they:

‘... did not meaningfully consider the long-term, future trends or multigenerational policy challenges’ and ‘implicit messages from the data needed further exploration to better understand the causes and effects of key issues and trends’.¹⁸

If well-being assessments are to be an important source of evidence for public bodies to continually draw upon, then PSBs will need to strengthen their information on future trends. The Welsh Government’s forthcoming Future Trends report should provide a valuable source of information for public bodies across Wales. Inevitably, all public bodies will need to reconsider medium and long-term trends as they begin responding to the aftermath of the global pandemic.

Case study – Gwent Futures Report

In March 2018, Ash Futures published its horizon scanning report for the Gwent area Public Services Boards (PSBs). It described the global and local trends and what they might mean for the people, business and the environment of Gwent over the next 10 to 20 years.

They used the ‘three horizons model’, which explores external factors in a) the present b) the less near future and c) the medium to long term. Whilst this work recognises the inherent unpredictability of the future, it also provides a helpful baseline from which to ask questions.

For more information on the Gwent Futures Report please follow this [link](#)

18 Future Generations Commissioner for Wales, **Well-being in Wales: Planning today for a better tomorrow**, 2017.

Planning for the future

- 38 We found a few notable examples of public bodies setting out and working towards a genuinely long-term vision, looking 10 or more years ahead. This should help guide the actions and decisions they take in the short and medium term. The Commissioner also notes that well-being objectives tend to be long term.¹⁹ We also saw a few examples of public bodies appraising the risk and benefits of projects over the very long term, for example 40 to 60 years.
- 39 More typically, we saw public bodies were planning to deliver activities over the short and medium term. But this didn't mean they weren't thinking further ahead. We found many examples of public bodies thinking about what they wanted to achieve over the long term, though we highlighted that some of those activities were disadvantaged by the lack of a clear long-term vision, actions, resources and measures. Overall, we saw more evidence of long-term thinking than long-term planning.
- 40 We also highlighted opportunities for public bodies to work together more to plan for the future. This would help them explore interconnected issues and work towards shared, long-term outcomes that tackle the root causes of problems.
- 41 Some public bodies were clear about how they would measure progress and impact over the long term. This was often not the case and we challenged many public bodies to think about how they could do this. We understand this can be difficult; different partners are involved in delivery, outcomes can be difficult to measure and it can be resource intensive. Nevertheless, it is important to be clear about what they want to achieve over the long term and whether they are on track to achieve it (see also '**prevention**').

Natural Resources Wales (NRW) is facilitating the development of a shared vision for the natural environment in Wales to 2050. NRW will monitor the natural environment in Wales through its State of Natural Resources Reports (SoNaRR) looking at Wales as a whole, together with medium-term performance measures and short-term annual targets to monitor NRW's own contribution.

[View the report here.](#)

A view from the auditor

It's positive to see that public bodies are thinking about what they need to do to improve well-being over the long term. To make that a reality, they need to be clear about what they want to achieve, how they will deliver, resource and measure it and over what time horizon. We want to see evidence of long-term thinking that is informed and supported by long-term planning.

Investing for the future

- 42 Public bodies need to think about the resources they need to deliver improvements in well-being over the long term. They need to think about how risks and opportunities could shape their investment decisions, as well as the impact that using resources now is likely to have on the resources that are available in future. This means thinking about financial sustainability and value over the long term and how costs might be avoided by taking preventative action.
- 43 We saw many public bodies investing for the medium and long term by building capacity, developing specific expertise and investing core or grant funding. We saw that public bodies were often redesigning services so that they would better meet need and be financially sustainable over the medium to long term. However, where public bodies were relying on grant funding there were concerns about long-term sustainability and development of 'exit strategies' (see also '**prevention**').
- 44 Many public bodies are grant funders, as well as grant recipients. We found a few examples of public bodies working to give the organisations they fund more certainty or encourage them to plan for the long term.

Things for public bodies to think about...

- Developing a more sophisticated understanding of the different factors that will shape the future and what this might mean.
- Being clear about what they want to achieve over the long term and how they will measure progress and impact.
- Investing resources to deliver well-being over the long term.



Prevention



Why it's important: Prevention is about protecting the well-being of people and places by building capacity, stopping problems from occurring or worsening. It's also about using resources in a smarter way and, ultimately, delivering better value as well as better well-being.

The expectation

Public bodies must...

Take account of how deploying resources to prevent problems occurring, or getting worse may contribute to meeting the body's well-being objectives, or another body's objectives.

Public bodies could demonstrate this by...

- Seeking to understand root causes of problems so that negative cycles and intergenerational challenges can be tackled.
- Seeing challenges from a system-wide perspective, recognising and valuing long-term benefits they can deliver for people and places.
- Allocating resources to preventative action likely to contribute to better outcomes and use of resources even where this may limit the ability to meet some short-term needs.
- Having decision-making and accountability arrangements that recognise the value of preventative action and accept short-term reductions in performance and resources in the pursuit of improved outcomes and use of resources.

What we found: Public bodies are thinking preventatively, but are sometimes missing opportunities to deliver and measure system-wide preventative benefits.

Thinking preventatively

- 45 We examined some activities that had been designed with prevention in mind. For example, projects to reduce ecosystem decline, improve health and well-being and ensure that children have the best start in life.

