Bundle Audit Committee 30 May 2019

09:30 - OPENING BUSINESS - OPEN SESSION

1 09:30 - AC19/24 Apologies for Absence

1.2 09:31 - AC19/25 Declarations of Interest

1.3 09:32 - AC19/26 Minutes of Previous Meeting and Summary Action Log

1) To confirm the Minutes of the last meeting of the Committee held on 14 March 2019 as a correct record and discuss any matters arising;
2) To note the deferment to future years of the 'Approval of Plans by the Board ' review from the Annual Audit Plan, agreed via Chair's action;
3) To note that the revised Model Standing Orders are expected to be issued by Welsh Government in July; and
4) To review the Summary Action Log

AC19.26a Minutes Open session - Audit Committee March 2019.doc

AC19.26b Summary Action Log Audit Committee live version.doc

1.4 09:37 - AC19/27 Issues Discussed in Previous In Committee Session

AC19.27 In committee items reported in public.docx

2 Internal Audit Reports - Dave Harries, Head of Internal Audit

2.1 09:39 - AC19/28 Head of Internal Audit Opinion and Annual Report 2018/19

AC19.28 Internal Audit v10 HeadofIA annual report and opinion 2019new.docx

AC19.28a Final Head of Audit Opinion.docx

2.2 09:49 - AC19/29 Internal Audit Progress Report

The following Internal Audit Limited Assurance Reports are presented for members consideration as part of the Progress Update. The Officers identified will be in attendance to respond to questions.

AC19.29a IA Progress report coversheet v10 May 2019 Audit Committee.docx

AC19.29b IA Progress Report May 2019v2.docx

2.3 10:09 - AC19/30 Internal Audit Report - Revenue Business Case - John Darlington, Assistant Director, Corporate Planning and Rob Nolan, Finance Director, Commissioning and Strategy

AC19.30 Internal Audit Report Revenue Business Cases.pdf

2.4 10:24 - AC19/31 Internal Audit Report - Business Continuity - John Darlington, Assistant Director, Corporate Planning

AC19.31 Internal Audit Report Business Continuity.pdf

2.5 10:39 - AC19/32 Internal Audit Report - Case Management and Disciplinary Process - Sue Green, Executive Director of Workforce and OD

AC19.32 Final Internal Audit Report - Case Managementv1.pdf

2.6 10:54 - AC19/33 Internal Audit Report - Mental Health and Learning Disabilities Governance Arrangements - Andy Roach, Director of Mental Health and Learning Disabilities

AC19.33 Internal Audit Report on MHLD Governance Arrangements.pdf

2.7 11:09 - AC19/34 Internal Audit Report - Corporate Legislative Compliance with the Nurse Staffing Levels (Wales) Act 2016 - Trevor Hubbard, Deputy Director of Nursing

AC19.34 Final Internal Audit Report for Corporate Legislative Compliance with the Nurse Staffing Levels (Wales) Act 2016.pdf

3 11:24 - AC19/35 Interim Accountability Framework - Jill Newman, Director of Performance

AC19.35 Audit Committee Coversheet Accountability Framework May 2019.docx

AC19.35a Interim Accountability framework v6 as presented to F&P.docx

4 11:34 - AC19/36 Clinical Audit - Melanie Maxwell

AC19.36a Clinical Audit coversheet V0.2.docx

AC19.36b Clinical Audit paper v6 10.5.19 at 1750.doc

AC19.36c Clinical Audit Appendix 1 Summary Action Log JAQS Committee v3.doc

AC19.36d Clinical Audit Appendix 2 logic diagram v2.docx

5 11:54 - AC19/37 Committee Annual Reports - Grace Lewis-Parry, Board Secretary

AC19.37 Committee Annual Reports - coversheet.docx

AC19.37a - Appendix 1 QSE Committee Annual Report.pdf

AC19.37b Appendix 2 F&P Committee Annual Report.pdf

AC19.37c Appendix 3 SPPH Committee Annual Report.pdf

AC19.37d Appendix 4 R&TS Committee Annual Report 2018_19 v2.0 Approved.docx

AC19.37e Appendix 5 MHAC Annual Report v2.0.docx

AC19.37f Appendix 6 LPF Annual Report.pdf

AC19.37g Appendix 7 Annual HPF Report 18 19 v 2.0.docx

AC19.37h Appendix 8 SRG Annual Report 2018-2019 v1.0.docx

AC19.37i Appendix 9 Audit Committee Annual Report.pdf

AC19.37j Appendix 10 IGI Committee Annual Report.pdf

6 11:59 - Wales Audit Office Reports - Mike Usher, Amanda Hughes, Andrew Doughton

6.1 11:59 - AC19/38 WAO Update Report

AC19.38a WAO May 2019 AC coversheet - WAO.docx

AC19.38b WAO Audit_Committee_Update_May 2019.pdf

6.2 12:14 - AC19/39 WAO Report - Clinical Coding Follow up

AC19.39 Updated 1181A2019-20_BCUHB_Clinical_Coding_Follow_up_Eng.pdf

6.3 12:29 - AC19/40 WAO - What's the hold up - paper circulated for information

AC19.40 WAO Whats-the-hold-up-english.pdf

7 12:31 - AC19/41 Issues of Significance for reporting to Board

8 12:36 - AC19/42 Date of Next Meeting - 12th September 2019, Carlton Court, St Asaph

9 12:37 - AC19/43 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."

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

AUDIT COMMITTEE DRAFT
Minutes of the Meeting Held on 14.3.19
In the Boardroom, Carlton Court, St Asaph

Present:

Medwyn Hughes	Independent Member - Chair
John Cunliffe	Independent Member
Jacqueline Hughes	Independent Member
Lucy Reid	Independent Member

In Attendance:

Deborah Carter	Associate Director of Quality Assurance (for Minute AC19/8.4 & 8.5)
Simon Cookson	Director of Audit and Assurance, NWSSP
Clare Darlington	Assistant Area Director, Primary Care (for Minute AC19/8.2)
Andrew Doughton	Performance Audit Lead, Wales Audit Office
Russ Favager	Executive Director of Finance
Steve Grayston	Assistant Area Director of Therapies (for Minute AC19/8.6)
Sue Green	Executive Director of Workforce and OD (for Minute AC18/8.1)
Dave Harries	Head of Internal Audit, NWSSP
Sue Hill	Finance Director, Operational Finance
Amanda Hughes	Financial Audit Manager, Wales Audit Office
Grace Lewis-Parry	Board Secretary
Dawn Sharp	Assistant Director, Deputy Board Secretary
Adrian Thomas	Executive Director of Therapies and Health Sciences (for Minute AC19/9)
Mike Usher	Engagement Director, Wales Audit Office
Steve Vaughan	Interim Director of Secondary Care (for Minute AC19/8.3)

Agenda Item	Action
AC19/1 Opening Business and Apologies for Absence The Chair welcomed everyone to the meeting. There were no apologies.	
AC19/2 Declarations of Interest No declarations of interest were made at the meeting.	
AC19/3 Minutes, matters arising and review of summary action log **RESOLVED:** That 1) the Minutes of the last meeting of the Committee held on 11.12.18 be confirmed as a correct record subject to Minute AC18/85 recording Independent Member John Cunliffe's query in relation to the Charitable Funds Accounts;	

2) updates to the summary action log be recorded therein; 3) Chair's action approval to defer the Rostering and Well-being of Future Generations reviews from this year's Internal Audit Plan be noted; 4) the deferral of the annual review of Standing Orders pending an all Wales review of the Model being undertaken by Welsh Government be noted; 5) the Board be recommended to approve the revised Scheme of Reservation and Delegation to enable progression of the operational schemes of delegation that sit beneath it (subject to the minor adjustments relating to paternity special leave and referencing the All Wales Policy). 5) the arrangements for the presentation of the suite of Committee Annual reports to the Workshop on 14th May and subsequent Committee meeting on 30th May at which the Health Board's Annual Report and Accounts would be formally presented be noted; 7) it be noted that a report on the Accountability Framework be presented to the May meeting.	JN
AC19/4 Issues discussed in previous In Committee session The Committee formally received the report in public session of those issues discussed in the private session at the meeting held on 11.12.18 which related to:- • Financial Conformance Report • Counter Fraud Progress Report • Update on Internal and External Audit Recommendations **RESOLVED: That the report be received.**	
AC19/5 Welsh Ambulance Service Internal Audit Report - Handover of Care - Health Board's Management Response update AC19/5.1 This report provided an update on the progress made against the action plan developed in response to the Welsh Ambulance Services Trust (WAST) internal audit on Ambulance Handovers at Emergency Departments 2017/18. The plan reflected the March 2019 position. AC19/5.2 Members welcomed the progress update and referred this to the Quality, Safety and Experience Committee for future monitoring purposes given the quality and safety issues. Whilst welcoming the reduction in Ambulance waits, Members expressed concerns regarding the associated risk transfer in terms of corridor nursing and emphasised that this should not become the norm. They also expressed disappointment at the removal of the HALO role give the value added by the role. It was noted that the Health Board had received notification from WAST that a follow up audit was to be carried out within the next three months. **RESOLVED:** That (1) the information on improvements made to date, and the work ongoing to move the UHB to a place where handover delays of >60minutes is considered a 'Never Event' be received; (2) the 'best practice' status that the UHB has achieved in regards to practice in	

ambulance handover be recognised; (3) the impact on ED risk and the practice of corridor nursing at YGC and YWM be noted; (4) the progress made against the Audit Action Plan and the impact for patients across North Wales be noted; (5) the positive feedback from WAST Executive and Independent member be noted; and (6) the Quality, Safety and Experience Committee monitor progress going forward given the quality and safety issues in respect of hospital corridor nursing during peak times.	LR/KD
AC19/6 Special Measures Review of Expectations allocated to the Committee AC19/6.1 Following approval from the Special Measures Improvement Task and Finish (SMIF T&G) Group and Health Board Chairman, it had been agreed that special measures expectations were to be allocated to the relevant committee for review, to provide updates where necessary, and to provide an assurance report on progress to the SMIF T&F Group. The latest versions of the expectations allocated to the Audit Committee were presented for review. AC19/6.2 The Committee reviewed the log and expressed concern that the narrative supporting the action log lacked sufficient detail and clarity with regard to outcomes and requested that the Board Secretary convey this to the SMIF T&F Group. Members were reminded that it was not the role of the Committee to sanction closure of any actions as this was the role of the SMIF. **RESOLVED:** **That the Special Measures Improvement Framework Task and Finish Group be informed of feedback as outlined above.**	DS
AC19/7 Internal Audit Plan 2019/20 and Internal Audit Charter AC19/7.1 The draft audit plan had been developed in accordance with mandated Public Sector Internal Audit Standards – Standard 2010 - Planning to enable the Head of Internal Audit to provide internal audit services in a way which would facilitate: • The provision to the Accountable Officer, of an overall annual opinion on the organisation's risk management, control and governance, which may in turn support the preparation of the Annual Governance Statement; and • Audit of the organisation's risk management, control and governance through operational audit plans, in a way which affords suitable priority to the organisation's objectives and risks. AC19/7.2 The Charter was produced and updated regularly to comply with the Public Sector Internal Audit Standards and was complementary to the relevant provisions included in the Health Board's own Standing Orders and Standing Financial Instructions. **RESOLVED:** That the draft plan for 2019/20 together with the Internal Audit Charter be approved.	

AC19/8 Internal Audit Progress Report

The Head of Internal Audit presented the progress report which summarised ten assurance reviews finalised since the last Committee meeting in December 2018, with the recorded assurance as follows:

- Reasonable assurance (yellow) – three;
- Limited assurance (amber) – six; and
- Assurance not applicable (blue) – one.

The report also detailed:

- Reviews issued at draft reporting stage as well as work in progress;
- Follow-up status of twenty-one recommendations reviewed in the period; and

In presenting the report the Head of Internal Audit referred to the deferment from the plan the reviews relating to Wellbeing of Future Generations (Wales) Act 2015 and Roster management (referred to earlier as reported under Chair's action) and additionally sought the Committee's approval to defer the Sustainability plan review. The following Internal Audit Limited Assurance Reports were presented for members' consideration as part of the Progress Update with the relevant officers in attendance to respond to questions:-

AC19/8.1 Booking of Medical Agency Staff

The Executive Director of Workforce and OD joined the meeting to respond to questions relating to the Review which had been completed in August 2018 with Executive approval having been received in December 2018. Auditors had highlighted inconsistent recording of information in MASDA and the Standing Operating Procedure (SOP) requirements were not always being adhered to. The Executive Director outlined the revised reporting mechanisms and ongoing monitoring arrangements that had been established together with a temporary staffing team. A limited number of staff were now authorised to contract locums and had been trained with regard to the revised SOP.

RESOLVED: That the update be received and the recommendations be tracked as part of the Team Central tracking arrangements.

AC19/8.2 Primary Care GP Leases - Assigning Leases to the Health Board

The Assistant Area Director joined the meeting to respond to questions regarding the Review which had been completed during October 2018 with Executive approval having been received in January 2019. The Review had identified that there was no overarching procedure through which the Health Board structured its decisions on making and identification of all costs prior to assuming lease ownership. Auditors also identified one lease which had not been formally approved by the Health Board at the time of the review but this had since been considered by the Board. The Assistant Area Director reminded Members of the overall context in terms of the issues being experience not just in North Wales but UK wide with an increasing number of lease transfers taking place over the last few years and outlined the specifics with regard to the ten buildings documented within the Audit. Members noted that single handed GP practices were only required to give three months' notice which was a set national

standard. New Standing Operating Procedures were now in place across North Wales. **RESOLVED**: That the update be received and the recommendations be tracked as part of the Team Central tracking arrangements.	
AC19/8.3 Managing the Outpatients Backlog The Interim Director of Secondary Care joined the meeting to respond to questions on the Review which was completed in November 2018 with Executive approval having been received in January 2019. The review had identified a number of issues surrounding data quality and the effective integration of systems to ensure the correct patients are on the outpatient follow-up list with those subject to formal discharge removed. During the course of the review Internal Audit had escalated details to management of patients who appeared at risk and should have been follow up. Members expressed serious concerns relating to demand and capacity and failure to manage the clinical risks effectively, and the lack of evidence and traction in terms of resolving any of the issues identified in the report despite the Board having been sighted on the issues previously. Members were concerned that the matter had not been escalated on the risk register and that the audit report stated that "there have been no reports (for oversight/scrutiny) in respect of the Outpatients Follow up Backlog by the Secondary Care Senior Management Team over a number of recent months". The Committee also felt that the management response to the recommendations did not contain sufficient detail to provide assurance that the issues would be effectively resolved in a timely manner going forward. Members felt that an overarching transformational plan was needed. The Committee concluded that the matter required escalation to both Quality, Safety and Experience Committee and Board to ensure sufficient oversight and traction given the scale of the issues involved, and the need to develop both a strategic and operation plan. The recommendations were now being tracked as part of the Team Central tracking arrangements. **RESOLVED**: That (1) the matter be escalated to both Quality, Safety and Experience Committee and Board to ensure sufficient oversight and traction given the scale of the issues involved, and the need to develop both a strategic and operation plan; and (2) the recommendations be tracked as part of the Team Central tracking arrangements.	MH/LR
AC19/8.4 Implementing the Falls Policy The Associate Director, Quality Assurance joined the meeting to respond to questions regarding the Review which had been completed in September 2018 with Executive approval have been received in October 2018. The review had identified that the policy had been implemented across all areas visited, with Internal Audit having identified issues of compliance with expected completion of documentation across the areas reviewed. Members acknowledged that this area of responsibility had only recently transferred to the Nursing Directorate. **RESOLVED**: That the update be received and progress with the recommendations	DH/DS

continue to be monitored via the Team Central tracker, realigned to the Nursing Directorate.	
AC19/8.5 Concerns, Complaints and Redress - Part 6: Redress The Associate Director, Quality Assurance again was present to respond to questions following the Review which had been completed in December 2018 with Executive approval having been received in January 2019. The Corporate Concerns Team and associated processes through to completion of redress documentation had been fully compliant with expected controls, however the audit findings indicated that Operational departments' compliance in responding to claimants was not routinely adhered to and breached Statutory timelines. Members questioned the current performance with regard to holding letters and the Associate Director confirmed that arrangements were being made to centralise this process going forward. With regard to the wider operational complaints management processes, whilst there were legacy issues arrangements were improving with local complaints meetings taking place in operational areas now on a weekly basis to ensure traction, resulting in the total number of open complaints having halved in the last six months. Changes in the process had also been made with the redirection of complaints to the original source. A monthly report was submitted to the Quality and Safety Group. The recommendations were now being tracked as part of the Team Central tracking arrangements. **RESOLVED**: That the update be received and the recommendations be tracked as part of the Team Central tracking arrangements.	
AC19/8.6 Hospital Catering and Patient Nutrition Follow up review The Assistant Area Director of Therapies East joined the meeting to respond to questions regarding the Review which had been completed during October 2018 with Executive approval having been received in December 2018. The review had identified that a great deal of work was being undertaken operationally through INCHS, however this had not been subject to formal reporting or scrutiny through the Health Board Committee structure. The findings also revealed that there were poor self-assessment scores with no evidence of how the wards were tasked with improving performance. The Assistant Area Director informed Members that touch pads to obtain patient feedback were now in place in the East and were being rolled out in the other two Areas. The limitations with only nurses completing the food chart at present were noted. The recommendations would continue to be tracked as part of the Team Central tracking arrangements. **RESOLVED**: That the update be received and the recommendations be tracked as part of the Team Central tracking arrangements.	
AC19/9 Clinical Audit Report The Executive Director of Therapies and Health Sciences presented the report which had been prepared to address the issues raised at the Joint Audit and Quality, Safety and Experience Committee in November 2018. Members were dissatisfied that the report did not address the specific actions identified as part of previous Structured Assessments but also recommendations arising from the Joint Audit and Quality, Safety	