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- 46 We also examined activities where prevention was not the foremost consideration but could still help to deliver wider preventative benefits. For example, town centre regeneration could be designed to improve the local economy, but could also promote active travel, improve air quality and improve health and well-being. In these cases, public bodies were often aware of the potential wider benefits, but they were not always planning to deliver or measure them.
- 47 We found that public bodies were sometimes missing opportunities to identify preventative benefits and to make the connections between their work and the outcomes that other bodies were seeking to achieve. Prevention cannot be the responsibility of one service or organisation and may require innovative thinking that connects different parts of the system. For example, actions undertaken by leisure or culture services could reduce demand for social care and health. Public bodies will need to integrate different agendas and work with a broader range of partners to deliver wider preventative benefits. This will enable them to focus their efforts far upstream so they can undertake ‘primary’ prevention.²⁰

²⁰ The Commissioner has agreed a definition of prevention with the Welsh Government that is based on four tiers; primary prevention, secondary prevention, tertiary prevention and acute spending. See the **Future Generations Report** for further information.

Understanding the root causes of problems

- 48 Some bodies were able to describe the reasons that certain problems were occurring or getting worse. For example, the connection between physical activity and health and mental health or the importance of early years and outcomes later in life. Public bodies often drew on national research for this, combined with local data and a few commissioned their own research.
- 49 We did identify several opportunities for public bodies to deepen their understanding of the root causes of problems. They need to understand the reasons behind an issue and how it might have developed over time, in some cases over multiple generations.
- 50 We know that comprehensive analysis of root causes can be technically challenging and time-consuming and might not always be feasible. However, public bodies can delve into root causes by working with partners, service users and the public to understand the factors affecting people's lives, ask why they are choosing not to take part in an activity or service or why interventions have not been successful. They can gather information that helps them interpret research in their local context. Understanding root causes, and having a common understanding, is important if public bodies are going to work together in a system-wide approach to prevention.

Investing in prevention

- 51 We found many examples of public bodies investing in prevention; often through leveraging external funding and making smarter use of existing resources. They were accessing grant funding, drawing funding streams together and adapting roles and responsibilities to help deliver preventative benefits.²¹

The Higher Education Funding Council for Wales' 'Learning Analytics Cymru' project will collect and analyse retrospective and real-time student data to help improve student support and learning outcomes. The analysis of learning patterns will also provide anonymised nationwide insights into:

- a) what causes different educational outcomes for students;
- b) the success or otherwise of student support interventions; and
- c) tracking improvements in learning and teaching on individual programmes.

View the report [here](#).

21 For information on the shift towards preventative delivery in adult social care, please see our report **The 'Front Door' to Adult Social Care**, September 2019.

- 52 Public bodies were often proactively seeking grant funding to help make a shift to more preventative models and deliver long-term, preventative benefits. But they often lacked a plan for sustaining the work when the funding had ended.
- 53 One source of funding for health and social care is the Integrated Care Fund; many of the projects focus on prevention and earlier intervention. Our [report](#) on the fund found that while there has been a clear expectation from the Welsh Government that effective projects should be mainstreamed into core budgets, funding pressures have made that difficult. Many have effectively become core services and regional partners may have to make some difficult decisions to disinvest from some services.²²
- 54 Public bodies find it difficult to redirect core resources to deliver new, preventative delivery models. Reasons include rising demand pressures, core funding constraints and performance monitoring that focuses on outputs. However, they need to consider how best to sustain or mainstream activities that are likely to help manage demand over the long term. Over time, public bodies will need to make a more extensive and fundamental shift to preventative working that connects different parts of their organisations and their partners. We will explore this further in future work, including through our planned thematic review of ‘prevention’ across local government in 2020-21.



A view from the auditor

Examining investment in prevention is an important way for us to understand whether and how public bodies are delivering value for money in the present and over the longer term. Our future examinations will explore whether they understand cost and benefits over time and whether these are informing the difficult choices they will inevitably face.

Measuring prevention

- 55 We saw that some public bodies had developed, or were developing, ways of measuring prevention. This included measuring the wider impact, such as in Cardiff where targets have been set to measure interventions to address poor air quality (for further information see [page 46](#)). It also included measuring the difference a service has made to individuals (see ‘**Connect**’ case study below).

56 For most of the steps we reviewed, public bodies had not identified a way of measuring the impact of prevention. This is difficult, but public bodies should consider how best to measure impacts on individuals, and how their efforts add up to overall improvements in well-being. This would help build the evidence base for preventative work, inform decisions about resources and strengthen the case for external funding, particularly when wider benefits are being delivered. This also needs to be a collective endeavour; public bodies can only really plan for and measure the impact of prevention across the delivery system. Benefits delivered by one partner may reduce demand for another. This underlines the importance of linking prevention with integration.

57 Furthermore, to work preventatively and improve well-being, public bodies need to understand what well-being means to individuals. This underlines the importance of linking involvement with prevention.²³

Working with key partners and using data, Mid and West Wales Fire and Rescue Authority's Arson Reduction Team spent time understanding the unique nature of the arson problem in the area. This included understanding the cyclical pattern of incidents, identifying the key community leaders, a lack of trust in emergency services, and a cultural acceptance of arson attacks as 'the norm'.

Things for public bodies to think about...

- Taking opportunities to work with others to deliver a broader prevention agenda.
- Measuring the impact of prevention.
- Investing in prevention and making sure that preventative benefits can be sustained.
- Exploring with the Welsh Government how preventative spend could best be supported and incentivised.



²³ See also our summary and supplementary reports on **The Well-being of Young People**, September 2019.

Case study – Oldham warm homes

The Warm Homes Oldham scheme was set up by Oldham Council, NHS Oldham Clinical Commissioning Group and Oldham Housing Investment Partnership (OHIP) in 2013. It offers advice, support and energy saving measures to residents in fuel poverty.

Sheffield Hallam University have evaluated this programme, considering savings to the NHS as well as wider economic benefits, using self-reported health outcomes. An investment of £250,000 per year from Oldham CCG resulted in a monetary benefit from an increase of Quality Adjusted Life Years (QALYs) of between £399,000 and £793,000 depending on the method used. The study reported £178,000 of extra GDP due to higher employment rates, £37,700 of extra GDP due to reductions in sickness absence, and £137,300 of reductions in benefits claims.

Source: Ashden Consulting, [A toolkit for city regions and local authorities: Chapter 2 Health and Well-being.](#)

Case study – New Connect: Weight Management Service for Children and Young People, Aneurin Bevan University Health Board

In May 2019, the Health Board launched ‘Connect’, a new Gwent-wide team of health care professionals working together to support children, young people and their families, to improve their physical and emotional health and to treat the complications of obesity. It was developed as a partnership between physical and mental health services.

The service was designed with a long-term, preventative focus. Staff worked collaboratively to identify the cost of obesity, as well as to estimate the current and future demand for the specialist service, service capacity and required resources both finance and workforce. They evaluated the resources used to provide care for children and young people with obesity to identify how much could be reinvested in the new service.

The Health Board worked with a range of partners to map services and resources for tackling obesity, for example in relation to physical activity and access to healthy affordable food choices. Connect is helping to shape a whole-systems approach to tackling childhood obesity. For example, Connect is linking with Health Visiting teams implementing the Healthy Child Wales Programme and the School Health Nursing Service, which undertakes the childhood measurement programme.

An outcomes framework was developed alongside, to inform service delivery and improvements, to monitor clinical outcomes and to understand the impact and experience of children and their families. Measures include specially developed patient (child) reported outcome measures, patient (child) experience measures and quality of life measures.

Developing a new service (the first in Wales) required trust, risk-taking and support from senior leaders within the organisation to commit resources where outcomes may not be evident in the short term.

View the report [here](#).

Integration



Why it's important: Integration requires public bodies to take a different perspective; one that considers social, economic, environmental and cultural well-being in combination. Thinking in an integrated way will help public bodies balance different factors, identify a broader range of benefits and work in a more co-ordinated way. It should also facilitate preventative work.

The expectation

Public bodies must...

Consider how the body's well-being objectives may impact on each other, on other public bodies' well-being objectives and on the well-being goals.

Public bodies could demonstrate this by...

- Everyone understanding their contribution to delivering the vision and well-being objectives.
- Everyone understanding what different parts of the organisation do and seeking opportunities to work across organisational and public sector boundaries.
- Everyone recognising that achieving the vision and objectives depends on working together.
- Having an open culture where information is shared.
- Gaining a well-developed understanding of how the well-being objectives and steps to meet them impact on other public sector bodies.
- Proactively working across organisational boundaries to maximise their contribution across the well-being goals and minimise negative impacts.
- Having governance structures, processes and behaviours that support this.

What we found: Public bodies can often describe connections between their objectives, their partners' objectives and the national goals. However, there are further opportunities for integration to add value and help deliver wider benefits.

Making the links

- 58 Public bodies were often able to describe some of the connections between their work and the national goals or, in more general terms, how they might improve social, economic, environmental or cultural well-being.²⁴ Many public bodies had formally documented the contributions and connections (see **paragraphs 65 and 66**).
- 59 We also found many public bodies aligning activity to other public bodies' plans and PSBs' well-being plans. We found good examples of joined-up planning with partners, often based on a good understanding of their objectives in related areas of activity. However, there were many other examples where we highlighted the need to develop or strengthen these links or to extend the range of organisations and issues public bodies were considering.
- 60 Many public bodies told us how what they were doing was helping to deliver their own well-being objectives. They could describe how those activities related to different parts of their business and we found some good examples of cross-organisational working. For example, Newport Council recognised that their city centre regeneration required a whole-system approach, linking environment, community safety and health and well-being. This demonstrated the council's consideration of impact on a number of different objectives.
- 61 Departments (in the same organisation) and partner organisations were often making important connections in areas where there is a clear need for integration; for example, health and social care, social care and housing, education and leisure. However, we also identified many examples where internal integration could be strengthened. There are opportunities for public bodies to challenge themselves to make the less typical connections and think more systematically about the range of potential positive and negative impacts on their own and their partners' well-being objectives.²⁵

24 See also our report, **The Effectiveness of Local Planning Authorities in Wales**, June 2019.

25 See also Future Generations Commissioner for Wales, **Progress towards the Well-being of Future Generations Act**, October 2019.

Case study – Sport Wales: understanding sport and well-being

Sport Wales commissioned the Sport Industry Research Centre (SIRC) at Sheffield Hallam University to conduct research on the overall impact that sport has on well-being. The research explored the value (or social return on investment) that sport has to the nation and the contribution that it can make towards health, crime, education, social cohesion and overall well-being.

Read our report [here](#).

Understanding and valuing integration

- 62 Integration is central to the Act. Public bodies will need to take it seriously if they want to use the Act to add value to their work.
- 63 It has a unique focus under the Act. It requires public bodies to think about social, economic, environmental and cultural well-being in combination. Public bodies that work in this way will take a wider view and ensure coherence between their own activities and the work of others. Integration is a precursor to effective collaboration and can facilitate a system-wide response, which enables public bodies to work preventatively. Ultimately, it enables them to deliver a broader range of benefits for people and places.
- 64 We found that ‘integration’ is still sometimes misunderstood as being ‘service integration’ or ‘joint working’ between organisations. This is partly a result of the language used in the Social Services and Wellbeing (Wales) Act 2014.
- 65 It is important that public bodies properly consider and can demonstrate integration. We highlighted opportunities for public bodies to more clearly and explicitly show these links.