and Experience Committee meetings in both 2017 and 2018 and the lack of traction and movement to date. Expectations were for the report to set out how clinical audit would address the strategic objectives of the organisation taking a risk based approach to support quality improvement going forward. Wales Audit Office urged that a plan setting out future arrangements, together with a clinical audit plan for the year ahead be presented to the next meeting in order to satisfy the requirements in both the Annual Governance Statement and the Annual Quality Statement. **RESOLVED:** That a plan setting out future arrangements, together with a clinical audit plan for the year ahead be presented to the next meeting in order to satisfy the requirements in both the Annual Governance Statement and the Annual Quality Statement.	AT
AC19/10 Wales Audit Office Reports AC19/10.1 Wales Audit Office presented the regular audit update alongside reports finalised since the last audit committee. The update provided: • Progress relating to the financial audit and performance audit programmes. • The Annual Audit Plan which contained detail on the programme of work to audit the 2018/19 accounts and prospective performance audit reviews • The Annual Audit Report which contained the summary of work reported during 2018 and since the publication of the 2017 Annual Audit Report. • Use of locum and agency staff – which was a national facts only report • Preparation for a no-deal Brexit AC19/10.2 Members welcomed the intention to present the Charitable Funds Accounts to the September meeting. It was also noted that with regard to the Health Board accounts BCUHB was likely to be one of four in Wales with a qualified opinion. Members acknowledged the risks and expectations associated with the current level of deficit. **RESOLVED:** That (1) the content of the audit progress update be noted; (2) the Annual Audit Plan be received; (3) the Annual Audit Report be received and be presented to the March Board; (4) the Use of locum and agency and Preparation for a no-deal Brexit reports be noted;	DS
AC19/11 WAO Structured Assessment AC19/11.1 The Board had considered the Structured Assessment from the Wales Audit Office and the associated management response at its meeting on 24.1.19. At that meeting Members had noted that the report contained a single recommendation which was for the Board to fully complete previous outstanding recommendations made by the WAO in 2016/2017. Some of the WAO's previous recommendations had been closed for the purposes of the audit tracker tool, as they were being measured and monitored	

as part of embedded standard business processes. Discussion ensued covering mental health, concerns management, estates, the need for appropriate infrastructure to be in place for the transformational journey and the importance of getting governance right in terms of ensuring changes were made in response to WAO recommendations. The Board resolved to receive the report, accept the recommendations in the Structured Assessment, and also receive and approve the management response to the Structured Assessment - noting that actions recorded as closed would, where appropriate, be included in the relevant plans such as the Three Year Plan, Annual Operational Plan, and workforce or quality strategy and plans. Wales Audit office would seek to gain assurance that this had happened and review progress against outstanding recommendations in April 2019. AC19/11.2 An updated version of the management response was presented to the Committee. This version had an additional column which provided a position update regarding future monitoring arrangements. **RESOLVED:** That the report together with the updated management response which provides a position update regarding future monitoring arrangements be received.	
AC19/12 Audit Committee Workshop - 30.11.18 - Update report The report provided an update on the feedback and observations from the Audit Committee Workshop held on 30th November 2018. Members noted the workshop planned for the 14th May primarily to review the Committee Annual Reports. In relation to future workshops it was agreed to arrange a further date in the Autumn and to agree the agenda nearer the time. **RESOLVED: That the update be noted and a further workshop be planned for the Autumn.**	DS
AC19/13 Issues of Significance for reporting to Board. The Chair agreed to prepare his assurance report for the Board.	MH
AC19/14 Date of Next Meeting – 30th May 2019 The date of the next formal meeting was noted as 30th May 2019 and Members also noted that a workshop for Members of the Committee to review the suite of Committee Annual Reports was to be held on 14th May 2019.	
AC19/15 Exclusion of the Press and Public **RESOLVED:** That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Last updated 22.5.19				
Dawn Sharp	AC18/65 – Board Assurance Map (BAM) – Document to be refined following outcome of discussions at September Board Workshop.	May 2019	Draft Board Assurance Map presented to Audit Committee Workshop in May 2019. Members agreed for the Map to be further refined to show the relevant reporting groups and for this together with the BAF to then be submitted to the September Audit Committee.	September 2019
Dawn Sharp	AC18/66 – Standards of Business Conduct Policy review	March 2019	Review of Policy underway – to be updated to reflect electronic system modifications which are due to be completed in July. The review of the policy will also take account of the latest Internal Audit follow up review recommendations issued in May 2019.	September 2019
Chris Stockport	AC18/82 – IA report – GPOOH – CS to confirm timelines for the management restructuring relating to OOH Services and business continuity arrangements.	March 2019	The last Job Description is currently being banded and a one to one with one individual is shortly due to take place following which a four week consultation will be undertaken (commencing June 2019).	Close
Jill Newman	AC19/3 Accountability Framework to be presented to May meeting.	May 2019	On agenda	Close
Kate Dunn	AC19/5 – Handover of Care – WAST IA report	March 2019	Referral of report to QSE for future monitoring purposes (discussed at March QSE)	Close
Dawn Sharp	AC19/6 Special Measures review of expectations allocated to the Committee - SMIF T&F Group to be informed of Committee's feedback	March 2019	Actioned.	Close
Medwyn Hughes/Lucy Reid	AC19/8.3 Managing the Outpatients Backlog – escalation to QSE and Board	March/ April 2019	Actioned.	Close
Dave Harries/Dawn	AC19/8.4 Implementing the falls policy – actions to be realigned	March 2019	Actioned.	Close

Sharp	to the Nursing Directorate.			
Adrian Thomas/Melanie Maxwell	AC19/9 Clinical Audit Report – further report to be presented to the May meeting.	May 2019	On agenda for May.	Close
Dawn Sharp	AC19/10 Annual Audit Report to be presented to March Board	March 2019	Actioned.	Close
Dawn Sharp	AC19/12 – Date for future workshop in the Autumn	Autumn	Date and programme yet to be finalised.	
Dawn Sharp/Medwyn Hughes	AC19/13 – Chair's Assurance Report	May 2019	Actioned	Close

Audit Committee **30.5.19**	 *To improve health and provide excellent care*
Title:	**Summary of In Committee business to be reported in public**
Author:	Dawn Sharp, Assistant Director and Deputy Board Secretary
Responsible Director:	Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Purpose of report:	Standing Order 6.5.3 requires the Committee to formally report any decisions taken in private session to the next meeting of the Committee in public session.
Approval / Scrutiny Route Prior to Presentation:	The issues listed below were considered by the Audit Committee at its private in committee meeting of 14.3.19.
Governance issues/risks:	Issues were considered as follows: • Financial Conformance Report • Counter Fraud Progress Report to the period up to 31.12.18 • Update on Internal and External Audit Actions • Post Payment Verification Progress Report • Tendering for Goods and Services – Estates Department
Financial Implications:	Not applicable
Recommendations:	The Committee are asked to note the report.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√

6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper Governance and Leadership			
Equality Impact Assessment Not applicable			

Audit Committee
30.5.19

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Head of Internal Audit Opinion and Annual Report 2018/19
Report Author:	Dave Harries, Head of Internal Audit
Responsible Director:	Mrs Grace Lewis-Parry, Board Secretary
Public or In Committee	*Public*
Purpose of Report:	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.
Approval / Scrutiny Route Prior to Presentation:	The report has been discussed with and agreed by the Board Secretary and details the annual opinion and individual opinions issued by internal audit in 2018/19.
Governance issues / risks:	The audit work undertaken during 2018/19 and reported to the Audit Committee through the year and in draft are detailed within the main report. The assurance by domain is: • Reasonable Assurance (yellow) – Financial governance and management; Information governance and security; and Capital and estates management. • Limited assurance (amber) - Corporate governance, risk management and regulatory compliance; Strategic planning, performance management and reporting; Quality and safety; Operational services and functional management; and Workforce management. The overall assurance opinion for 2018/19 is limited assurance (amber).
Financial Implications:	The report may record issues/risks, identified as part of a specific review, which had financial implications for the Health Board.
Recommendation:	That the Audit Committee receives the Head of Internal Audit opinion and annual report for the 2018/2019 financial year.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable*	√

		development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)	
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper
http://www.wales.nhs.uk/sitesplus/861/page/81806
The internal audit report provides independent assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.

Equality Impact Assessment
The internal audit report provides independent assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.

This report does not, in our opinion, have an impact on equality nor human rights and is not discriminatory under equality or anti-discrimination legislation.

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

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

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Local Health Board

Head of Internal Audit Opinion & Annual Report 2018/19

May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents

Report status: Final
Draft report issued: 17th May 2019
Final report issued: 17th May 2019
Author: Head of Internal Audit
Executive Clearance: Board Secretary
Audit Committee: 30th May 2019

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 **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Several significant matters require management attention with **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.

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 for 2018/19. We are now able to state that our service 'conforms to the 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:

- Financial governance and management;
- Information governance and security; 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:

- Corporate governance, risk management and regulatory compliance;
- Strategic planning, performance management and reporting;
- Quality and safety;
- Operational services and functional management; 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 Wales Audit Office 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 2018/19.

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.

 - + 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.

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

The audit work undertaken during 2018/19 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 (Amber)

- We identified reasonable assurance for both the Welsh Risk Pool claims management standard and Risk Management Strategy where embedded controls appeared to be operating as expected. We made one recommendation surrounding the scrutiny of operational compliance against the strategy and note the establishment of the Risk Management Group which is to be chaired by the Chief Executive which will discharge this function.
- Operational compliance with the Standards of Business Conduct was satisfactory although the approval of declarations of interests across some operational divisions requires improvement. The Office of the Board Secretary now scrutinise and uphold the requirements of the Standards for all recorded gifts and hospitality, which ensures independence in the process – reasonable assurance.
- Corporate Legislative Compliance: Nurse Staffing Levels (Wales) Act 2016 where we identified issues surrounding Ward compliance with the Act; a number of the wards were not using the nurse staffing levels approved by the Board or the shift times used to calculate the nurse staffing levels; inconsistent and in some cases incomplete input of information on the Safecare system; monthly performance reporting identifying safe staffing is not ward specific and was a requirement on the Action Plan – limited assurance.
- The review of governance arrangements in Mental Health and Learning Disabilities division identified issues of compliance with established terms of reference; limited evidence that the transformation agenda is being subject to scrutiny; and the quality and safety agenda is reviewed so that the divisional quality and safety meeting is not overwhelmed in both detail and expectations as it attempts to 'catch-all' matters of quality and safety within the division – limited assurance.
- The review concerning the tendering for goods and services in the Estates Department identified significant matters of non-compliance with Standing Financial Instructions aswell as the department's own operational procedure. Management have been actively working to address the issues identified and ensure existing internal controls are improved to reduce the risk of a similar issue occurring in the future – no assurance.
- The Health Board have been actively tracking internal and external audit recommendations throughout the year, where all require sign-off as implemented by the relevant executive director. Follow-up reviews of agreed actions has resulted in the closure of recommendations where we found evidence of implementation and these have been reported to the Audit Committee during the year.

Strategic Planning, Performance Management & Reporting (Amber)

- Overall assurance is positive in the review of the Annual Report – verification of reported data where minor issues were identified and the action plan developed was agreed by management.
- Business Continuity Arrangements recorded limited assurance; whilst the Business Continuity Department (BCD) actively support the roll out/work plan developed, assurance on the effectiveness of the developed Business Continuity Plans will not be possible until such time they are subject to

testing, which business continuity leads advised they had not done. Progress has been made since the last review and the corporate department are active in providing training, however there remains a gap in the establishment of regular lead meetings per Policy – limited assurance.

- The review of Revenue Business Cases, against a sample due for development in the annual operational plan, identified a gap in following the guidance aswell as the maintenance of a log recording receipt and scrutiny of business cases – limited assurance.

Financial Governance and Management (Yellow)

- The reviews relating to West locality compliance with the budget setting methodology; Procurement arrangements: Integrated Care Fund, Cluster and Primary Care funding aswell as the Reporting arrangement for delivery of savings plans all were assessed as reasonable assurance.

  We did however identify opportunities for management to improve internal controls and these have been reflected within the findings and agreed action plans.

Quality & Safety (Amber)

- The reviews of the Annual Quality Statement and Infection Prevention and Control – Safe clean care recorded reasonable assurance; However, three reviews within this domain recorded limited assurance, as noted below.
- The review of managing the outpatients backlog identified a number of issues surrounding data quality and the effective integration of systems to ensure the correct patients are on the outpatient follow-up list with those subject to formal discharge removed. However, we did escalate details to management of patients who appeared at risk and should have been followed up – limited assurance.
- The review of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Part 6: Redress identified the Corporate Concerns Team and associated processes through to completion of redress documentation were fully compliant with expected controls. Operational departments' compliance in responding to claimants was not routinely adhered to and breached Statutory timelines – limited assurance.
- Implementing the Falls Policy identified the policy had been implemented across all areas visited; we identified issues of compliance with expected completion of documentation across the areas reviewed.

Information Governance & Security (Yellow)

- Three reviews within this domain recorded a mix of assurance ratings.
- Management of patient safety incidents related to informatics processes and Clinical Coding (in partnership with Informatics) received not applicable assurance.

  We undertook a questionnaire based survey for the patient safety incidents review to obtain views; followed up recommendations made by NWIS concerning their most recent clinical audit review at the Health Board.
- The Freedom of Information Act review identified that whilst evident the

Health Board has its Publication Scheme, the internet pages and associated information have not been maintained [recognising that the information is likely to be available through other searches or through formal requests to the Health Board]; the site is not the most intuitive and accessing the information can be challenging – reasonable assurance.

Operational Service and Functional Management (Amber)

- The Wales Audit Office report 'Hospital Catering and Patient Nutrition Follow up review: Have the agreed actions made a positive difference' review identified a great deal of work was being undertaken operationally through the INCHS Group, however this has not been subject to formal reporting or scrutiny through the Health Board Committee structure; There was poor self-assessment scores and no evidence how the wards were tasked with improving performance – limited assurance.
- The review of Patients Monies identified several issues of compliance with Policy, including the non-display of disclaimer notices; completion of required documentation was not in accordance with expected controls – limited assurance.
- The GP Out of Hours: Compliance with National Standards review recorded assurance not applicable as the management requested advisory review identified some differences between the self-assessment and evidence made available to support the assessment.

Workforce Management (Amber)

- Both the Review of staff earning more than £200,000 and the case management and disciplinary process recorded limited assurance.

  The review of staff earning over £200,000 noted a positive reduction in locum/agency and waiting list initiative payments, however the accuracy of one payment could not be corroborated to source timesheets/work done and did not appear to follow process for such ad-hoc payments.

  The review relating to the case management and disciplinary process noted issues surrounding the timeliness of completing investigations and how these are monitored.

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 performance trends require additional narrative to underpin the reported data – reasonable assurance.
- The Sub-Regional Neonatal Intensive Care Centre (SuRNICC) review identified matters across areas reviewed including the reporting of realised benefits in accordance with the strategy – reasonable assurance.
- The capital systems review identified positive assurance surrounding monitoring and reporting; capital approval process and the procedural framework. However, less assurance was noted in the discretionary bidding process and prioritising the bids submitted – reasonable assurance.

- The primary care GP leases: Assigning leases to the Health Board review identified that there is no overarching procedure through which the Health Board structures its decision making and identification of all costs prior to assuming lease ownership. We identified one lease which had not been formally approved by the Health Board at time of this review but has since been considered by the Board – limited 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 2018/19 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 required to be published by 31st May 2019. 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 2017/18 Annual Report and Quality Statement, together with the preliminary results of any audit work already undertaken in relation to the 2018/19 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.

This is further evidenced through the letter sent to the Chief Executive on the 22nd February 2019 from the Director General Health and Social Services/NHS Wales Chief Executive which noted the following:

> *"On the basis of the tripartite group discussion, Welsh Government officials recommended to the Minister that the escalation status of Betsi Cadwaladr University Health Board would remain unchanged at 'special measures'."*
>
> *"Your progress on finance, unscheduled care, RTT and planning will remain the key criteria for assurance under the leadership and governance category of special measures."*

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 2019/20 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 2018/19.

Our conformance statement for 2018/19 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2018/19 which will be reported formally in the Summer of 2019;
- 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 2018/19 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 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:

- Primary Care Services – General Medical Services (Substantial)
- Primary Care Services – General Pharmacy Services (Substantial)
- Primary Care Services – General Ophthalmic Services (Reasonable)
- Primary Care Services – General Dental Services (Substantial)
- Procurement Services – Accounts Payable (Reasonable)
- Information Governance – GDPR (Substantial)
- Employment Services – Payroll (Reasonable)

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

In addition, as part of the internal audit programme at Cwm Taf 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 Specialist Services Committee

- High cost drugs review (Reasonable)
- Review of network groups and advisory boards (Reasonable)
- Risk management (Reasonable)
- Governance arrangements (Reasonable)

Emergency Ambulance Services Committee

- Non-emergency patient transport service – follow up of baseline review (No opinion given)
- Governance and performance (Reasonable)

NHS Wales Informatics Service (NWIS)

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

- Business Continuity (Reasonable)
- Change Control (Limited)

While these audits do not form part of the annual plan for the 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 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 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 2018/19. 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.