- 66 However, there is a risk that integration can be approached as a bureaucratic exercise, mainly focused on showing the links between steps and well-being objectives or the national goals. Retrofitting or cosmetic alignment of objectives and actions is both a missed opportunity and a waste of time.



A view from the auditor

With integration, seeing the links is important but we need to ask the ‘so what?’ question. Clear links between strategic documents are good to see, but what practical differences do they make, how are they shaping the thinking and what is going to be different as a result?

Case study – Nottingham Good Food Partnership: improving health and cutting the carbon footprint of food

The Nottingham Good Food Partnership is part funded by Nottingham City Council. It is a growing coalition of over 50 member organisations working together to transform the sustainability of Nottingham’s local food system.

As part of the Sustainable Food Cities (SFC) Network, the Partnership aims to improve the health and well-being of all and to create a more connected, resilient and sustainable Nottingham.

It is addressing several key issues including:

- promoting the importance of healthy and sustainable food to the diverse local communities;
- working towards a circular food economy;
- radically reducing the ecological footprint of the food system; and
- aiming for zero edible food waste.

Source: Ashden Consulting, [A toolkit for city regions and local authorities: Chapter 2 Health and Well-being](#)

Case study – Building a greener and fairer Scotland

The Scottish Government has set up a ‘Just Transition Commission’ to advise Ministers on how ‘just transition principles’ can be applied to climate change action in Scotland. The aim is to help ensure that climate targets can be met, whilst also considering the economic and social impacts of climate action:

‘The imperative of a just transition is that Governments design policies in a way that ensures the benefits of climate change action are shared widely, while the costs do not unfairly burden those least able to pay, or whose livelihoods are directly or indirectly at risk as the economy shifts and changes.’

The Commission’s interim report can be viewed [here](#). It will share its final recommendations with the Scottish Ministers by January 2021.

Things for public bodies to think about...

- Being clear about what integration means and how they can use it to add value to their work.
- Challenging themselves to expand their thinking so that they better understand how they can take every opportunity to improve the social, economic, environmental and cultural well-being of Wales.



Collaboration



Why it's important: Collaboration is a longstanding feature of policy and service delivery in Wales. Thinking about collaboration alongside the other ways of working helps define why it's important and what it can achieve. By working together public bodies can have a wider impact, tackle the root causes of problems and prevent them from occurring in future.

The expectation

Public bodies must...

Take account of how collaborating with others could assist the body to meet its well-being objectives, or assist another body to meet its objectives.

Public bodies could demonstrate this by...

- Focusing on place, community and outcomes not organisational boundaries.
- Understanding partners' objectives and their responsibilities, which helps to drive collaborative activity.
- Having positive and mature relationships with stakeholders, where information is shared in an open and transparent way.
- Recognising and valuing the contributions that all partners can make.
- Seeking to establish shared processes and ways of working, where appropriate.

What we found: There are many positive examples of collaboration, but we identified opportunities for public bodies to work with a broader range of partners to increase impact. They could also continue to strengthen their collaborations by reviewing their effectiveness and applying the learning.

Working with the right partners

67 We found many examples of public bodies working with key partners to deliver shared outcomes. In some cases, this was an extensive range of partners, often co-ordinated through the PSBs and in some cases with regional partners through the Regional Partnership Boards (RPBs) or city region and growth deals. However, we did identify valuable opportunities for public bodies to work with different partners (both internal and external) to increase and broaden their impact (see also 'integration' and 'prevention').

- 68 We identified a good degree of trust, mutual respect and shared understanding between partners for many of the examples we reviewed. These public bodies described how they valued their partners and recognised the need to work with others to deliver better outcomes.
- 69 We saw examples of joined-up delivery, including through shared processes, co-located and multi-agency teams and multi-agency steering groups. However, we found some instances where under-developed processes were getting in the way. Examples include unclear roles and arrangements, lack of common vision and data sharing challenges.
- 70 A significant amount of partnership working is coordinated through the PSBs. However, our **‘Review of Public Services Boards’ report** found that inconsistent attendance and a sense among some third sector representatives that the agenda is owned by the local authority were seen to reduce effectiveness and collective ownership. The review also found that PSBs invite a wide range of organisations to participate but there were opportunities to involve other partners, including from the private sector and faith groups.²⁶



A view from the auditor

We have continued to look at arrangements – they will always be important – but effective collaboration relies on **relationships** and **trust**. We’ve explored both in these examinations and we’ll continue do so in future work.

Resourcing collaboration

- 71 This report has already set out some of the challenges associated with grant funding (see **‘prevention’**). Our review of PSBs highlighted that resources and capacity are key risks and PSBs feel there is a need for a dedicated PSB funding stream.²⁷
- 72 RPBs can access funding through the Integrated Care Fund. Our 2019 **report** on the fund found that it has ‘helped bring organisations together to plan and deliver services’. However, it also found that short-term funding horizons hampered regional delivery.²⁸

26 Auditor General for Wales, Review of Public Services Boards, October 2019.

27 Ibid.

28 Auditor General for Wales, **Integrated Care Fund**, July 2019.

- 73 The disparity in resourcing these two related partnerships has also been identified as an issue by the Commissioner, who reported that it has:

‘...meant that the attention of Health Board staff is often diverted from the work of Public Services Boards to Regional Partnership Boards, where the scope of improving well-being is more limited’.²⁹

This is due to the PSB having broader representation and the potential to influence the wider determinants of health.³⁰

- 74 Some public bodies can also struggle with the capacity to work in partnership, both at a strategic and operational level. Our ‘year one’ report highlighted the difficulties that smaller bodies and national bodies face when engaging with PSBs.