In accordance with the internal audit charter, we have sought the support of the Board Secretary to progress a management response and closure of the review on a number of occasions.

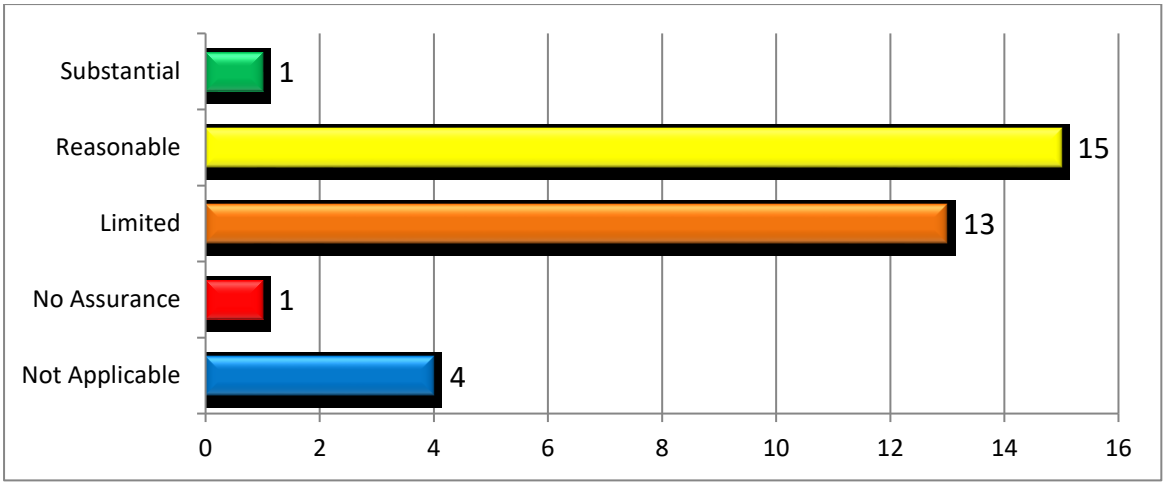
5. RISK BASED AUDIT ASSIGNMENTS

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 five audits 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.

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	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.
Risk Management Strategy	To ensure the Risk Management Strategy has been embedded across the Health Board via its directorates; divisions; sites; services and departments
Standards of Business Conduct (Draft)	To ensure compliance with Standing Order 7: Values and Standards of Behaviour.
East Area governance arrangements	To review the governance arrangements in place for the East Area, in line with the requirements issued by the Office of the Board Secretary.
Annual Report: Performance analysis – Verification of reported data	To review the completeness of the reported performance report as contained within the Annual Report for 2017-18 [Sections 3.14 to 3.21 inclusive of the MfA].
West Locality: Compliance with the budget setting methodology	To review was to establish whether there is a robust control environment in place within the Health Board to manage and support the budget setting process.
Annual Operational Plan (Draft)	To review the reporting mechanisms, coupled with reviewing arrangements operationally to monitor progress against expected milestones.
Procurement arrangements: Integrated Care Fund; Cluster funding; and Primary care funding (Draft)	To ensure procurement of goods and services from ICF/Primary Care Fund/Primary Care Cluster monies comply with the Health Board's governing documents for the procurement of goods and services.
Delivery of Savings plans (Draft)	To establish whether there is a robust control environment in place within the Health Board to

	support the management and reporting of the Health Board savings plan.
Annual Quality Statement	To review the consistency of information published within the AQS with organisational data previously reported to the Board and its Committees.
Infection Prevention and Control – Safe, Clean Care (Draft)	That expected actions and controls for Safe, Clean Care have been applied operationally, across the Health Board.
Freedom of Information (FoI) Act	To establish whether a robust control environment is in place to ensure the Health Board's compliance with response times as per the Freedom of Information Act.
Environmental sustainability report	To assess the adequacy of management arrangements for the production of the Sustainability Report.
Sub-Regional Neonatal Intensive Care Centre (SuRNICC)	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.
Capital Systems (Draft)	To determine the adequacy of, and operational compliance with, the systems and procedures of the University Health Board, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

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
Corporate Legislative Compliance: Nurse Staffing Levels (Wales) Act 2016	To review the evidence that the Nurse Staffing Levels (Wales) Act 2016 Action Plan had been implemented and to validate a number of tasks, which were live for completeness and accuracy.

Mental Health and Learning Disabilities governance arrangements	To review the governance arrangements in place for the Mental Health and Learning Disabilities Division in line with the requirements issued by the Office of the Board Secretary.
Secondary Care Division governance arrangements (Draft)	To review the governance arrangements in place for the Secondary Care Division, in line with the requirements issued by the Office of the Board Secretary.
Business Continuity arrangements (Draft)	To ensure the Health Board is compliant with the stated Business Continuity Management Policy Objectives.
Revenue Business Cases (Draft)	To establish whether there is a robust control environment in place within the Health Board to ensure that the delivery of service change and investment through revenue funding has been subject to appropriate scrutiny and approval.
The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Part 6: Redress	To establish whether there is a robust control environment in place within the Health Board to manage and support redress.
Managing the Outpatients Backlog	To establish the robustness of processes in place to ensure all backlog outpatients are being effectively managed within the agreed process.
Implementing the Falls Policy	To ensure that the falls pathway has been implemented in all ward areas within the Health Board and is subject to regular review on a case by case basis.
Wales Audit Office Report: Hospital Catering and Patient Nutrition Follow-up review – Have the agreed actions made a positive difference?	To identify whether the actions implemented, following the publication of the four Wales Audit Office reports and management action to implement the recommendations, have made a positive difference and delivered the outcomes as intended.
Patients Monies (Draft)	To provide the Health Board with assurance that it is discharging in full, its obligations to safeguard and administer patients' monies in a sample of locations, following discussions with Finance Directorate officers.
Staffing costs – Review of staff earning more than £200,000	To establish the controls operating in approving ad-hoc payments over and above those contractually obliged and whether there is adequate monitoring and reporting on 'high

	earners' within the respective Hospital Management Teams.
Case management and disciplinary process	To establish that a robust control environment is operating across the Health Board to ensure compliance with the Disciplinary Policy (WP9), ensuring all investigations are undertaken with fairness and transparency in a timely manner.
Primary Care GP Leases: Assigning leases to the Health Board	To determine if the Health Board is actively agreeing with outgoing General Practice (GP) leaseholders a schedule of dilapidation at transfer for all inward GP lease transfers agreed by the Health Board for the period April 2017 through to August 2018.

5.5 No Assurance (Red)

There is one audited area in which the Board has **no assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively, or where action remains to be taken to address the whole control framework with high impact on residual risk exposure until resolved.

Review Title	Objective
Tendering for goods and Services – Estates Department	To review compliance with Standing Financial Instructions and operational procedure within the Estates Operational Services Department – Wrexham Maelor.

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

Delivering the Mental Health Strategy (Draft)	To establish that the updates on the strategy provided to the Quality, Safety and Experience/ Strategy, Partnerships and Population Health Committees have been implemented and can be supported.
Management of patient safety incidents related to informatics processes (Draft)	To ensure mechanisms are in place to manage patient safety incidents related to informatics processes.
Clinical Coding (in partnership with Informatics)	To follow-up the recommendations made in the NWIS report issued in April 2018.
GP Out of Hours (OOH) – Compliance with National Standards	To verify the self-assessment back to core data [underpinning evidence] for the period detailed "End of Year March 2018".

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**
Corporate Legislative Compliance: Wellbeing of Future Generations (Wales) Act 2015	The Future Generations Commissioner for Wales issued a self-reflection tool for completion by 14th December 2018 with further planned work in January 2019 by an independent team established by the Commissioner.
Approval of Plans by the Board	This review was to follow-up a recommendation made by the Wales Audit Office in their 2017 Structured Assessment; since this risk was identified and in reviewing the recommendation tracker, we note that it has been signed off as implemented and supported as such by the Wales Audit office, coupled with the Finance & performance Committee undertaking enhanced scrutiny of plans.
Sustainability Plan	In scoping and developing this review, the plan is still being developed and the outline strategy is in draft format.
Quality Improvement Strategy	This review has commenced but will be included in the 2019/20 reporting period.
Roster Management	The Paybill Review Progress Report presented to the Finance & Performance Committee [17th January 2019 (Item FP19/13)] outlines continuing actions up to 31st March 2019 –

	Reviewing now would not capture all steps and improvements being taken.
NHS Wales staff survey – Delivering the findings	The original scope intended to review survey action plan from 2016, however this has subsequently been superseded by the recently published 2018 survey results published in October. Consequently, reviewing an action plan that will be superseded adds no value to the Health Board and it is too early to review progress against the 2018 findings and developed action plans.

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 2018/19 plan.

Dave Harries CMIIA QiCA
Head of Internal Audit
Audit and Assurance Services
NHS Wales Shared Services Partnership
May 2019

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. WAO 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

	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. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with WAO, HIW and LCFS.
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	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. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's

	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	6		●		● ● ●	● ●	
Corporate Governance, Risk and Regulatory Compliance	8			●	● ● ●	● ● ● ●	
Financial Governance and Management	3					● ● ●	
Strategic Planning, Performance Management and Reporting	4				● ●	● ●	
Information Governance and Security	3		● ●			●	
Operational Service and Functional Management	3		●		● ●		
Workforce Management	2				● ●		
Capital and Estates Management	5				●	● ● ●	●

Key to symbols:

● Audit undertaken within the annual Internal Audit plan including those issued as draft

PERFORMANCE INDICATORS

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2018/19	G	May 2018	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2018/19	G	100%	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]	A	62%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	95%	80%	v>20 %	10%<v<20%	v<10%

Key: v = percentage variance from target performance

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.

Audit Committee
30.5.19

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Internal Audit Progress Report - 1st March 2019 to 20th May 2019
Report Author:	Dave Harries, Head of Internal Audit
Responsible Director:	Mrs Grace Lewis-Parry, Board Secretary
Public or In Committee	*Public*
Purpose of Report:	The progress report is produced in accordance with the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management and the Board. The report summarises ten assurance reviews finalised since the last Committee meeting in December 2018, with the recorded assurance as follows: • Reasonable assurance (yellow) – three; • Limited assurance (amber) – five; and • Assurance not applicable (blue) – one. The report also details: • Reviews issued at draft reporting stage as well as work in progress; • Follow-up status of one recommendation reviewed in the period; and • Recommendation for deferment from the plan the review concerning approval of plans by the Board.
Approval / Scrutiny Route Prior to Presentation:	The report has been discussed with and agreed by the Board Secretary and details the individual opinions issued by internal audit.
Governance issues / risks:	The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan.
Financial Implications:	The progress report may record issues/risks, identified as part of a specific review, which had financial implications for the Health Board.
Recommendation:	The Audit Committee is asked to: • Receive the progress report; and • Approve the deferment of the one review from the 2018/19 plan.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√

1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper
http://www.wales.nhs.uk/sitesplus/861/page/81806
The internal audit progress report provides independent assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.

Equality Impact Assessment
The Internal Audit report provides independent assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.

This report does not, in our opinion, have an impact on equality nor human rights and is not discriminatory under equality or anti-discrimination legislation.

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

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

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Internal Audit Progress Report

1st March 2019 to 20th May 2019

Audit Committee 2019/2020

Betsi Cadwaladr University Local Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

Contents

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

Please note:

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

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

Introduction

1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues and progress against the Internal Audit (IA) Plan for 2018/19 which have been finalised since the last Committee meeting. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Deputy Board Secretary.

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

Reports Issued

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

Table 1 – Summary of assurance reviews issued as final

Title	Assurance Level	High	Medium	Low	Key Messages
Welsh Risk Pool – Claims Management Standard Review completed February 2019 with Executive approval April 2019 *No issues were identified relating to reimbursement documentation but we did identify a duplicate payment and two payments that were not supported by the required documentation.*	Reasonable	-	1	-	Reimbursement Documentation We reviewed the relevant documentation for the ten cases within our sample. We found no issues of significance with regards to the administration of reimbursement documentation. Cost Schedules and Invoice Reconciliation We reviewed the relevant cost schedules for all claims within our sample and verified a sample of copy invoices retained to the cost schedules. The following findings and limitations were noted: • We were able to verify and reconcile a sample of cost schedule costs to retained invoices and backing documentation for each submissions within our sample. • However, we did find two payments that were not supported by a signed Finance Request Form. • We also found one duplicate payment in our sample, whereby an invoice had been paid twice (£300). LaSPaR We confirmed that all claims within our review sample had been recorded within LaSPaR. Policies and Procedures The Health Board Claims Management Policy (PTR02) was due for review in June 2017. We confirmed that a newly revised policy document has been developed and is in the final stages of Health

Title	Assurance Level	High	Medium	Low	Key Messages
					Board policy approval as at the time of our review (pending approval from the January 2019 Quality, Safety and Experience Committee).
Operational compliance with the Standards of Business Conduct Review completed April 2019 with Executive approval May 2019 *Gaps identified in mandatory post holders completing annual declarations of interest; hospitality declarations had limited evidence provided to the Deputy Board Secretary of Director pre-approval.*	Reasonable	-	2	1	**Declarations of Interest** Staff and officers in posts Band 8c and above are required to complete an annual declaration of interest. The Health Board's dedicated intranet page states that *"Declarations of Interest need to be submitted by Board Members and all Staff on pay band A4C-8C or above (or equivalent) each financial year, normally at the commencement of the year even if this is a nil return".* Our findings [which were based on submissions made as at 25th March 2019] note the following: • Seven hundred and twenty-nine (729) employees have submitted declarations. • There has been an increase in posts identified for completing declarations as we note that the number of employees has increased to eight hundred and thirty one (831) from six hundred and eighty seven (687) employees in 2017/18. There is an 88% compliance rate concerning declarations made. **Hospitality Declarations** The electronic register of declarations of hospitality recorded ninety five (95) submissions made between 2nd April 2018 and 8th March 2019. As in previous years a number of these involved financial sponsorship by private companies (primarily pharmaceutical) which have enabled Health Board staff to attend conferences, training and other events. Of the ninety-five, sixty nine have been listed as accepted with comments. For these the Deputy Board Secretary has requested further information, which in the main was for the identification of who had approved the acceptance of this hospitality. The process of requesting further information was managed within the electronic system and involved the generation of an email to the subject completing the declaration. However it is noted that thirteen (13) of those contacted in this way had not responded.

Title	Assurance Level	High	Medium	Low	Key Messages
					The Office of the Board Secretary will continue to raise awareness quarterly.
Capital systems Review completed March 2019 with Executive approval May 2019 *Overarching procedure requires update to reflect organisation structure changes; differences noted in the expected development groups.*	Reasonable	-	4	1	**Procedural Framework** The Finance Capital Management Procedure (CAP02) supports capital investment protocols and. 'sets out the financial controls that should be applied to all capital schemes; and the management controls that are appropriate to local capital schemes only'. Whilst comprehensive, the procedure required updating to reflect changes in committees and governance arrangements. **Bidding** Audit testing identified that the current operational arrangements for the Capital Development Groups/Teams did not reflect the defined structure and processes i.e. the dedicated Capital Development Group for Informatics and Innovation Investment was absent, and separate groups were operating within the East Area. There was also a need to ensure the consistent attendance (including the respective Chairperson) and regularity of the Area Capital Development Groups in accordance with the defined terms of reference and the requirements of the Capital Procedure Manual. Good practice was observed in that standardised capital bid proformas were available within the Procedure Manual for Managing Capital Projects and the Finance Capital Management Procedure (CAP02) for the submission of capital and equipment bids.
Mental Health and Learning Disabilities governance arrangements Review completed January 2019 with Executive approval March 2019 *Issues of compliance with Terms of*	Limited	2	4	1	**Governance** The Division issued a revised governance structure in September 2018. The Division has a Director of Transformation but we could find no specific reference at tier 2 meeting which takes forward this agenda. Tier 1 – Divisional Directors (Operational) and Divisional Directors (Strategy) footnote Both meetings have similar ToR; membership; Chair [Director]; and Vice Chair noted as '*TBC'*. In addition we noted omissions in membership when comparing to the minutes - Director of Clinical Psychology and Medical Director are not recorded as

Title	Assurance Level	High	Medium	Low	Key Messages
Reference were identified across the groups reviewed; scrutiny of the transformation agenda was not evident through the organisational structure; QSEEL agenda is large and could become overwhelmed.					members of either group but regularly attend the meetings. Neither ToR formally record the established tier 2 groups/meetings that report to them. We identified two meetings that were not quorate and therefore any decisions taken should be reconsidered. The review also identified no formal reporting, through a Chair's report from the relevant tier 2 meetings or the receipt of minutes [as noted in some tier 2 ToR]. <u>Tier 2 – Quality – Safe, Effective, Experience, and Leadership Group (QSEEL)</u> Within the organisational structure, QSEEL has fifteen established sub-groups, however none of these are formally noted as reporting to QSEEL in its ToR. Whilst reviewing the fifteen sub-groups and their effectiveness was outside the scope of this review, our observation of the organogram suggests maintaining effective scrutiny and monitoring performance of such a significant number of groups may not be possible and expose the Division and Health Board to risk. There is a cycle of business which we reviewed for compliance with the agenda shared with us – we noted a number of variances between expected agenda items and those actually recorded, coupled with items on the agenda that did not appear on the cycle of business. <u>Tier 2 – Operational Accountability Group (OAG)</u> Quorum of the meeting states the Chair/Vice Chair must be present, however the Director of Transformation chaired the meeting of the 16th August 2018 – consequently this meeting was not quorate as neither Chair or Vice Chair attended. <u>Tier 2 – Strategy and Service Re-design Group (SSRD)</u> Within the organisational structure, SSRD has six established quality and workforce sub-groups, however none of these are formally noted as reporting to SSRD in its ToR. Reporting and assurance arrangements within the ToR are very detailed [in comparison to others] and include a number of actions which we would expect