Assessing the impact and effectiveness of collaboration

- 75 We found that some public bodies needed to ensure they could assess the impact of an activity and progress towards well-being objectives. However, the challenges of measuring long-term, preventative impacts that have already been outlined clearly also relate to measuring the impact of collaborative activities.
- 76 We also highlighted opportunities for public bodies to assess the effectiveness of their collaborative activity. We saw a few examples of public bodies doing this through citizen stories, scrutiny and formal evaluation. Public bodies need to understand whether their collaborations are delivering what was originally intended, whether they are still fit for purpose and how they can strengthen partnership working in future.
- 77 Our review of PSBs found that scrutiny arrangements were ‘too inconsistent and variable’, and that ‘despite some positive and effective work to embed and make scrutiny truly effective, more work is required to ensure a consistent level of performance and impact’.³¹
- 78 Similarly, our report on the Integrated Care Fund found that ‘despite some positive examples, the overall impact of the fund on improving outcomes for services users remains unclear’.³²

29 Future Generations Commissioner for Wales, **Progress towards the Well-being of Future Generations Act**, October 2019.

30 Future Generations Commissioner for Wales, **Future Generations Report**, May 2020.

31 Ibid.

32 Ibid.

Case study – North Powys Well-Being Programme, Powys County Council and Powys Teaching Health Board

The North Powys Wellbeing Programme (NPWBP) is focused on the development of a new integrated delivery model in North Powys. It brings partners together across health, social care and the third sector with linkages to education, housing, leisure, police and ambulance services.

The scope of the NPWBP includes working with local communities to co-design, test and deliver a new integrated model to a rural population. The programme has taken a robust and innovative approach to gathering and visualising Health and Social Care data. An example of this is the Well-being Information bank, and the North Powys Population Assessment which is available online [here](#). The intention is to use the visualised data to help engage stakeholders and citizens in the development of the NPWBP.

View the report [here](#).

Case study – Greater Manchester Combined Authority (GMCA): Cost Benefit Analysis Tool for Partnerships

The GMCA is made up of ten local authorities and the Mayor of Greater Manchester, who work with other partners, and serve a city region of 2.8 million people. The GMCA has also had a series of ‘devolution deals’, giving the region more powers and control of budgets.

The GMCA sought to develop a rigorous means of understanding how benefits – whether to the public, the public purse, the planet or the wider economy – are likely to be accrued by different organisations and communities. The GMCA worked with New Economy to produce its ‘Partnerships Cost Benefit Analysis’ (CBA) model, which helps them consider the value for money offered by different interventions that might otherwise be difficult to compare. It quantifies economic benefits and social benefits, including improved health and well-being. It helps inform decisions by showing how money flows between organisations that invest and those that accrue the benefits.

The CBA model has been used by different sectors and applied to different issues. For more information follow this [link](#).

Things for public bodies to think about...

- Working with the appropriate range of partners to ensure they can deliver a wider range of benefits, including system-wide approaches to prevention.
- Assessing the effectiveness of collaboration, determining whether it is delivering intended outcomes and using the learning to help them improve.
- The Welsh Government should consider how it can better incentivise and enable public bodies (including via funding flows) to work together to deliver national strategic priorities.³³



³³ See also recommendation 3 in our Review of Public Services Boards report.

Involvement



Why it's important: Involvement can help public bodies understand what people might need and want now and in the future; how they can effectively tackle the root causes of problems; and how they can identify opportunities to deliver a broader range of benefits.

The expectation

Public bodies must...

Take account of the importance of involving people with an interest in achieving the well-being goals and ensuring they reflect the diversity of the population.

Public bodies could demonstrate this by...

- Understanding who needs to be involved, and why.
- Reflecting on how well the needs and challenges facing those people are currently understood.
- Working co-productively with stakeholders to design and deliver.
- Seeing views of stakeholders as vital information to help deliver better outcomes.
- Ensuring the full diversity of stakeholders is represented and that they are able to take part.
- Having mature and trusting relationships with its stakeholders.
- Sharing with stakeholders in an open and transparent way.
- Ensuring stakeholders understand the impact of their contribution.
- Seeking feedback from key stakeholders which is used to help learn and improve.

What we found: Public bodies are often not creating opportunities for citizens to be involved from the early stages of design through to evaluation and they need to do more to involve the full diversity of the population.

Involvement: What and when?

- 79 The definition of involvement in the Act and guidance challenges public bodies to go further by ‘involving people in decisions that affect them’.³⁴ This suggests an open, iterative and shared process – a progression from seeking more narrowly defined information at a set point in time. It suggests that public bodies should speak to people early and look for opportunities to involve them in delivery through to evaluation.
- 80 We found many examples of public bodies seeking the views of the public and stakeholders to help inform their activities. These examples were often consultation and engagement exercises, aimed at gathering views on specific issues as part of the process of designing a given activity. Public bodies were speaking to established forums and networks to engage with specific groups. In some cases, they were drawing on the expertise of others to help them connect with the public, recognising that they were not always best placed to do it themselves.
- 81 We found some examples of bodies involving the public early, working with them to shape the design of new services or buildings. Taken one step further, public bodies could consider how they involve people in ‘problem definition’, i.e. what they are trying to solve and why. This could help them better understand the root causes of problems and help identify preventative solutions that improve well-being. Early involvement can also help to deliver better value for money by ensuring public bodies design services that people want and need and that they get it right first time.

Conwy County Borough Council has worked with families to design family centres.

Families have helped shape the concept of the family centre; the location of centres and the services they offer; and the way centres measure outcomes.

View the report [here](#).

34 Welsh Government ‘Shared Purpose: Shared Future’ – statutory guidance on the Well-being of Future Generations (Wales) Act 2015, 2016.

- 82 Some public bodies are using the language of ‘co-production’, which is a more radical approach to working with others, characterised by sharing power and responsibility.³⁵ We examined some steps where people and community groups were directly involved with delivering solutions. We saw a few notable examples in NHS bodies, where patients and former patients share their experiences to inform others or champion certain issues. There were other examples of public bodies recruiting volunteers and working with community groups.
- 83 We saw a few examples where public bodies were working directly with individuals to involve them in decisions about their well-being and the services they receive, often taking a ‘strengths-based’ approach. This included ‘what matters’ conversations undertaken as part of work under the Social Services and Well-being (Wales) Act 2014.³⁶ Our report **The ‘Front Door’ to Adult Social Care** also found that local authorities are making good progress.

‘...and there has been a positive change in focus to strengths-based assessments, ‘what matters’ conversations and citizens have voice, choice and control’.³⁷

- 84 We found a few examples of public bodies seeking and responding to views on a routine basis. This included creating opportunities for ‘real time’ feedback, often using digital technology. However, we also challenged bodies to consider how they could continually seek and respond to the views of service users and communities. Public bodies should make sure that people who use their services can comment and contribute to their ongoing improvement.

Hywel Dda Health Board’s Education Programmes for Patients (EPP) offers educational opportunities for people to implement changes to improve their health and wellbeing particularly those living with a long-term/chronic condition and that of their families. Staff and volunteers work together to deliver the programme. Volunteers are recruited to provide their personal perspective; for example, in relation to mental health, disability, substance misuse, and gender identity.

35 The Coproduction Network for Wales defines **co-production** as:

‘... an asset-based approach to public services that enables people providing and people receiving services to share power and responsibility, and to work together in equal, reciprocal and caring relationships. It creates opportunities for people to access support when they need it, and to contribute to social change.’

36 ‘The 2014 Act and its Codes require practitioners to work with individuals as equals – sharing power and esteem by co-producing the ‘what matters’ conversation’. Social Care Wales.

37 Auditor General for Wales, **The ‘Front Door’ to Adult Social Care**, September 2019.

- 85 Overall, we sense that most public bodies are still consulting and engaging more often than involving. Similarly, our review of PSBs found that they have ‘tended to follow traditional approaches focused on informing rather than involving’.³⁸
- 86 The definition may be more stretching, but there has been a longstanding drive to encourage a more responsive, citizen-centred public service in Wales. Existing legislative requirements, alongside the Citizen-Centred Governance Principles, National Principles for Public Engagement and the National Participation Standards for Children and Young People should have provided a good foundation for public bodies to carry out ‘involvement’. However, findings from our examinations and other reviews, and from work conducted by the Commissioner show that there remains more to do.
- 87 Public bodies and PSBs need to consider how they make the shift to a more open, responsive and inclusive way of working with others. The level of actual involvement will vary, but the Act requires public bodies to challenge themselves to look for opportunities to involve others throughout design and delivery.

Involvement: Who?

- 88 We challenged many public bodies to involve a broader range of people in design and delivery. We highlighted some instances where certain stakeholders who could add value had not yet been involved. We also identified opportunities for public bodies to go beyond involving partner organisations, community groups or even current service users and speak directly to the public, or those who might use a service or facility in future.
- 89 We found many examples where public bodies needed to do more to involve the full diversity of the population. They need to think about how they can best involve vulnerable people and those with different protected characteristics, recognising that decisions and activities will impact different people differently.³⁹ To do this they need to understand the make-up of their populations, use appropriate methods and build sufficient time into the process.
- 90 Public bodies have opportunities to connect involvement to their equality duties, which include engagement and carrying out equality impact assessments. This would help ensure they are listening to different voices and reflecting them in their decisions.

38 Auditor General for Wales, [Review of Public Services Boards](#), October 2019.

39 The Equality Act 2010 sets out nine protected characteristics; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

- 91 Public bodies should also ensure they review the effectiveness of their involvement activity. They could review the rate and diversity of responses and ask for feedback on the quality of the process to help learn lessons for the future. The numbers of people involved might be an important measure, but public bodies should also review the outcomes of involvement. This could include the impact and people's experience of the process.

Case study – Cardiff Council: Working with others to develop the 'big ideas' for sustainable travel

In March 2018 the council launched its Green Paper on Transport and Clean Air containing 18 'big ideas' for the future of transport in the city. These ideas included a wide range of initiatives such as; the 'Future of the Metro and buses', 'Clean Air Zones', a 'comprehensive cycle super-highway and primary cycle route network' and 'autonomous vehicles'. One of the main drivers for this work was research from the local public health team that clearly showed that investment in sustainable and active travel has both short and long-term preventative benefits on the environment and on health and well-being.

These are potentially big changes, which could be unpopular with some, so the council wanted to engage its citizens in helping to prioritise the initiatives. In early 2018 it undertook an extensive, independent and well-resourced consultation process. This included a survey which received over 3,500 responses, face-to-face conversations with seldom-heard groups and sessions as part of geography lessons in secondary schools. The results have directly informed the Transport and Clean Air White Paper published in 2019.

For more information on Cardiff's approach to sustainable travel and clean air service please follow this [link](#) to the council's Green Paper.

View the report [here](#).