Title	Assurance Level	High	Medium	Low	Key Messages
					it to receive and consider as opposed to develop. **Quality and Safety** Divisional QSEEL The Division has established a corporate Quality – Safe, Effective, Experience, and Leadership Group (QSEEL) chaired by the Director of Nursing with eleven specific functions detailed in its ToR. The organogram details four established (three Area and one Region) QSEEL meetings with an additional eleven sub-groups having been established and reporting to the divisional meeting. We were advised that the Division had not held a quality meeting since October 2017 which is why the division tried to catch all in its first inception. The inaugural QSEEL meeting commenced following the 11 months period of not holding this meeting. Further, we were told it was a divisional priority to ensure all quality and safety issues outstanding and current were addressed in this first meeting. As part of this review, we have not corroborated the lack of Quality Meeting prior to the new governance structure. The governance and reporting arrangements need refining and revisiting to ensure the divisional meeting does not become overwhelmed [in both detail and expectations] as it attempts to 'catch-all' matters of quality and safety within the division. Area and Regional QSEEL We obtained a sample of agendas for the four meetings to review HARMS focused areas. We did not review meetings for compliance with their ToR or whether meetings were quorate. The Director of Nursing sent an email on the 9th September 2018 to a number of officers, under the subject heading of *"Harms Dashboard data via IRIS"*; the content stated: *Dear All* *Please can you confirm you are reviewing the harms dashboard accessed via this link http://bcuiris.cymru.nhs.uk/IRIS/Nursing.aspx* *This will need to be a standing agenda item on local Q-SEEL from September, please can you ensure this is included in the monthly business cycle.*

Title	Assurance Level	High	Medium	Low	Key Messages
					In reviewing agendas provided since this email was issued we noted: • West and East QSEEL meetings did not have HARMS on their agenda; • Central QSEEL included only this email at its meeting of the 3rd October 2018 under Agenda Item *20181003.10 – For Information*; • Regional Services QSEEL meetings of 10th September and 1st October 2018 both have HARMS dashboard as an agenda item; 10th September 2018 - Minute 20180910.4 states *"Reviewed and agreed that all inpatient services for RSS are captured."*; 1st October 2018, Agenda Item 20181001.5.5 – HARMS dashboard has no paper included. **Performance** The Division has established the Operational Accountability Group (OAG) which has a broad role from financial planning and monitoring to performance management – The Director of Operations and Service Delivery chairs this meeting. The Chair is very active in the meeting with a number of actions assigned to them – There is limited evidence in the minutes that other members challenge on performance. In reviewing the latest agenda and draft minutes we received [18th October 2018], focusing solely on performance, the minutes recorded delayed transfers of care; PADR; Mental Health Measure; sickness; but were scant in detail where the relevant Performance Report was included. We were also unclear from the minutes what steps were to be taken to improve performance and whether the actions recorded were robust to deliver improvement.
Corporate Legislative Compliance: Nurse Staffing Levels (Wales) Act 2016 Review completed January 2019 with Executive	Limited	5	2	1	The Nurse Staffing Levels (Wales) Act 2016 became law in Wales from 2016 and was implemented in April 2018. The Act requires Health Service bodies to make appropriate provision for nurse staffing levels wherever nursing services are required and to ensure they provide sufficient nurses to ensure patients are treated sensitively. Person designate Section 25B (1) (a) requires the Health Board to

Title	Assurance Level	High	Medium	Low	Key Messages
approval April 2019 *The review identified the Board reporting was in accordance with expectations however we identified inconsistent use of Safecare and gaps in e-rostering data.*					designate a person with sufficient seniority to be responsible for the calculation of nurse staffing levels. The Health Board has assigned this role to the Executive Director of Nursing and Midwifery [on behalf of the Chief Executive]. Board responsibilities Under Section 25A of the Act the Board have a responsibility to ensure compliance with the Act. Under Section 25B and 25C of the Act the Executive Directors of Nursing, Finance, Workforce and Operations have a responsibility to provide evidence and professional opinion to the Board regarding nurse staffing levels. We have been advised that some responsibilities have been transferred to the Director of Secondary Care however this officer is not an Executive Director [as required by the Act]. Triangulated approach The Acute Skill Mix Review for Secondary Care dated December 2017 ensured compliance with the Chief Nursing Officer All Wales Nursing Act 2016 use of a triangulated approach to the calculation of nurse staffing levels in line with Welsh Government requirements. Operational Framework Operational Guidance is in place supporting Statutory Guidance and legislation. Our review of the Health Board's Nurse Staffing Level (NSL) and Escalation Plan: Acute Services Policy identified that the Policy has not been updated to reflect the reallocation of the roles and responsibilities following changes to the senior corporate management structure. We found that the policy does not clearly provide guidance on documenting the occasions when the Nursing Staffing Levels do not meet minimum standards. Board Reporting There is evidence of six monthly staffing reviews to comply with the Act and Health Board requirements. Identification of Wards We established that the Health Board has identified twenty-one adult acute medical and seventeen surgical inpatient wards in line with the requirements of Section 25B of the Act.

Title	Assurance Level	High	Medium	Low	Key Messages
					Ward Compliance with the Act A sample of six wards were reviewed across the three District General Hospital's (DGH'S) and included both medical and surgical wards. The following findings were noted: • Safecare training was up to date for wards reviewed in Ysbyty Gwynedd (YG) and Ysbyty Glan Clwyd (YGC); • Staffing levels had been calculated and agreed by the Board in December 2017 and reviewed as part of the bi-annual audits of NSL; • A number of wards were not populating the e-rostering system with the approved NSL or using the shift times used to calculated the staffing levels; • Policy does not provide clear guidelines on the use of Safecare. Information generated from the Safecare system identified a number of missing entries; reported breaches of the NSL but no corresponding information noted as the professional judgement taken to address the breach; a patient fall that had not been reported on Safecare as a result of unsafe staffing levels but was not evident on the Breach report with information taken directly from Datix (incident reporting system); harms as a result of unsafe NSL noted on the West Area Breach report but not recorded on Safecare; • One ward noted 4 major breaches in July 2018 (not date specific) on the Breach report. All were NSL related but had not been recorded on Safecare as Red flag events and no mitigation or professional judgement was evident. • One ward noted a Red flag event on the Safecare system on the 17th June 2018 noting a patient fall. This fall was not on NSL Breach report (we were given to understand this information was taken directly from Datix); Health Board Reporting Systems Audit sample testing of information from e-rostering, identified a number of the wards were not using the nurse staffing levels approved by the Board or the shift times used to calculate the nurse staffing levels.
Case	Limited	2	2	-	**Non-Medical and Dental Staff**

Title	Assurance Level	High	Medium	Low	Key Messages
management and disciplinary process Review completed February 2019 with Executive approval April 2019 *Timelines for recording investigation start/end date were not routinely captured thus undermining the ability of Workforce and Organisational Development to report on the efficiency of the process.*					The review considered a random sample of twenty ongoing cases made up of twelve disciplinary cases. Reviewing these cases against the scope of the review based on the requirements set-out in the all-Wales Disciplinary Policy (WP9), the findings were as follows: <u>Training for Investigating Officers (IO)</u> Most internal Investigating Officers have completed the *A Step into Management* (ASiM) Investigations module, however we are unclear whether all officers assigned investigations have completed this training. External IO's will not have been allowed to conduct any investigations until the Head of Workforce: Mental Health has personally trained them. This training is conducted over a whole day in groups. <u>Scope of Investigation provided at the outset</u> Based upon the evidence viewed, we did not identify a clear, formalised scope provided to investigating officers prior to commencing the investigation – Whilst we recognise the investigation will be the driver, no formalised scope is detailed to ensure the IO remains 'in scope' and does not deviate from the allegation. There is a COM1 form for the Commissioning of Employee Relations Investigation (WP9a Appendix 2 - Responsibility Matrix Disciplinary Policy) which is completed to initiate the investigation and used to facilitate a conversation and provide structure for the IO. We have been informed that the Investigation Commissioning Form (COM1) form is not mandatory and would not be held on the disciplinary file. The COM1 form includes key fields relating to the investigation including: • Date investigation commissioned; • Expected duration; • Allegation(s) to be investigated; and • Documentary evidence to be examined. We did not view any COM1 form for the sample reviewed. <u>Investigation timeline</u> As investigation times are not always recorded they cannot be measured. From our sample of both open and closed cases, we were unable to identify the

Title	Assurance Level	High	Medium	Low	Key Messages
					investigation start and if applicable end date - the absence of this data undermines the ability of Workforce and Organisational Development Directorate to report on the efficiency of the process. <u>Delivery Timeline set</u> The Letter sent out upon initiation of a formal investigation from the Manager to the Investigating Officer clearly sets out expectations of the role. Workforce systems do not record all of this data and as a result we are unable to ascertain the reasons where delays in the process are occurring. <u>Monitoring the delivery of ongoing cases</u> All employment cases are recorded within Electronic Staff Record system (ESR) and monitored by Workforce via a spreadsheet using exported data from ESR; there was no evidence from the results of the review that the spreadsheet is routinely updated or details provided as to why the cases were taking longer than the three month expected. **Medical and Dental Staff** When any concerns arise with medical and dental staff the Health Board will invoke the Upholding Professional Standards in Wales (UPSW) procedure which supersedes the WP9 Disciplinary Policy and WP9a Guidelines for Managers to Support the All Wales Disciplinary Policy. UPSW procedure sets out the way by which Health Boards in Wales address concerns about capability, performance and conduct for all employed doctors and dentists. We reviewed the internal process for a sample of six concerns. Internal management reports identified: • One case is over four years old; • One case does not have a clear start date; • Two cases are over eleven months old; • One case has a recorded update date eight days prior to the case start date; • Only one of the four UPSW cases had a Board Member allocated; and • Two cases had not been allocated Investigating Officer. We were advised that there were no medical and dental staff under investigation under UPSW on

Title	Assurance Level	High	Medium	Low	Key Messages
					"gardening leave" at the time of the review – We did not corroborated this assertion. At the time of the review Medical Workforce had only three representatives who are fully trained and experienced to support such cases.
Revenue Business cases Review completed April 2019 with Executive approval May 2019 *Only a small number of expected business cases had been developed with some not following the expected guidance; Guidance paper should be published as a formal operational procedure.*	Limited	2	1	-	Each year the Health Board engages in numerous service and/or workforce development projects to deliver benefits that support key organisational objectives. It is imperative that each project is backed by a robust business case which clearly and precisely defines exactly what is to be achieved, how to achieve it, and the resources required to achieve it. The Executive Management Group (EMG) meeting of the 6th September 2017, under Agenda Item EMG 17/96 - Business Case Process considered and approved the outlined process. Of the small number of developed business cases viewed as part of this review, some did not follow this approved guidance. Evidence has been provided identifying the training that has taken place through the Step into Management programme 2018 (ASIM); however, the Business Cases' workshop was removed from the ASIM programme in August 2018. We have been advised that this is set to be re-introduced through the Senior Management Programme, but will not take place until March 2020 at the earliest.
Business continuity arrangements Review completed April 2019 with Executive approval May 2019 *Implementation of the continuity plans is progressing well; Pre-planned operational testing of plans is*	Limited	2	1	-	Comparisons made between the work plans we reviewed in 2017/18 and 2018/19 identified improvement in departments' implementation of Business Continuity Plans (BCP) and associated Business Impact Analysis (BIA). **Lessons learnt and field testing** Following from last year's review, it was identified that the testing of the plans were to be undertaken within the work plan for 2018/19. Through discussions with the Business Continuity Manager (BCM) and the BC Leads within the sample it was specified that not all department plans have been tested on an individual basis. We did however receive evidence from the BCM detailing Health Board wide business continuity exercises/events

Title	Assurance Level	High	Medium	Low	Key Messages
not routinely happening.					have taken place which would impact on various departments. Whilst there is evidence of wider plans being tested, through co-ordinated pre organised events, we have again been unable to confirm that all plans are being subject to testing annually. <u>Estates</u> We were unable to establish that any pre-planned testing of the department's plans had taken place and are unable to evidence lessons learnt. <u>ICT</u> Evidence was provided by means of an excel spreadsheet illustrating that plans have been tested due to operational issues. We noted future test dates were also identified. We noted that clinical systems BCP need reviewing with a formal test date also needed. <u>Critical Care</u> The department has not undertaken any pre planned testing and could not evidence any lessons learnt. **Training provided to Business Continuity Leads** No formal training has been undertaken/received by the business continuity leads **Business Continuity Leads assemble annually** All Health Board departments included within the Business Continuity Management Policy are required to assemble (BC Leads) at least annually to ensure that business continuity plans are not developed in isolation and appropriate interdependences between departments are identified and written into plans and tested accordingly. We spoke to the three departments identified for testing as well as the Business continuity manager and confirmed this was not currently happening. In discussion with the business continuity leads, they advised that this would be beneficial. This would encourage the requirements for training and also drive the regular testing of the plans and feedback on lessons learnt.
Delivering the Mental Health	Not applicable	1	1	-	Whilst the Strategy has been approved and is being worked to, we have been unable to state,

Title	Assurance Level	High	Medium	Low	Key Messages
strategy Review completed March 2019 with Executive approval May 2019 *There is no specified annual project plan which underpins the strategy implementation.*					definitively, that the first year priorities have been achieved; this is predicated on the fact that there is no specific project plan outlining all the steps that could/should be undertaken through which management self-assessment and subsequent scrutiny can be applied. <u>Governance</u> Within the Together for Mental Health Partnership Board (MHPB) on the 14th September 2018 [Agenda item 180914.12] the new governance structure was presented to the group. The previous governance structure was revised due to the Regional Partnership Board (RPB) identifying mental Health as a priority area. The revised structure also reflects the Integrated Service Boards (ISB) and the Public Service Boards (PSB) to evolve and work closer with the Local Implementation Teams (LITs). The LITs were formed covering the six local authority areas of Conwy & Denbighshire; Wrexham & Flintshire; and Anglesey & Gwynedd. Supporting the work of the LITs are six Quality and Workforce groups (Q&W). Both the LITs and Q&W work alongside each other and feed into the MHPB. We reviewed minutes from the MHPB and minutes from the three LITs. Both the LITs and the Q&W can be seen providing updates into the MHPB. The minutes demonstrated building of relationships within the teams and the development of collaborative ideas. There does however appear to have been barriers to overcome in areas before being able t work collectively. Although the LITs and Q&W groups can be seen escalating matters to the MHPB, there is limited evidence of information being disseminated from the MHPB to the groups coupled with information being circulated/cascaded between the LITs and the Q&W groups. To identify whether the Health Board *Together for Mental Health in North Wales strategy* first year priorities (scheduled for completing/implementation by September 2018) had progressed and evidence was available to underpin such, we reviewed the five, first year priorities. Whilst there is positive evidence to substantiate progress against the

Title	Assurance Level	High	Medium	Low	Key Messages
					priorities, we were unable to confirm that all actions that could/should have been completed had been.

Work in Progress Summary

4. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Secondary Care Division governance arrangements	Draft report issued and comments received from management which are subject to consideration.	1st February 2019
Delivery of savings plans	Draft report issued and awaiting management response.	7th February 2019
Procurement arrangements: Integrated Care Fund; Cluster funding; and Primary care funding	Draft report issued and management has accepted the report in the West Area; we await confirmation of the Central and East Areas and a combined management response to the recommendations made.	16th April 2019
Patients Monies	Draft discussion report has been issued for management review.	16th April 2019
Management of patient safety incidents related to informatics processes	Draft briefing paper issued – management request to review existing methods for recording issues where informatics systems may impact on patient safety.	1st May 2019
Annual Operational Plan 2018/2019	Draft report has been issued.	9th May 2019
Infection Prevention and Control – Safe, Clean Care	Draft report has been issued.	23rd May 2019

Fieldwork

5. The following reviews are currently in progress:

- Quality improvement strategy – Brief has been discussed and is subject to amendment.
- Ysbyty Gwynedd Emergency Department – Review is ongoing.

Follow Up

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

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

Table 3: Follow-up status of recommendations reviewed

Review Title	Recommendation Title	Follow-up status
Primary Care GP Leases: Assigning leases to the Health Board	Reviewing and approving business cases	Closed - Verified

Third party assurance

8. No third party assurance reports are expected, within this reporting period, from the NHS Wales Shared Services Partnership (NWSSP) internal auditors relating to reviews undertaken on services operated on behalf of the Health Board.

Capital assurance

9. Fieldwork is complete and queries have been resolved with external advisers in respect of the Ysbyty Gwynedd Emergency Department development. The draft report is currently being prepared for issue.

10. As previously reported, the final audit briefs for the Open Book review and the examination of the Pain/Gain Mechanism at the Ysbyty Glan Clwyd redevelopment were issued on the 19th February 2019. Initial information has been received from the Health Board's Cost Adviser to assist in the identification/selection of areas for audit testing. However, we are currently awaiting the return of the standard Systems and Costing Statement utilised at Designed for Life: Building for Wales open book audits (which confirms the operation of associated Supply Chain Partner systems) from the Supply Chain Partner. The Supply Chain Partner has previously requested deferment of the provision of the same due to company year-end pressures. Fieldwork will be initiated as soon as the completed Systems and Costing Statement is received.

11. Audit briefs are currently being prepared for issue in respect of the post project evaluation/benefits realisation processes applied at primary care projects (previously agreed to defer to Quarter 1, 2019/20) and the Substance Misuse Action Fund projects (2019/20 Audit Plan).

Contingency/Organisational Support/Advice

12. Internal Audit is supporting the Health Board through providing advice and guidance on areas of control, new systems and processes, with increased time being used to support attendance and provide input at the three project meetings we are in attendance.

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

- 'In attendance' at the Health Informatics Programme – WPAS Replacement Programme Board.

Delivering the Plan

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

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

16. We have been requested to review the system relating to the Non-emergency patient transport service which replaced previous systems for commissioning taxis – This review is scheduled to commence in December 2018.

17. The following reviews have been identified for deferment from the 2018/2019 original plan and have been agreed in principle with the Board Secretary prior to Audit Committee approval:

    - Approval of Plans by the Board

      This review was a follow-up of a recommendation made by the Wales Audit Office in their 2017 Structured Assessment however in reviewing the recommendation tracker, we note that it has been signed off as implemented and records supported as such by the Wales Audit Office. In addition we note, per the Board Secretary, that additional scrutiny of plans is undertaken by the Finance & Performance Committee.

    It is recommended that the review is removed from the 2018/19 plan for future planning consideration.

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

19. Table 4 is reporting an amber status in the time taken to provide management response and has decreased to 62% [5%] from the last Committee reporting period. We continue to experience delays in turnaround times of the management response and are referring more this year for the Board Secretary/Deputy Board Secretary's attention per the Charter.

Table 4 – Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement] with agreed extension by the Executive Lead at time of agreeing the audit brief	Amber	62%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 5 – Core Plan 2018-19

Planned output	Outline timing	Status	Assurance
Corporate governance, risk and regulatory compliance			
Annual Governance Statement	Q1	Complete – Head of internal audit annual report.	N/A
Welsh Risk Pool Claims Management Standard	Q4	Final report issued.	Reasonable
Risk Management Strategy	Q3	Final report issued.	Reasonable
~~Corporate Legislative Compliance: Wellbeing of Future Generations (Wales) Act 2015~~	Q4	Recommended for deferment.	The Future Generations Commissioner for Wales issued a self-reflection tool for completion by 14th December 2018 with further planned work in January 2019 by an independent team established by the Commissioner.
Corporate Legislative Compliance: Nurse Staffing Levels (Wales) Act 2016	Q2	Final report issued.	Limited
~~Approval of Plans by the Board~~	Q4	Recommended for deferment.	This review was a follow-up of a recommendation made by the Wales Audit Office in their 2017 Structured Assessment however in reviewing the recommendation tracker, we note that it has been signed off as implemented and records supported as such by the Wales Audit Office. In addition we note, per the Board Secretary, that additional scrutiny of plans is undertaken by the Finance & Performance Committee.
Standards of Business Conduct	Q4	Final report issued.	Reasonable
Mental Health and Learning Disabilities governance arrangements	Q3	Final report issued.	Limited
Secondary Care Division governance arrangements	Q3	Draft report issued.	
East Area governance arrangements	Q2-3	Final report issued.	Reasonable
Tendering for goods and services – Estates Department	Q3	Final report issued.	No assurance
Strategic planning, performance management and reporting			
Annual Report: Performance Analysis – Verification of reported data	Q1	Final report issued.	Reasonable

Planned output	Outline timing	Status	Assurance
Annual Operational Plan - 2018/19	Q3-4	Draft report issued.	
Business Continuity arrangements	Q4	Final report issued.	Limited
~~Sustainability Plan~~	Q4	Recommended for deferment.	In scoping and developing this review, the plan is still being developed and the outline strategy is in draft format.
Revenue Business Cases	Q4	Final report issued.	Limited
Financial governance and management			
West Locality Compliance with the Budget Setting Methodology	Q2-3	Final report issued.	Reasonable
Procurement arrangements: Integrated Care Fund; Cluster funding; and Primary care funding	Q3-4	Draft report issued.	
Delivery of savings plans	Q3-4	Draft report issued.	
Quality and Safety			
Annual Quality Statement	Q1	Final report issued.	Reasonable
Infection Prevention and Control – Safe, Clean Care	Q4	Draft report issued.	
Quality Improvement Strategy	Q4	Work in progress.	
The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Part 6: Redress	Q3-4	Final report issued.	Limited
Delivering the Mental Health strategy	Q3-4	Final report issued.	Not applicable
Managing the Outpatients Backlog	Q2-3	Final report issued.	Limited
Implementing the Falls policy	Q1-2	Final report issued.	Limited
Information governance and security			
Management of patient safety incidents related to informatics processes	Q4	Draft report issued.	
Freedom of Information (FoI) Act	Q2-3	Final report issued.	Reasonable
Clinical Coding (in partnership with Informatics)	Q2	Final report issued.	Not applicable

Planned output	Outline timing	Status	Assurance
Operational service and functional management			
Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference?	Q2-3	Final report issued.	Limited
Patients Monies	Q4	Draft report issued.	
GP Out of Hours (OOH) – Compliance with National Standards	Q1-2	Final report issued.	Not applicable
Workforce management			
Staffing costs – Review of staff earning more than £200,000	Q1	Final report issued.	Limited
~~Roster management~~	Q2-3	Recommended for deferment.	The Paybill Review Progress Report presented to the Finance & Performance Committee [17th January 2019 (Item FP19/13)] outlines continuing actions up to 31st March 2019 – Reviewing now would not capture all steps and improvements being taken.
Case management and disciplinary process	Q2-3	Final report issued.	Limited
~~NHS Wales staff survey – delivering the findings~~	~~Q3-4~~	Deferred.	Review has been superseded following publication of the 2018 survey findings and action plans were in the process of being developed.
Capital and estates management			
Environmental sustainability report	Q1	Final report issued.	Reasonable
Carbon Reduction Commitment Order	Q1	Final report issued.	Substantial
Primary Care GP Leases: Assigning leases to the Health Board	Q2-3	Final report issued.	Limited
SuRNICC	Q2	Final report issued.	Reasonable
Capital Systems	Q3	Final report issued.	Reasonable
Ysbyty Gwynedd Emergency Department	Q4	Work in progress.	
Ysbyty Glan Clwyd Follow Up	Q2-3	Complete	N/A
Ysbyty Glan Clwyd – Open Book	Q3-4	Work in progress.	
Ysbyty Glan Clwyd – Pain/Gain Mechanism	Q3-4	Work in progress.	
Compliance with the public sector internal audit standards – Contingency/assurance reviews			

Planned output	Outline timing	Status	Assurance

Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Revenue business cases

Internal Audit Report

BCU 2018/19

May 2019

NHS Wales Shared Services Partnership

Contents

Review reference:	BCU-1819-15
Report status:	Internal Audit Report
Fieldwork commencement:	1st March 2019
Fieldwork completion:	3rd April 2019
Draft report issued:	3rd & 24th April 2019
Management response received:	10th May 2019
Final report issued:	20th May 2019
Auditor/s:	Principal Auditor Head of Internal Audit
Executive sign off:	Director Of Planning And Performance
Distribution:	Assistant Director - Strategic and Business Analysis Finance Director - Commissioning & Strategy Board Secretary & Deputy Board Secretary Compliance and Assurance Manager
Committee:	Audit Committee

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

1. Introduction and Background

The assignment originates from the internal audit plan and the subsequent report will be submitted to the Chief Executive and Audit Committee. The relevant Executive lead for the assignment is the Director of Planning and Performance.

Each year the Health Board engages in numerous service and/or workforce development projects to deliver benefits that support key organisational objectives. It is imperative that each project is backed by a robust business case which clearly and precisely defines exactly what is to be achieved, how to achieve it, and the resources required to achieve it.

The Business Case will be the driver for investment decisions that are based on strategic benefits, options appraisals, affordability; improvements on efficiency, achievability and commercial arrangements that provide value for money (VfM) and link in to the organisation's strategy.

2. Scope and Objectives

The overall objective of the review was to establish whether there is a robust control environment in place within the Health Board to ensure that the delivery of service change and investment through revenue funding has been subject to appropriate scrutiny and approval.

The review will ensure that Business Cases have been scrutinised to ensure that they are:

- Appropriate (fits with what the organisation aims and plans);
- Affordable;
- Deliver value for money;
- Achievable (based on considering and analysing inherent risks); and
- Measurable and accountable.

3. Associated Risks

The potential risks considered at the outset of this review are as follows:

- Risks have not been clearly defined or specified;
- Purported project benefits are not realised;
- No clear accountability process in place;
- No mechanism in place to review and monitor progress;
- Outcomes do not support achievement of Welsh Governments Wellbeing of Future Generations (Wales) Act, or Health Board strategic aims.

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 Revenue business cases review is limited assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Expected Revenue Business cases due have been completed in line with the Executive Management Group approved guidance		✓		

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weakness in the system control/design for Revenue business cases.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for Revenue business cases.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided to us by the lead authors, we have relied solely on the documents, information and explanations provided,

except where otherwise stated. We have not sought to or undertaken work to verify the accuracy of the information provided within the business cases.

Each year the Health Board engages in numerous service and/or workforce development projects to deliver benefits that support key organisational objectives. It is imperative that each project is backed by a robust business case which clearly and precisely defines exactly what is to be achieved, how to achieve it, and the resources required to achieve it.

The Executive Management Group (EMG) meeting of the 6th September 2017, under *Agenda Item EMG 17/96 - Business Case Process* considered and approved the outlined process, noting the following:

> *[DoS] advised that with regards to Business Cases we have been in need of a process for some time and a single framework for all to work from. [ADSAD] attended to go through the process and advised that it is a one size fits all document so it will need to be followed proportionately but the points in section 2.3 will always need to be followed.*
>
> *[DoS] advised that it is a finance and service planning tool and all agreed that the objectives of any case need to be well defined with an emphasis on the outcomes and a better understanding of the opportunity costs.*
>
> *[COO] queried whether we are clear on who puts the business cases together and where they go for sign off. It was discussed whether this could link in with the threshold delegation that we already have in place for the organisation. All agreed to sign off the process but with a bit of extra work to set out the approval process. All agreed for training to be arranged after the launch.*

We noted an update paper submitted to the EMG on the 7th February 2018 – Item EMG 18.017 which details under Section 3, a clear process for approving business cases. We note however that there are no financial limits included within the guidance by which decisions are made concerning investment/dis-investment.

We noted however, at time of review, that the old version of the guidance was included on the intranet site but understand this is in the process of being updated.

Evidence has been provided identifying the training that has taken place through the Step into Management programme 2018 (ASIM); however, the Business Cases' workshop was removed from the ASIM programme in August 2018.

We have been advised that this is set to be re-introduced through the Senior Management Programme, but will not take place until March 2020 at the earliest.

We met with the Assistant Director - Strategic and Business Analysis and the Assistant Director - Corporate Planning to identify the sample from the Board approved Annual Operational Plan [Meeting 12th July 2018 - Agenda Item 18.165b] using the '*Summary of Business Cases to be completed during 2018/19*' details [*page 155 of the Annual Operational Plan*].

Using the expected completion date [cases due upto and including quarter 3] we contacted the noted lead officers or other colleagues as agreed with the Assistant Directors.

Expected Revenue Business cases have been completed in line with the Executive Management Group approved guidance

Revenue Business Cases Guidance and Template

2. Overview

2.1 What a business case is

Essentially a business case is a document that outlines the reasons for making an investment decision, states how the scheme will be delivered and describes the benefits that will be achieved. It makes a clear recommendation to a decision-maker.

The business case must demonstrate that the proposal is:

- *supported by a compelling case for change*
- *the best value for money solution to the issue(s) it seeks to address*
- *affordable*
- *deliverable*

We identified nine schemes (scheduled for completion in either quarter 2 or 3) which required business cases.

Following receipt of evidence/correspondence from the identified leads, the findings are detailed in Table 1.

Table 1: Summary of Business Cases for completion during 2018/19 which have a revenue consequence

Scheme of Work	Lead Author	Expected Completion Date	Audit Comments
Orthopaedic Services	Secondary Care Director	Q2	We have been advised by the Director of Secondary Care that this scheme has not yet reached business case submission.
Transforming Pharmacy Services to support people with Mental Health and Learning Disabilities	Head of Pharmacy for Mental Health & Learning Disabilities	Q2	Business case provided as evidence - developed March 2019 and followed the template in the guidance; however neither the financial case nor the value for money assessment has been completed. We were advised that the original business case has been supported by Pharmacy and the MHLD Division - no

			funding has been identified.
Improving Health	Executive Director of Public Health	Q2	Drafted business case was provided and fully complied with the requirements of the guidance. We also noted that a summary of the business case was presented to the EMG on the 6th February 2019 - Agenda Item EMG19.014 Health Improvement & Inequalities Transformation. Minutes note the following: *EMG19.014.3 – Discussions ensued and all agreed that this was a prudent approach and is the right thing to do. The costs will require further work but all agreed with the direction of travel. It was also suggested that this is built into invest to save schemes and we need to ensure the Business Case is clear and that the right systems need to be put in place and is an opportunity to redistribute the resources.*
Infant Feeding Coordinator	Assistant Area Director, Children's – West	Q3	We were advised that an Infant Feeding Protocol has been developed, but we have not been provided with a business case for this scheme and are unsure if it has been progressed.

Promotion of Healthy Weight - Tier 3 services	Assistant Area Director of Therapies, East	Q3	The business case provided pre-dates the guidance and was developed on the 12th November 2015. We were advised that the Tier 3 service is up and running and started from early October 2018. We were advised that EMG approved the business case in 2016 but have been unable to corroborate this.
Prevention of ACEs	Assistant Area Director, Children's, West	Q3	We have not seen /been provided with a business case for this scheme and are unsure if it has been progressed.
Improving Emotional Health, Mental Well-being and Resilience of Children	Consultant Clinical Psychologist	Q3	We have not seen /been provided with a business case for this scheme and are unsure if it has been progressed.
Stroke Services (Pre-Consultation Business Case)	Secondary Care Director	Q3	A draft pre consultation case was presented to the EMG on the 7th March 2018. The Stroke Service Review Pre Consultation Business Case was presented to the EMG on the 9th May 2018 (version 13 020518). It is evident that the headings included in the template are addressed in version 13; we could not confirm that the approval process was documented.
Integrated clinical hub – Unscheduled Care	Secondary Care Director	Q3	A coversheet and a document entitled Transforming Integrated Urgent Unscheduled

			Care/GPOOH Future Service Model was presented to the EMG on the 5th September 2018. Part of the document included section on the integrated clinical hub however we cannot relate this to the expected development of a business case as detailed within the Operational Plan.

In reviewing the completion of revenue business cases, in line with the EMG approved guidance, Section 2.2 (extracted below) notes that Finance should be maintaining a log of all cases submitted.

2.2 How business cases fit into the overall planning and decision-making structure

Business cases should be used as an integral part of the organisation's planning process, either to inform the planning cycle or to respond to a priority that is identified in the organisation's Annual Plan or Integrated Medium Term Plan (IMTP).

They can be used at various levels of decision-making, including Divisions, Areas, Executives and the Board. Finance will keep a log of all submitted business cases.

At the point of writing this we have been provided with a log for 2019/20 business cases but have not seen the log relating to 2018/19 revenue business cases.

We were also provided with a copy of the '*Business Case Tracker 2018*' which is maintained by Planning and Performance to identify and capture existing cases in the 2018/19 operational 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	**2**	**1**	**0**	**3**

Finding - ISS.1 – Record of submitted business cases	Risk
EMG approved guidance, Section 2.2 notes that Finance should be maintaining a log of all cases submitted. At the time of our review, we did not receive the 2018/19 log of submitted revenue business cases but did receive the 2019/20 log.	Financial consequences of submitted revenue business cases are not considered and validated by Finance for affordability; Guidance not complied with.
Recommendation	**Priority level**
The Finance Directorate ensure all revenue business cases are subject to scrutiny in accordance with the approved guidance.	High
Management Response	**Responsible Officer/ Deadline**
A log of all Business Cases that have been submitted as part of the 2019/20 Financial Plan has now been produced, and will be maintained by the Planning Accountant. This is supporting a review of all new business cases included within the 2019/20 financial plan by the Finance & Performance Committee. Before any business case is submitted to the Executives for approval, a formal sign-off of the financial implications by the finance department will need to be evidenced within the document. If a formal sign-off is not evident, then the business case will be rejected immediately.	Finance Director – Commissioning & Strategic Financial Planning. Immediate.