Case study – Amgueddfa Cymru: Involving others in the future of St. Fagans

Amgueddfa Cymru set up ‘participatory forums’ and other collaborative ways of working to involve people in redeveloping St. Fagans National Museum of History. The forums have given a large number of people, from different backgrounds, the opportunity to genuinely shape work at the museum.

This approach won the ‘Art Fund Museum of the Year Award’ in 2019 and was described by the chair of judges as ‘a monument to modern museum democracy... a major development project involving the direct participation of hundreds of thousands of visitors and volunteers, putting the arts of making and building into fresh contexts’.

View the report [here](#).

Things for public bodies to think about...

- Involving others throughout planning and decision-making, from the early stages of defining problems through to delivering and evaluating the solutions.
- Creating opportunities for people who are likely to be affected to be involved. This means current and potential service users and the full diversity of the population.
- Asking for feedback, learning and improving involvement.



So, what's next?

What's next for public bodies?

The challenges ahead

- 92 The Act is intended to bring about changes in culture and practice that will help public bodies address the major challenges facing Wales, both now and over the long term. Findings from our 2018 report suggest that most public bodies recognise that the Act should indeed be central to what they do, and that it can help them in designing and delivering more sustainable services and better outcomes.⁴⁰
- 93 This initial 2015-2020 reporting period has been a time of very considerable change, during which a combination of significant economic, political and social factors have affected trends, strategies and plans. New issues and challenges – some foreseen, and others unexpected – have appeared or have risen in prominence. One constant factor has been the rising demand pressures on public services, despite some recent easing of the public finance austerity that began in 2008. For Wales in 2020, grappling with the immediate and unprecedented emergency pressures of the COVID-19 pandemic, the challenges and problems facing public services are complex and immense.
- 94 **Exhibit 5** looks ahead at the next reporting period (2020-2025), giving an overview of four of the major challenges that those leading Welsh public services will have to address.
- 95 In the next reporting period, we will expect to see public bodies using the framework of the Act to address these and other challenges. When we look at the setting of well-being objectives, we will expect these key trends to have been considered. When developing our audit work programmes, we will consider the significance of activities and the contribution they make to meeting well-being objectives.

40 Auditor General for Wales **Reflecting on Year One: How Have Public Bodies Responded to the Well-being of Future Generations (Wales) Act 2015?** May 2018.

Exhibit 5 – four defining challenges for Welsh public services from 2020-25

The impact of the COVID-19 pandemic

The Covid-19 crisis response is necessarily focused on saving lives and putting in place measures to reduce the immediate economic impacts on businesses and individuals.



The wider implications of the crisis are extremely complex and are likely to have wide-ranging and long-lasting consequences, particularly for the most vulnerable.

Public bodies already appear likely to come through this period with even stronger collaborative relationships, having supported each other with dedication and ingenuity in the face of the crisis. This should stand them in good stead to tackle the medium and longer-term impacts. The framework of the Act can help build the foresight and resilience that can ensure bodies are well-placed to plan for and respond to emergencies.

Tackling inequality

Inequality continues to be a particularly important issue in Wales. There remains a 'stark gap between the experiences and opportunities of different people, particularly people born into poverty, disabled people, and some ethnic minority groups in Wales'.⁴²



Evidence shows that health inequalities have continued to grow.⁴³ Homelessness has risen dramatically since 2015-16, despite spend on homelessness increasing. Public bodies will need to do even more to improve well-being for disadvantaged groups, against a challenging social and economic backdrop as Wales grapples with the medium and longer-term effects of the COVID-19 emergency.

Climate change and biodiversity loss

Climate change is increasingly a defining issue in public and political debate, as countries across the world struggle to meet their commitments to reduce carbon emissions. The Welsh Ministers and 11 local authorities have declared a 'climate emergency', and the Welsh Government has stated its ambition for the Welsh public sector to be carbon neutral by 2030.



We depend on biodiversity in a number of ways, including regulating the climate and reducing the impact of natural hazards, such as the devastating flooding experienced in South Wales in February 2020. But biodiversity is declining faster than ever before and the World Economic Forum included major biodiversity loss and ecosystem collapse as one of its top three global risks in 2020.⁴¹

A key challenge will be how the Welsh Government and other public bodies can ensure a fair transition to a low carbon economy, and how they can protect the most disadvantaged from the effects of climate change and biodiversity loss.

The UK's departure from the European Union

The UK's departure from the European Union is an historic event and one that will have a very significant impact across the entire public sector, including here in Wales.



Whilst negotiations on the nature of the UK's future relationship with the European Union continue, much remains uncertain. However, the risks of 'no-deal' appear considerable and, whatever the eventual outcome, the immediate, medium and longer-term effects will all need to be carefully managed.⁴⁴

When considered in combination with the still-developing impacts of the COVID-19 pandemic and the resultant pressures on public services and economies across the globe, it is clear that the UK's new trading status will pose a wide range of new challenges, risks and opportunities.

41 ['Top risks are environmental, but ignore economics and they'll be harder to fix'](#), World Economic Forum 15 January 2020.

42 Equality and Human Rights Commission, **Is Wales Fairer?** 2018.

43 Public Health Wales, **Life Expectancy and Mortality in Wales**, 2020.

44 Auditor General for Wales, **Preparations in Wales for a 'no-deal' Brexit**, February 2019.

What's next for the Well-being of Future Generations Act?