Finding – ISS. 2 – Revenue Business Cases Guidance and Template	Risk

The Executive Management Group (EMG) meeting of the 6th September 2017, under *Agenda Item EMG 17/96 - Business Case Process* considered and approved the outlined process. The guidance is located on the Financial Strategy and Planning intranet site but is not cross referenced to other key planning sites on the intranet. Of the small number of developed business cases viewed as part of this review, some did not follow this approved guidance.	Guidance is not widely known across the Health Board.
Recommendation	**Priority level**
The Assistant Director - Strategic and Business Analysis considers publishing this guidance as a formal operational procedure/Policy to be followed across the Health Board. The Health Board considers including financial limits by which decisions are delegated.	High
Management Response	**Responsible Officer/ Deadline**
Following discussion with the Deputy Board Secretary, it has been agreed that the guidance (when amended in light of this audit) will be published as a Non-Clinical Procedure, in line with the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents. As a "Non-Clinical other written control document BCU wide" it will go to the Executive Team or EMG for approval. The revised guidance will specifically include financial limits which are in line	Assistant Director, Strategic & Business Analysis – August 2019

with the Scheme of Delegation and SFIs	Finance Director – Commissioning & Strategic Financial Planning – August 2019

Finding – ISS. 3 – Management training	**Risk**
The Assistant Director - Strategic and Business Analysis Strategic Analysis has advised that training will be provided through the Senior Leadership programme however has been informed that this will not take place until March 2020.	There is a lack of appropriately trained officers across the Health Board equipped to develop business cases for consideration.
Recommendation	**Priority level**
Given the importance of this area, this training should be brought forward and targeted at key posts across the Health Board structure where there is a need for the post to develop/input into business cases.	Medium
Management Response	**Responsible Officer/ Deadline**
Agreed. Discussions are being held with OD to agree the best way to accelerate the training.	Assistant Director, Strategic & Business Analysis – July 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Business Continuity Arrangements

Internal Audit Report

BCU 2018/19

May 2019

NHS Wales Shared Services Partnership

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Review reference:	BCU-1819-13
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Executive sign off:	Executive Director Of Planning and Performance
Distribution:	Assistant Director, Corporate Planning Business Continuity Manager Finance Director - Commissioning & Strategy Board Secretary & Deputy Board Secretary Compliance and Assurance Manager
Committee:	Audit Committee

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

1. Introduction and Background

Business continuity is a process of creating systems of prevention and recovery to deal with potential threats to the Health Board. Any foreseeable event that could negatively impact operations such as loss of or damage to Health Boards critical infrastructure. Should be identified within a business impact analysis (BIA) and included within a business continuity plan (BCP).

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

Due to the nature of the Health Board's business and geographical spread, it is imperative that there are systems and arrangements in place to ensure the smooth running of healthcare operations in the event of major disruption. Directors are accountable and responsible for ensuring they have robust disaster recovery and business continuity plans in place for their areas of responsibility which dovetail into the wider service, thus ensuring a seamless service continues in the event of a disaster.

The Business Continuity Management (BCM) Policy (BCMP01) identifies its aim as:

> *"To have an effective Business Continuity Management Strategy in place to meet our legal and statutory obligations, to ensure that that in the event of a business disruption we can continue to undertake our prioritised activities".*

The Policy continues to bed down within the divisions through the implementation of a BCM roll out/work plan. This was developed based on which areas present the greatest risk to the Health Board.

2. Scope and Objectives

The overall objective of this review was to ensure the Health Board is compliant with the stated Business Continuity Management Policy Objectives.

The scope of this review evaluated progress against the following objectives:

- We specifically focused on the BCM roll out / workplan developed by the Civil Contingencies Group based on an assessment of risk.
- We reviewed the frequency of plan testing and lessons learnt.
- Has Business Continuity been embedded into the culture of all aspects of the organisation through training and education and raising awareness through staff engagement?
- All Health Board departments included within the Business Continuity Management Policy are required to assemble (BC Leads) at least annually to ensure that business continuity plans are not developed in isolation and appropriate interdependences between departments are identified and written into plans and tested accordingly.

During the review we met with identified key officers with responsibility for business continuity management to undertake the appropriate testing.

3. Associated Risks

The risks considered at the outset of the review were:

- In the event of a business disruption the Health Board cannot continue to undertake its activities.
- Inadequate or out of date impact/risk assessments may affect the Health Board's ability to respond to a disaster appropriately;
- Disaster recovery and business continuity plans have not been developed and/or communicated effectively; and
- Lack of regular testing may prove disaster recovery plans ineffective.

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 Business Continuity Arrangements review is limited assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Policy is embedded within the divisions			✓	
2	Lessons learnt and field testing		✓		
3	Training provided to Business Continuity Leads		✓		
4	Business Continuity Leads assemble annually		✓		

** 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 Business Continuity Arrangements.

Operation of System/Controls

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

6. Summary of Audit Findings

This report is based upon the information provided by the business continuity leads and business continuity department aswell as supplementary information obtained/responses made during discussions.

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

Policy is embedded within the divisions

The Business Continuity Manager confirmed that the policy is still currently being delivered through a phased implementation roll out/work plan that has been developed based on the areas with greatest risk to the Health Board.

This review has sought to evidence progress made across the high risk areas identified within the work plan which has been developed and provided to us by the Business Continuity Department (BCD).

We undertook testing at various departments identified in the monitoring report (full monitoring table can be seen in Appendix C), result of testing can be seen in the table 1 below:

Table 1 – Findings of focused testing based on the workplan priorities

Service Area	Priority	BCP In place	BIA In place	Monitoring Report status	Audit Status	Audit Comments
Estates	High	Yes	Yes	G	G	BCP & BIA received as evidence. Last review of the plan June 2018 next review date is June 2019 no signature on the plan.
Critical Care	High	Yes	Yes	G	G	BCP & BIA received as evidence, No signature, date and no review date evident. However it was stated that the plan will be reviewed as part of the Emergency Planning Group
ICT	High	Yes	Yes	G	G	BCP & BIA received as evidence signed and dated with review dates. Plans are in the process of being updated due to the "split" of programmes and clinical systems that was applied on the 1st December 2018.

Please note: Comparisons made between the work plans we reviewed in 2017/18 and 2018/19 identifies improvement in departments' implementation of Business Continuity Plans (BCP) and associated Business Impact Analysis (BIA).

Lessons learnt and field testing

BCMP01 3.8 Process bullet point 4

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

Following from last year's review, it was identified that the testing of the plans were to be undertaken within the work plan for 2018/19. Through discussions with the BCM and the BC Leads within the sample it was specified that not all department plans have been tested on an individual basis. We did however receive evidence from the BCM detailing Health Board wide business continuity exercises/events (identified below) have taken place which would impact on various departments.

- In July 2018 (YGC) and September 2018 (Wrexham) - a planned data switch took place which involved no IT for the day, for both sites; evidence of lessons learnt was provided, however we received no evidence to support changes to existing plans to reflect lessons learnt.
- 15th February 2019 - a planned exercise (requested by the Chief Medical Officer) focusing on BREXIT and the EU transition with all departments

noted to be involved in the exercise – we've not requested sight of lessons learnt from this exercise.

Whilst there is evidence of wider plans being tested, through co-ordinated pre organised events, we have again been unable to confirm that all plans are being subject to testing annually.

The areas subject to focused testing, as outlined in table 1 above, notes the following:

Estates

We were unable to establish that any pre-planned testing of the department's plans had taken place and are unable to evidence lessons learnt.

Whilst there has been no planned testing of the BCP by the department themselves, it was stated that part of the plan has been tested with two major blackouts Wrexham Hospital – we have not corroborated this assertion or been provided with any lessons learnt from both events.

ICT

Evidence was provided by means of an excel spreadsheet illustrating that plans have been tested due to operational issues. We noted future test dates were also identified.

We noted that clinical systems BCP need reviewing with a formal test date also needed.

A Chairs report from the Informatics User Group and System Owners Group dated 31st November 2018 identified the following.

Agenda item - System Owners Training / Business Continuity

There is a risk that business continuity for IT systems are not supported within the Health Board, this may be due to a lack skill / knowledge of System Owners to complete business continuity plans / identify when the hardware / software that their system relies upon is unsupported. This may result in poor contingency management and an increased risk of cyber-attack.

Critical Care

The department has not undertaken any pre planned testing and could not evidence any lessons learnt.

We were advised that an element of the plan has been tested due to a fire evacuation - we have not corroborated this assertion or been provided with any lessons learnt from this event.

Training provided to Business Continuity Leads

BCMP01 4.2 Business Continuity Lead

"Nominated individuals must meet the requirements of the Business Continuity Lead role profile, full training and ongoing support will be provided to the Business Continuity Lead by the Business Continuity Manager".

Estates

No formal training has been undertaken by the business continuity lead, however it was stated that Operational managers would coordinate the staff during any service interruption. Whilst staff are not necessarily aware of the plans they are trained on the potential situations (subject matter training) due to the nature of the work.

ICT

No formal training has been received by the business continuity lead. It was stated that through discussions, the plans have been discussed within local departmental meetings. However we were unable to corroborate this as we did not received any evidence to support the aforementioned.

A Chairs report from the User Group and System Owners Group dated 31st November 2018 identified the following.

Agenda item - System Owners Training / Business Continuity

There is a risk that business continuity for IT systems are not supported within the Health Board, this may be due to a lack skill / knowledge of System Owners to complete business continuity plans / identify when the hardware / software that their system relies upon is unsupported. This may result in poor contingency management and an increased risk of cyber-attack.

Critical Care

No formal training has been received by the business continuity lead.

Business Continuity Leads assemble annually

2.2 BCMP01 Business Continuity Management Policy Objectives

All Health Board departments included within the Business Continuity Management Policy are required to assemble (BC Leads) at least annually to ensure that business continuity plans are not developed in isolation and appropriate interdependences between departments are identified and written into plans and tested accordingly.

We spoke to the three departments identified for testing as well as the Business continuity manager. The above policy requirement is not currently happening.

In discussion with the business continuity leads, they advised that this would be beneficial. This would encourage the requirements for training and also drive the regular testing of the plans and feedback on lessons learnt.

We have been provided with a presentation for a planned exercise concerning the EU transition. We recognise this as a step bringing together the Continuity leads, however this is for a specific matter rather than a planned, regular meeting per the Policy.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - ISS.1 – Compliance with Health Board Policy (Operating effectiveness)	Risk
The review has identified: • No routine business continuity leads meeting is being convened in accordance with Paragraph 2.2 - Policy Objective (last bullet point); • No evidenced annual testing of departmental continuity plans in accordance with BCMP01 Paragraph 3.8 - Process [bullet point 4]; and • No training for business continuity leads has been undertaken in accordance with BCMP01 Paragraph 4.2 – Training expectations for staff.	Health Board policy is not being achieved and exposes service continuity and learning lessons to risk.
Recommendation	**Priority level**
Corporate business continuity management ensure the Policy is complied with and obtains regular assurance, for subsequent reporting, of compliance from officers accountable for its implementation.	High
Management Response	**Responsible Officer/ Deadline**
A Business Continuity Group (BCG) has now been established and will meet bi-annually (the frequency can be reviewed at subsequent meetings). The first meeting has been scheduled for Monday 21st June 2019. A draft Terms of Reference will be circulated for comment at the Civil Contingencies Group in June and is attached herewith. Annual testing of departmental plans will be a standing agenda item at the BCG. An exercise schedule will be prepared and exercises will be facilitated and supported by the newly appointed Business Continuity Manager (this position is	Business Continuity Manager June 30th 2019

currently being advertised with a view to appointing in June 2019). Until this position is filled, the Head of Emergency Preparedness will support and facilitate exercises. Following each exercise, the BC departmental lead will be expected to produce an exercise report and action plan and this will be reviewed at the subsequent BCG where good practice and lessons learnt will be shared. Outstanding actions will be reviewed at each meeting until complete. Training requirements will be formally reviewed at each BCG meeting. The Head of Emergency Preparedness will be delivering formal training to the BC Leads followed by a desktop exercise (Exercise Estrella) at the initial meeting in June. Training records will be held by the Resilience Unit.  Business Continuity Group TOR.docx	

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.

Appendix C Business Continuity – Monitoring Report

Service Area	Priority	Lead Manager	BCP	BIA	TARGET PLAN COMPLETION	Status	Comments
Emergency Dept.							
YG	H	Lynne Roberts	Yes	Yes	14/07/16		Walkthrough of plan complete.
YGC	H	Ruth Milward	Yes	Yes	31/03/18		Plan received 30/04/19 requires approval and testing.
Wrexham	H	Charlotte Revell	Yes	Yes	31/01/18		Complete
ICT							
Informatics	H	Tracy Williams/Joy Littlehales	31/03/18	Yes	31/03/18		Plans received March 2018
Estates							
Operational Estates	H	John Peet	June 2018	Yes	June 2018		June 2018 – tested as part of data switch YGC July 19.
Facilities	H	Paul Clarke	10/11/17	Yes	31/03/17		Tested as part of data switch 2018.
Critical Care							

Service Area	Priority	Lead Manager	BCP	BIA	TARGET PLAN COMPLETION	Status	Comments
Directorate Wide	H	Chris Littler	Yes	Yes	October 2018		Plans approved at CCG – tested as part of data switch.
Renal							
Directorate Wide	H	Toni Hamlett	Draft prepared	31/01/2017	31/12/18		Email sent to Toni Hamlett 17/04/19 requesting update.
SCBU							
Directorate Wide	H	Siobhan Gorthorp Michelle Wright Martin Mcsppaden	January 19	31/03/18	31/03/18		Approved January 19
Theatres							
Directorate Wide	H	Dafydd Pleming	Yes	Yes	30/11/2018		Plan Complete.
Cath Lab							
Directorate Wide	H	Tracy Sellar	Partly	08/06/17	31/07/18		Meeting scheduled for May 19 to complete plan.
Mental Health (Acute)							
Directorate Wide	H	Sam Watson Fleur Evans Carole Evanson	Yes	Yes	30/09/17		Plans complete.
Womens							

Service Area	Priority	Lead Manager	BCP	BIA	TARGET PLAN COMPLETION	Status	Comments
Directorate Wide	Director ate Wide	Directorate Wide	January 19	Yes	March 19		Draft plan complete awaiting approval – tested during exercise Brexit.
Pathology							
Pathology	H	Ian Walker	Yes	Yes	31/01/19		Part of the plan tested as part of Exercise Brexit. Plan also tested during YGC data switch.
Pharmacy							
Pharmacy	H	Sue Lord Jacqui Liddle Lis Duborg	Yes	Yes	31/05/19		A further meeting was held on 03/05/19. The plan has been updated and action cards are being drafted by the BC Leads. An exercise will then be scheduled.
Radiology							
Radiology	H	Vicky Freeman	Yes	No	31/03/18		Radiology have their own plan. This was tested during the YGC data switch and at Exercise Brexit.
Childrens							
Children's Ward	H	Martin McSpadden	Yes	Yes	31/03/18		Plan complete
Children's							
Wrexham Child Health Centre	H	Siobhan Gorthorp	Yes	Yes	31/01/18		Plan complete

Service Area	Priority	Lead Manager	BCP	BIA	TARGET PLAN COMPLETION	Status	Comments
Substance Misuse							
BCU Wide	H	Tracy Griffiths	Yes	Yes	29/02/18		Awaiting approval – email update requested April 2019.
Audiology Business Continuity Plans							
BCU Wide	M	Anna Powell	Draft	Yes	31/05/19		Meeting in January 2019 – audiology department is within EMS corridor at Wrexham Maelor Hospital therefore plan necessary due to potential heating issue. Further EMS meeting 01/05/19.
EMS Contingency Plan							
Wrexham Maelor Hospital	H	Maureen Wain	Yes	Yes	Ongoing		This plan has been prepared due to the issues identified with the heating at the Wrexham Maelor Site. This is a working document and arrangements are being prepared. Further meeting 15/05/19
Area Plan - Central	H	Emma Lea	No	No	30/09/19		A workshop for key departments is currently being arranged and due to take place mid May 19.

Betsi Cadwaladr University Health Board

Case management and disciplinary process

Final Internal Audit Report

BCU 2018/19

April 2019

NHS Wales Shared Services Partnership

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Executive sign off:	Executive Director of Workforce & Organisational Development
Distribution:	Assistant Director - Employment Strategies & Practices Workforce Governance Manager Head Of Medical Workforce Board Secretary Deputy Board Secretary Compliance & Assurance Manager
Committee:	Audit Committee

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

1. Introduction and Background

All Employers are required by law, as a minimum, to outline their disciplinary rules and procedures in the employees' written statement of terms and conditions.

The policy should follow the basic principles set out in the Advisory, Conciliation and Arbitration Service (ACAS) code of practice on disciplinary and grievance procedures (March 2015) and must inform employees on what is acceptable and unacceptable behaviour in the workplace and what action will be taken if the rules are broken.

If an employee is dismissed without following a contractual disciplinary policy a breach of contract case can be brought against the Health Board in a County Court or High Court, or wrongful dismissal (i.e. dismissal in breach of contract – regarding the notice period and loss of salary over the period in which the disciplinary procedure should have been followed) and unfair dismissal in an Employment Tribunal.

It is worth noting that not following the ACAS code is not illegal, however, if someone wins an employment tribunal against the Health Board and the code was not followed, then their award could be up to 25% more.

2. Scope and Objectives

The objective of this review was to establish that a robust control environment is operating across the Health Board to ensure compliance with the Disciplinary Policy (WP9), ensuring all investigations are undertaken with fairness and transparency in a timely manner.

Following the requirements set-out in the all-Wales Disciplinary Policy (WP9) and Guidelines for managers to support the all Wales Disciplinary Policy (WP9a), the scope of the review will consider the most recent *Employee Relations Case Management Report* presented to the Finance & Performance Committee and using the reported performance data identify a sample of disciplinary cases which focus on the following:

- Adequate training is provided for investigating officers;
- Investigations have a clear scope and expected delivery within a reasonable timescale;
- Review of the timeline taken from instigation of the investigation to completing the investigation and documenting the underpinning reasons for delay [and that these do not contravene Health Board policy];
- Investigating officers are subject to monitoring for delivery of assigned investigations;
- Identify the process for reporting the medical and dental data.

The sample has been drawn from cases over 26 weeks and aimed to include Medical and Dental staff. The review did not consider any investigation relating to Tawel Fan.

3. Associated Risks

Risks identified at the outset of this review were, but not limited to the following:

- Investigation is not reasonable (full investigation for a verbal warning offence);
- Investigating officer is not appropriately trained;
- Suspension is not/is required; and
- Investigation is not undertaken in a reasonable time.

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 **Case management and disciplinary process** review is limited assurance.

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

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

5. Assurance Summary

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

Assurance Summary						
1	Training for Investigating Officers		✓			
2	Scope of Investigation		✓			
3	Investigation timeline		✓			

Assurance Summary						
4	Delivery Timeline set		✓			
5	Monitoring the delivery		✓			
6	Medical Workforce					✓

** 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 two issues that are classified as weakness in the system control/design for Case management and disciplinary process.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weakness in the operation of the designed system/control for Case management and disciplinary process.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Non-Medical and Dental Staff

The review considered a random sample of twenty ongoing cases as at 1st April 2018; these were made up of twelve disciplinary cases. Reviewing these cases against the scope of the review based on the requirements set-out in the all-Wales Disciplinary Policy (WP9), the findings were as follows:

Training for Investigating Officers

Per the all Wales Policy, all investigations are to be assigned an Investigating Officer (IO) with exception to any cases that are deemed a 'fast track' case. All 'fast track' cases are identifiable by the case reference number where the letters "DIFT" are prefixed, fast track cases do not require an investigation as the employee has admitted misconduct or there is prima facie evidence available. None of the cases reviewed were classified as 'fast track'.

Most internal Investigating Officers have completed the *A Step into Management* (ASiM) Investigations module, however we are unclear whether all officers assigned investigations have completed this training. External IO's will not have been allowed to conduct any investigations until the Head of Workforce: Mental Health has personally trained them. This training is conducted over a whole day in groups.

Scope of Investigation provided at the outset

Based upon the evidence viewed, we did not identify a clear, formalised scope provided to investigating officers prior to commencing the investigation – Whilst we recognise the investigation will be the driver, no formalised scope is detailed to ensure the IO remains 'in scope' and does not deviate from the allegation. There is a COM1 form for the Commissioning of Employee Relations Investigation (WP9a Appendix 2 - Responsibility Matrix Disciplinary Policy [Page 3]) which is completed to initiate the investigation and used to facilitate a conversation and provide structure for the IO.

We have been informed that the Investigation Commissioning Form (COM1) form is not mandatory and would not be held on the disciplinary file.

The COM1 form includes key fields relating to the investigation including:

- Date investigation commissioned;
- Expected duration;
- Allegation(s) to be investigated; and
- Documentary evidence to be examined.

We did not view any COM1 form for the sample reviewed.

Investigation timeline

As investigation times are not always recorded they cannot be measured. From our sample of both open and closed cases, we were unable to identify the investigation start and if applicable end date - the absence of this data undermines the ability of Workforce and Organisational Development Directorate to report on the efficiency of the process.

We were able to identify that all disciplinary cases (with exception of one which was terminated due to staff member receiving a prison sentence) had taken over the three months to conclude or were still ongoing/open cases. At the time of the review two of the five grievance cases were still open twenty two months after the cases were opened. Management have advised a target has been set in a paper tabled at the Finance and Performance Committee to get to a twelve week position by the end of quarter three.

Delivery Timeline set

The Letter sent out upon initiation of a formal investigation from the Manager to the Investigating Officer clearly sets out expectations of the role, stating:

- *The investigation commences promptly and is completed as soon as is reasonably practicable*
- *It is expected that the complete process should take no longer than 3 months*
- *Should the investigation not be completed in a timely manner, or there are delays within the process outside your remit then the progress of the investigation must be provided to me as the Commissioning manager, and regular verbal updates on the progress must be provided to the employee and their representative. Updates to me should be reported through the Commissioning of Employee Relations Investigation form.*
- *Obtain all relevant information. This will include interviews with all relevant witnesses, statements taken, documentary evidence obtained (e.g. employment records) and as appropriate, outside agencies, bodies or individuals concerned.*

Workforce systems do not record all of this data and as a result we are unable to ascertain the reasons where delays in the process are occurring.

The Responsibility Matrix in WP9a (Appendix 2) provides clear guidance on the case management roles, responsibilities and documentation, again, this is not mandatory and a standard audit trail of the investigation is not recorded.

Monitoring the delivery of ongoing cases

All employment cases are recorded within Electronic Staff Record system (ESR) and monitored by Workforce via a spreadsheet using exported data from ESR; there was no evidence from the results of the review that the spreadsheet is routinely updated or details provided as to why the cases were taking longer than the three month expected.

The review identified that each Investigating Officer/HR Manager are responsible for their individual case documentation; this is not maintained centrally and we are unclear whether all files are retained in accordance with Corporate Records Management Procedure (IG02).

Medical and Dental Staff

When any concerns arise with medical and dental staff the Health Board will invoke the Upholding Professional Standards in Wales (UPSW) procedure which supersedes the WP9 Disciplinary Policy and WP9a Guidelines for Managers to Support the All Wales Disciplinary Policy.

UPSW procedure sets out the way by which Health Boards in Wales address concerns about capability, performance and conduct for all employed doctors and dentists. This procedure replaces all relating policy and procedures in operation within the Health Board and has been effective since the 1st of September 2015; it also replaces previous disciplinary procedures enshrined in WHC(90)22 and DGM(95)44 and the provisions in WHC(82)17 for Special Professional Panels.

In addition, the right of appeal to the Secretary of State, held by certain practitioners under paragraph 190 of their terms and conditions of service, is also abolished from the effective date of this procedure. As well as applying to all practitioners employed by the Health Board, the procedure includes staff in training and on temporary, locum or honorary contracts. There are five key elements to UPSW, these are as follows:

- Action when a concern arises;
- Restriction of practice and exclusion from work;
- Handling concerns about a practitioner's health;
- The Standard Procedure; and
- Extended Procedure.

A key principle of this procedure is that allegations are "promptly and thoroughly investigated to verify the facts so that appropriate action can be taken".

It is also states that nothing within this procedure precludes any individual from referring a matter of concern directly to the General Medical Council (GMC) or

General Dental Council (GDC) where they have concerns regarding a practitioner's compliance with standards laid out in the "Good Medical Practice" or the "Standards for the Dental Team".

We reviewed the internal process for a sample of six of the eight ongoing concerns. Internal management reports identified:

- One case is over four years old;
- One case does not have a clear start date;
- Two cases are over eleven months old;
- One case has a recorded update date eight days prior to the case start date;
- Only one of the four UPSW cases had a Board Member allocated; and
- Two cases had not been allocated Investigating Officer.

We were advised that there were no medical and dental staff under investigation under UPSW on "gardening leave" at the time of the review – We have not corroborated this assertion.

UPSW state that in the majority of cases, matters can be dealt with locally without escalation to formal proceedings.

We were advised that the Health Board enter formal proceedings with less than one UPSW case per month, which is less than what would be undertaken following the WP9 process.

The Health Board is required to ensure that Case managers and Investigating Offices are trained in the use of UPSW. The Medical Workforce are currently undertaking a Training Needs Analysis with a view to procuring more training from the National Clinical Assessment Service (NCAS) specific to the UPSW in the near future.

It is noted that some complex cases can take many months to investigate and a large proportion of working time can be spent on conducting the investigation alone. Due to clinical pressures it can be difficult for staff to be released from clinical facing duties.

We were advised that in situations where the fact finding identifies a case as being complex, it has proved difficult for investigations to be conducted with internal investigators, consequently Workforce try to ensure that an external investigator is used.

At the time of the review Medical Workforce had only three representatives who are fully trained and experienced to support such cases.

The Health Board use up to four external investigators who have been specifically trained within the use of UPSW by NCAS, and have either previous working experience of the Health Board or have previous investigation skills such as former police or former HR professionals.

There can be a need for investigations to take longer than the stipulated time period of 28 days due to complexity of the case or other reasons such as sickness/availability of staff representatives.

We were informed that the Board receive reports through the Committee structure of Finance & Performance and Remuneration and Terms of Services (RATS), concerning UPSW cases which have been ongoing for six (6) months or more; and where is there is a restriction to the duties the individual can carry out/full suspension from work.

At the time of our review, we noted that the Terms of Reference for the Finance & Performance (F&P) Committee stated that the F&P Committee shall receive quarterly assurance reports in relation to workforce – the last noted report received was the 26th April 2018 pertaining to the Employment Relations Case Management update (FP18/70.1).

The Remuneration and Terms of Services Committee has the responsibility, per its Terms of Reference: Delegated Power 3.1.3 *'to monitor compliance with issues of professional registration.'* We note from the Committee's draft annual report for 2018/19 [Agenda Item R19.27 – section 3.8 of the report] that two reports have been presented on the 30th April 2018 and 14th January 2019 – we have not reviewed their content.

Delays are monitored and dealt with through regular reporting and monitoring on how cases are progressing. However the reporting of this through the Doctors in Dispute (DiDs) report does not clearly evidence timelines.

The Medical Workforce representative supporting the case will liaise with the Budget Holder for the area which the individual is being investigated concerning costs that are specifically incurred as a result of the review - These costs include:

- External investigator costs;
- Formal Panel Costs including barrister, independent panel member and specialist member costs, room and facilities hire, materials;
- Legal Costs – Legal support is provided by Blake Morgan (with authority from Assistant Director of WOD). This can include advice at the initial stages of investigation if required or as part of fully supporting a formal panel, depending on the case in question.

There is a monthly Meeting with the Executive Medical Director to discuss the progress of cases.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**2**	**0**	**4**

Finding - ISS.1 - Record of Investigating Officers and training provided (Control design)	Risk
We were unable to ascertain whether all investigating officers [internal and external] had undertaken the relevant training provided by Workforce & OD.	Investigation is not conducted in line with the all Wales policy.
Recommendation	**Priority level**
A central repository maintained of all available investigating officers and when they completed/received the relevant ASiM/equivalent training.	Medium
Management Response	**Responsible Officer/ Deadline**
All ASiM training is routinely recorded on ESR. External investigating officers received bespoke training on appointment. However their use is currently being phased out, and they will only be utilised in exceptional circumstances. A central record will be developed of investigating officers, but dates may not be available for those who have been trained for some time and conduct investigations regularly.	Assistant Director HR 28.2.19

Finding - ISS.2 - Monitoring arrangements (Operating effectiveness)	Risk
There are no clear arrangements in place to monitor ongoing cases, thus ensuring that adequate support is provided when necessary and avoid delays.	Delays in delivery of cases.
Recommendation	**Priority level**
The COM1 form is mandated for completion and additional section added for completion and signing by the IO.	Medium
Management Response	**Responsible Officer/ Deadline**
Cases are monitored monthly by the Assistant Director HR and Executive Director of Workforce and Organisational Development. Exception reports are produced by Heads of Workforce for all cases of over 12 weeks' duration. The COM1 form is not optional, and staff will be reminded that this must be completed.	Assistant Director HR 31st January 2019

Finding - ISS.3 - Investigation files and File retention (Control design)	Risk
The review identified that each investigating officer/HR Manager were responsible for their individual case documentation which is not maintained centrally.	Breach of legislation.
Recommendation	**Priority level**
A central document repository for investigation files (electronic) with clear retention timelines for deletions set up for access by the Workforce and Organisational Development department. This ensures that all documentation is stored in a central location with a clear destruction schedule to ensure compliance with GDPR/DPA.	High
Management Response	**Responsible Officer/ Deadline**
This will be investigated in conjunction with IT to ensure an electronic solution with sufficient storage space.	Assistant Director HR / Workforce Governance Manager 28.2.19

Finding - ISS.4 - Recording of timelines (Operating effectiveness)	Risk
We were unable to determine where delays in the disciplinary/case process sit as dates for investigation start; investigation end were not recorded in most cases and not recorded on the COM1.	Lack of effective control.
Recommendation	**Priority level**
All details of case timelines and reasons for delays should be recorded to ensure that cases are concluded in a timely manner for both individual and service. There should be a clear process to ensure all delays are subject to follow-up with summary data reported.	High
Management Response	**Responsible Officer/ Deadline**
Cases are monitored monthly by the Assistant Director HR and Executive Director of Workforce and Organisational Development. Exception reports are produced by Heads of Workforce for all cases of over 12 weeks' duration. A tracker has been developed with more detailed timelines than available in ESR. This will more clearly demonstrate where delays occur. This will be operational from January 2019.	Assistant Director HR 31.1.19

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

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Shared Services Partnership
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Betsi Cadwaladr University Health Board

Mental Health and Learning Disabilities Governance Arrangements

Final Internal Audit Report

BCU 2018/19

March 2019

NHS Wales Shared Services Partnership

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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.

1. Introduction and Background

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

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

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

2. Scope and Objectives

The overall objective was to review the governance arrangements in place for the Mental Health and Learning Disabilities Division in line with the requirements issued by the Office of the Board Secretary.

The scope of this review sought to:

- establish the governance structures in situ to deliver on their obligations and to apply appropriate scrutiny to performance, decision making and the resolution of issues arising. To assist in this we obtained sight of the organogram, which presents in a pictorial fashion the structure(s) of assurance and accountability;
- review the quality and safety arrangements in place to include evidence that the HARM dashboard and ward quality and safety audit findings are used by management to improve services; and
- ascertain performance management reporting mechanisms are in place.

3. Associated Risks

The following risks have been identified at the outset of this review:

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

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Mental Health and Learning Disabilities Governance Arrangements review is limited assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Governance		✓		
2	Quality & Safety		✓		
3	Performance			✓	

** 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 Mental Health and Learning Disabilities Governance Arrangements.

Operation of System/Controls

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

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

The review has identified matters that require attention, however we recognise that this review was timed and agreed with the Director, to coincide with the formal adoption of its revised governance structure which went live in September 2018 and the findings should be seen in this context. We would still expect that key systems and controls would have been in place and functioning as designed.

Governance

The Division issued a revised governance structure in September 2018 and through its 'Governance Structure documents v23 4/10/18' detailed its organogram and provided Terms of Reference (ToR) available, coupled with the template documents for use across the Division.

The Division has two 'tier 1' and three 'tier 2' meetings[1] established through which it governs its business. Underpinning both tiers, there are a further twenty-five 'groups/meetings' established, from which the tier 2 receive assurance and hold to account.

The Division has a Director of Transformation but we could find no specific reference at tier 2 which takes forward this agenda.

The Division's key objectives were noted in the IMTP Planning 18-19 document shared with us, however it is unclear how these have been used to shape and inform the design of a meeting/group governance structure which provides the means to scrutinise achievement against them.

We have not reviewed the timeliness of the submission of papers and issuing of agenda/minutes as per any timelines recorded in relevant ToR.

The Division delivers services pan-North Wales, with relevant Directors assigned as Chairs, being accountable for ensuring compliance with ToR, and through support staff ensuring papers are received. There is no officer whose sole responsibilty is to ensure the Health Board's governance arrangements; compliance with Standing Orders; Standing Financial Instructions; and all ToR are all met, or ensuring that its governance and accountability structure remains fit for purpose.

Tier 1 – Divisional Directors (Operational) and Divisional Directors (Strategy) footnote

The Division has established an Operational meeting which notes its purpose as "…. *accountability for all aspects of performance, governance, quality and patient safety, patient experience, operational standards, financial performance, workforce and environmental issues.*"

[1] Tier 1 meeting refers to the Divisional Directors meetings and Tier 2 refers to those meetings established by the Division and directly reporting to Divisional Directors.

The Strategy meeting notes its purpose as *"…accountability for all aspects of strategy, planning and transformation of Mental Health, Learning Disability and Substance Misuse Services across North Wales."*

Both meetings have similar ToR; membership; Chair [Director]; and Vice Chair noted as '*TBC'*. In addition we noted omissions in membership when comparing to the minutes - Director of Clinical Psychology and Medical Director are not recorded as members of either group but regularly attend the meetings.

Both ToR were signed by the Chair on the 14th August 2018.

With the exception of the opening statement included within the *'Purpose'* of each meeting's ToR, there are few differences between the remaining elements within this and it is unclear why there needs to be two separate meetings established, particularly when one similar statement in each ToR notes, *'It will ensure robust scrutiny and challenge for items tabled at Divisional Directors [Business/Strategic] Group meetings'*, thus the respective meeting is reviewing its counterpart.

Both ToR require deputies to be sent in the absence of members; in reviewing the minutes provided we saw no evidence of this happening.

In addition, neither ToR formally record the established tier 2 groups/meetings that report to them.

We requested sight of the cycles of business for both meetings but were advised there were not any currently.