- 96 Public services are changing. The Local Government and Elections (Wales) Bill proposes significant changes in governance, including a general power of competence for local authorities and the establishment of joint committees. These changes will sit within an already complex system of local and regional partnerships, which span different sectors and geographies. Public bodies are operating in a complex environment, seeking to navigate these arrangements to address multifaceted problems.
- 97 The Well-being of Future Generations Act has the potential to provide a common purpose and consistent culture, to simplify some of this complexity. However, five years on from its enactment, we have learned a lot about the Act and its practical workings.
- 98 Public bodies will need to use the Act when addressing the major challenges outlined in **Exhibit 5**. To do so effectively, the barriers to successful implementation described in this, and the Commissioner's, report will need to be overcome. Early consideration of how this can be achieved, by the Senedd and the Welsh Government after the next election, would help Wales remain at the forefront of actions to improve well-being and maintain its reputation as a global leader on sustainable development.

Recommendation 1

The Auditor General therefore recommends that:

- The **Senedd** and the **Welsh Government** should give post-legislative consideration to the Act to explore:
 - a. how the barriers to successful implementation described in this report, and that of the Commissioner, can be overcome; and
 - b. how Wales can remain at the forefront of actions to improve well-being.

- 99 The public sector landscape has also changed since the original designation of the 44 bodies under the Act, and the schedule of designation could usefully be revisited. The Act requires a collective and co-ordinated effort across the public sector. However;
- several new public bodies have been established since 2015 but have not been designated under the Act;⁴⁵ and
 - other pre-existing bodies (such as the Wales Ambulance Service NHS Trust) may also warrant designation.

Recommendation 2

The Auditor General therefore recommends that:

- The **Welsh Government** considers whether additional public bodies should be designated by Order to be subject to the Act.

What's next for our audit approach?

- 100 We are continuing to involve and collaborate to ensure our examination methodology adds value. We will soon be seeking feedback on the approach taken so far.
- 101 We will have discussions with stakeholders, including the Commissioner, to help inform the strategic direction of our work under the Act from 2020-2025. We intend to invite views on our proposals through a formal consultation, which will launch at an appropriate point later in 2020.

45 The new bodies include: Health Education and Improvement Wales, Social Care Wales and the Welsh Revenue Authority.



Appendix

1 Examination methodology

1 Examination methodology

- The evidence base for this report is drawn from a wide range of sources, including relevant value for money examinations undertaken and published by the Auditor General in the period 2015-2020:
 - [The Effectiveness of Local Planning Authorities in Wales](#), June 2019
 - [The 'Front Door' to Adult Social Care](#), September 2019
 - [Integrated Care Fund](#), July 2019
 - [Preparations in Wales for a 'no-deal' Brexit](#), February 2019
 - [Reflecting on Year One: How Have Public Bodies Responded to the Well-being of Future Generations \(Wales\) Act 2015?](#), May 2018
 - [Review of Public Services Boards](#), October 2019
 - [The Well-being of Young People](#), September 2019
- However, the bulk of the evidence is derived from the specific examinations that we conducted at all 44 public bodies named in the Act:

Our examinations of the 44 public bodies

- We undertook a total of 71 examinations across the 44 public bodies. In local government, fire and rescue authorities and national parks we carried out examinations in both 2018-19 and 2019-20 as part of our programmes of audit work. At the other bodies we carried out an examination in either 2018-19 or 2019-20.
- For each of these examinations, we selected a single 'step' that the body was taking to meet its well-being objectives. At the Welsh Government itself, we examined three separate steps to ensure appropriate coverage of its main delivery groups.
- In considering the extent to which bodies acted in accordance with the sustainable development principle in taking steps to meet their well-being objectives, we also sought to understand the corporate context in which 'steps' are being taken. This information will also help inform our future planning.

Method

The table below describes our core activities for each examination:

| Activity | Description |
|---------------------------------------|---|
| Planning | In discussion with each public body, we identified an appropriate 'step' for detailed examination. |
| Fieldwork scoping workshop | <p>We ran a structured workshop at the beginning of our fieldwork to understand:</p> <ul style="list-style-type: none"> • why key officers/members/other stakeholders involved in designing and delivering the step/activity did so in the way that they did. • what they felt they achieved and what they learned. Specifically, considering how they had applied the five ways of working. <p>The output from this workshop was a narrative informed by attendees' contributions, which formed an important part of our audit evidence.</p> |
| Document reviews | We reviewed documents relevant to the delivery of the selected step. |
| Interviews | We conducted interviews and focus groups to seek the views of a wide cross-section of staff and other stakeholders. |
| Feedback and response workshop | We ran a workshop where we shared our findings to promote discussion and encourage the body to reflect on what we found, then develop its own improvement actions in response. |
| Summary report | <p>These reports included:</p> <ul style="list-style-type: none"> • a summary of the key findings from the examination grouped under each of the five ways of working; and • the actions the body decided upon in response to our findings, agreed at the Feedback and Response workshop. <p>We reserved the right to make proposals for improvement in addition to the action identified by the body.</p> |

Main examination questions

The table below sets out the main questions we sought to answer in undertaking this examination, and these centred on the 'five ways of working':

To what extent has the body acted in accordance with the sustainable development principle when taking the step?

- 1 To what extent has the body considered how the step will meet short-term and long-term need?

- 2 To what extent has the body considered how the step will prevent problems from occurring or getting worse?

- 3 To what extent has the body considered the need to take an integrated approach in delivering the step?

- 4 To what extent has the body taken account of the need to collaborate in delivering the step?

- 5 To what extent has the body taken account of the need to involve the right people and ensure those people represent the diversity of the population?

Reporting on the examinations

- The findings from each examination were set out in a report. These reports also included the bodies' actions in response to our findings.
- This report provides an overview of the diverse findings, important themes and main learning points from those examinations. It does not set out definitive conclusions on the performance of each body, sector or of the 44 public bodies as a whole.



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