Minutes provided do not appear to be using the template; there was no attendance list to aid scrutiny by the Chair of regular apologies, coupled with ensuring deputies are sent [where relevant]. Minutes also show deferments of papers to following meetings are happening, but it is not clear how these are addressed, for example:

> Minute DD 18.182 [28th August 2018] – "*TQIP – Deferred to next meeting."* – We can find no clear reference of this item considered in the 25th September 2018 meeting.

We identified two meetings that were not quorate and therefore any decisions taken should be reconsidered – Business meeting [14th August 2018] and Strategy meeting [11th September 2018].

The review also identified no formal reporting, through a Chair's report from the relevant tier 2 meetings or the receipt of minutes [as noted in some tier 2 ToR].

<u>Tier 2 – Quality – Safe, Effective, Experience, and Leadership Group (QSEEL)</u>

The ToR were signed by the Chair [Director of Nursing] on the 20th September 2018; Vice Chair is the Medical Director – we have been unable to confirm that Divisional Directors has ratified the ToR.

Within the organisational structure, QSEEL has fifteen established sub-groups, however none of these are formally noted as reporting to QSEEL in its ToR.

Whilst reviewing the fifteen sub-groups and their effectiveness is outside the scope of this review, our observation of the organogram suggests maintaining

effective scrutiny and monitoring performance of such a significant number of groups may not be possible and expose the Division and Health Board to risk.

There are a total of thirty-one posts noted as members with a quorum of seven; Minutes provided of the inaugural meeting of the 16th August 2018 confirmed quorum, however we did note a large number of apologies recorded.

There is a cycle of business which we reviewed for compliance with the agenda shared with us – we noted a number of variances between expected agenda items and those actually recorded, coupled with items on the agenda that did not appear on the cycle of business.

We noted that there were a number of papers recorded as 'Paper to be submitted' or 'Paper required'. We did not review the timings of groups reporting to Divisional QSEEL, but were advised by the Director of Nursing that the dates of these meetings, were not at the time of being established, synchronised with the Divisional QSEEL meeting to ensure timely reporting of assurance and issues of significance.

Tier 2 – Operational Accountability Group (OAG)

We were provided with a signed but undated ToR [Operational Accountability Meeting TOR v7 - DRAFT] with some housekeeping/typographical issues noted; the Chair is the Director of Operations and Service Delivery with Vice Chair being the Chief Finance Officer - we have been unable to confirm that Divisional Directors have ratified the ToR.

Within the organisational structure, OAG has four established sub-groups, however none of these are formally noted as reporting to OAG in its ToR.

We requested the meeting cycle of business but had not received it at the time of reporting.

Quorum of the meeting states the Chair/Vice Chair must be present, however the Director of Transformation chaired the meeting of the 16th August 2018 – consequently this meeting was not quorate as neither Chair or Vice Chair attended.

The review of agenda and minutes noted effective scrutiny and challenge by the Chair; the attendance list noted poor attendance from Workforce & OD (WOD) which was reflected in a formal note in the 20th September 2018 meeting:

> ***Action**: [Chair] will address consistent WOD attendance at this meeting as these metrics are key performance issues.*

We reviewed the 18th October 2018 minutes and the WOD representative is minuted as not attending.

A key requirement for the group is to '*11. Monitor adherence to Declarations of Interest*' – We could find no reference on the agendas provided to us that the group actively fulfills this role.

The OAG has a rolling action plan to capture matters requiring further reporting – In the October 2018 meeting, items from June 2018 remained outstanding.

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

We were provided with signed ToR by the Chair [Medical Director] dated the 21st November 2018; the Vice Chair is the Director of Nursing - we have been unable to confirm that Divisional Directors has ratified the ToR.

Within the organisational structure, SSRD has six established quality and workforce sub-groups, however none of these are formally noted as reporting to SSRD in its ToR.

In addition, we noted four additional Chairs of Commissioning; Liaison; Primary Care; and Forensic[2] Quality & Workforce Group as members but cannot locate these groups within the organogram. We also noted *'Senior Leader representation from East, West and Central areas'* are recorded as members but are unclear on the posts attending.

Reporting and assurance arrangements within the ToR are very detailed [in comparison to others] and include a number of actions which we would expect it to receive and consider as opposed to develop:

- *Advise the SPPH on progress with regard to the development and delivery of the Division's medium and long term plans in relation to MH & LD strategies.*
- *Respond to Welsh Government in relation to national delivery plans including Together for Mental Health Delivery Plan, Crisis Care Concordat, Co-occurring Framework.*
- *On request will provide assurance reports to regional groups and Boards.*
- *The Group will also advocate and make recommendations regarding the redesign of services to ensure that they are reflective of the needs of the population, particularly those with the greatest health needs, as part of tackling health inequalities and delivering evidence-based models of care.*

We have not received a copy of the cycle of business and noted it had its inaugural meeting on the 4th September 2018 with a second meeting held on the 24th October 2018 – the attendance list records a number of apologies/non-attendance considering the meeting has only just commenced.

Using the 24th October 2018 minutes, we reviewed attendance to verify quorum – Whilst names and post titles are recorded, these do not correspond to the membership titles in the ToR and cannot confirm quorum.

Quality and Safety

Divisional QSEEL

The Division has established a corporate Quality – Safe, Effective, Experience, and Leadership Group (QSEEL) chaired by the Director of Nursing with eleven specific functions detailed in its ToR. The organogram details four established (three Area and one Region) QSEEL meetings with an additional eleven sub-groups having been established and reporting to the divisional meeting.

We were advised that the Division had not held a quality meeting since October

[2] The Membership of SSRD records a second Chair of Forensic Quality & Workforce Group attending this meeting.

2017 which is why the division tried to catch all in its first inception. The inaugural QSEEL meeting commenced following the 11 months period of not holding this meeting. Further, we were told it was a divisional priority to ensure all quality and safety issues outstanding and current were addressed in this first meeting. As part of this review, we have not corroborated the lack of Quality Meeting prior to the new governance structure.

The governance and reporting arrangements need refining and revisiting to ensure the divisional meeting does not become overwhelmed [in both detail and expectations] as it attempts to 'catch-all' matters of quality and safety within the division.

In reviewing the evidence provided, we sought to establish whether the Division utilises the HARMS dashboard as a means for scrutinising and driving improvements in patient care.

We were advised at the outset [meeting on the 27th September 2018] that the Division does not routinely use the HARMS dashboard as it does not always deliver meaningful data and is geared, in the main, for acute and community hospitals.

We were advised that the HARMS dashboard is specific to areas across the Division and is reviewed in Acute Care Meetings held daily and weekly at locality TodayWeCan (TWC) meetings.

This is a live dashboard and is utilised by all areas. Items of significance are reviewed at Divisional TWC weekly. Additionally, there is a template 'chairs assurance report' for QSEEL which now includes HARMS dashboard and remedial actions taken – It should be noted that we have not corroborated this assertion since the change happened post this review.

However, it is evident from the QSEEL ToR, that whilst not specifically detailing all aspects reported upon by HARMS [per the following extract], it does allude to aspects, although it is unclear the data source used:

> *Ensure the adequacy of safeguarding and infection, prevention and control arrangements;*
>
> *Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:*
>
> - *Sources of internal assurance (including clinical audit) are reliable*
> - *Recommendations made by internal and external reviewers are considered and acted upon on a timely basis*
>
> *Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.*

Using the latest divisional agenda provided to us [18th October 2018], we noted within the *'SAFE'* domain the following:

> *Agenda item 180816.5*

5.1 - *Receive reports from Area QSGs* - No papers were included in the agenda;

5.2 - *Receive Reports from area Risk Registers* – No papers were included in the agenda;

5.3 – *Receive Safeguarding Report* - No paper was included in the agenda;

5.4 – *Receive Violence and aggression Report* - Report included;

5.5 - *Health & Safety update* - No paper was included in the agenda;

5.6 - *Patient safety alerts* - Report included;

5.7 - *Falls report* – Paper included; The paper provided was for quarter one (2018/19) and annual report for 2017/18; Reviewing the content, the report noted *"Within that OPMH pattern there is variability as shown below. Bryn Hesketh experienced almost a tenfold increase (833%) in comparison to the same quarter last year and now accounts for 43% of all OPMH falls and almost 40% of all divisional falls. This ward is currently subject to a separate thematic review to try and understand the cause."* The recommendations and actions made did not raise the issue of Bryn Hesketh.

5.8 - No agenda item title;

5.9 - *Safe Clean Care* – Papers included; The Safe Care run charts paper provided incorporates run rate charts relating to HARMS topics: Pressure ulcers (report shows spike in West area but no evidenced action noted); Medication errors (report shows an upward trajectory); and Infection (report shows a MSSA spiked in August 2018).

Area and Regional QSEEL

We obtained a sample of agendas for the four meetings to review HARMS focused areas. We did not review meetings for compliance with their ToR or whether meetings were quorate.

The Director of Nursing sent an email on the 9th September 2018 to a number of officers, under the subject heading of *"Harms Dashboard data via IRIS"*; the content stated:

Dear All

Please can you confirm you are reviewing the harms dashboard accessed via this link http://bcuiris.cymru.nhs.uk/IRIS/Nursing.aspx

This will need to be a standing agenda item on local Q-SEEL from September, please can you ensure this is included in the monthly business cycle.

I would suggest you review this daily in your escalation meetings as a means to spot any immediate safety concerns.

[Officer/Officer] are there any omissions that we need adding? Can you list these so I can raise with [Associate Director of Quality Assurance] and [Director of Nursing and Midwifery].

In reviewing agendas provided since this email was issued we noted:

- West and East QSEEL meetings did not have HARMS on their agenda;
- Central QSEEL included only this email at its meeting of the 3rd October 2018 under Agenda Item *20181003.10 – For Information*;
- Regional Services QSEEL meetings of 10th September and 1st October 2018 both have HARMS dashboard as an agenda item; 10th September 2018 - Minute 20180910.4 states *"Reviewed and agreed that all inpatient services for RSS are captured."*; 1st October 2018, Agenda Item 20181001.5.5 – HARMS dashboard has no paper included.

Performance

The Division has established the Operational Accountability Group (OAG) which has a broad role from financial planning and monitoring to performance management – The Director of Operations and Service Delivery chairs this meeting.

In reviewing the sample of minutes provided against the purpose outlined in the ToR, we identified that performance forms a key part of the meeting with the four Heads of Operations noted as providing updates.

The Chair is very active in the meeting with a number of actions assigned to them – There is limited evidence in the minutes that other members challenge on performance.

In reviewing the latest agenda and draft minutes we received [18th October 2018], focusing solely on performance, the minutes recorded delayed transfers of care; PADR; Mental Health Measure; sickness; but were scant in detail where the relevant Performance Report was included. We were also unclear from the minutes what steps were to be taken to improve performance and whether the actions recorded were robust to deliver improvement.

Whilst noting specific focus by the four areas, we could not identify divisional reporting of the performance data included in the Health Board's Integrated Quality and Performance Report – September 2018 data reported non-achievement across all measures bar one [MHM3 – Copy of agreed plan within 10 days].

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**4**	**1**	**7**

Finding - ISS.1 – Compliance with governing documents (Operating effectiveness)	Risk
The review has identified housekeeping/issues of compliance with the Terms of Reference (ToR) developed by the Division. In reviewing the Tier 1 and Tier 2 established meetings, we identified the following: • Could not confirm that all Tier 2 meetings ToR had been approved by Divisional Directors; • ToR do not formally record the establishment of sub-groups that report to them; • Identified two Divisional Directors and one Operational Accountability Group meetings were not quorate; • Noted cycles of business were not evident for all meetings which map out delivery against ToR; • Established 'in-house' templates were not always followed (attendance lists missing; action lists not included); • Deputies did not attend meetings whilst ToR explicitly stated they should; • Action plans reviewed had matters outstanding dating back to June 2018 with no expected closure date noted; • Membership of some meetings were not complete (e.g. Medical Director and Director of Psychology not noted as being members of Divisional Directors but regularly attended); • Papers not included in Agendas;	Established Terms of Reference are not complied with/incomplete.

• We could not see Chairs reports from Tier 2 meetings being considered at Divisional Directors.	
Recommendation	**Priority level**
The Director of Mental Health & LDS, through the management team: • Ensure Tier 1 and Tier 2 ToR are reviewed for completeness, accuracy and can be achieved. • Servicing of meetings to ensure compliance with expected governance standards including establishing cycles of business; minute taking; submission of papers is subject to review. • Liaise with the Office of the Board Secretary for ad-hoc support and guidance.	**High**
Management Response	**Responsible Officer/ Deadline**
The Division will ensure that Tier 1 and Tier 2 ToR are reviewed for completeness. Issues of housekeeping and compliance will be addressed to ensure that the Division meets expected governance standards. In addition, MHLD will strengthen links with the Office of the Board Secretary.	Director MHLD End April 2019

Finding - ISS.2 – Role accountable for governance arrangements (Operating effectiveness)	**Risk**

The Division delivers services pan-North Wales with relevant Directors accountable for ensuring compliance with ToR and through support staff ensure papers are received – There is no officer whose sole role is to ensure the Health Board's governance arrangements; compliance with Standing Orders; Standing Financial Instructions; and all ToR are met, coupled with ensuring its governance and accountability structure remains fit for purpose.	Lead Directors are not supported in discharging their roles as Chairs and are not held to account where governing documents are not complied with.
Recommendation	**Priority level**
The Director of Mental Health & LDS reviews and considers the merits of establishing a senior role, with relevant authority, to ensure governance arrangements are complied with across the Division.	**High**
Management Response	**Responsible Officer/ Deadline**
The Director of MHLD will review how support to Lead Directors will be facilitated to ensure compliance with Governance arrangements.	Director MHLD End April 2019

Finding - ISS.3 – Divisional Directors (Operating effectiveness)	**Risk**
The organogram records two Tier 1 Divisional Directors meetings established – Business and Strategy respectively, both held monthly.	Established meeting duplicate their role and purpose.

In reviewing both ToR, we noted that there are only minor differences evident in their purpose, with both scrutinising each other.	
Recommendation	**Priority level**
The Director of Mental Health & LDS reviews both ToR, and considers amalgamating the Divisional Directors meetings into one monthly management team meeting, ensuring its purpose is refreshed and captures existing responsibilities.	**Low**
Management Response	**Responsible Officer/ Deadline**
The ToR for the Divisional Directors Strategy and Business meetings will be reviewed to ensure they accurately reflect the business of each meeting and a schedule of meetings, together with cycles of business will be agreed.	Director MHLD End April 2019

Finding - ISS.4 – Transformation (Operating effectiveness)	**Risk**
The Division has a Director of Transformation in post but we could not locate a specific reference or tier 2 meeting which takes forward the important agenda attached to this post.	Transformation agenda is not subject to focus, traction or scrutiny.
Recommendation	**Priority level**

The Director of Mental Health & LDS reviews how assurance and scrutiny of the transformation agenda is taken forward through its governance structure.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The ToR for the Divisional Directors Strategy and Business meetings will be reviewed to ensure they accurately reflect the business of each meeting. This will include the transformation agenda, to ensure focus, scrutiny and traction.	Director MHLD End April 2019

Finding - ISS.5 – Quality and safety – Governance structure (Operating effectiveness)	**Risk**
The Division has established a corporate Quality – Safe, Effective, Experience, and Leadership Group (QSEEL) chaired by the Director of Nursing. The organogram details four established (three Area, and one Region) QSEEL meetings with an additional eleven sub-groups having been established and reporting to the divisional meeting. At first glance, the Divisional QSEEL agenda is significant and may become overwhelmed [in both detail and expectations] as it attempts to oversee all matters of quality and safety within the division.	The Divisional QSEEL is over-burdened and cannot fulfil its expected role.
Recommendation	**Priority level**

The Director of Mental Health & LDS reviews the quality and safety assurance structure.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The QSEEL agenda has been reviewed, together with the business of the sub-groups that report to it. A revised cycle of business is now in place, together with template documents in support, ie front sheet and Chair's assurance report. The revised cycle of business has now been implemented. In addition, the Director of Nursing MHLD has written to all chairs of the sub-groups clearly outlining expectations in terms of content and submission timescales in advance of QSEEL meetings. Papers for QSEEL meetings are distributed to members, in accordance with the cycle of business, 7 days prior to the meeting.	Director of Nursing MHLD Complete

Finding - ISS.6 – Quality and safety – HARMS Dashboard (Operating effectiveness)	**Risk**
We were advised at the outset [meeting on the 27th September 2018] that the Division does not routinely use the HARMS dashboard as it does not always deliver meaningful data and is geared, in the main, for acute and community hospitals.	Patient safety performance measures are not subject to routine scrutiny and improvement.

However, the division does undertake alternative reporting in Divisional QSEEL; within Agenda Item titled *Safe Clean Care* –The Safe Care run charts paper provided incorporated run rate charts relating to HARMS topics: Pressure ulcers; Medication errors; and Infection (report shows a MSSA spiked in August 2018). Operational QSEEL review of HARMS dashboard was instructed by the Director of Nursing who sent an email on the 9th September 2018 to a number of officers, under the subject heading of *"Harms Dashboard data via IRIS"*, which stated: *Please can you confirm you are reviewing the harms dashboard accessed via this link http://bcuiris.cymru.nhs.uk/IRIS/Nursing.aspx* *This will need to be a standing agenda item on local Q-SEEL from September, please can you ensure this is included in the monthly business cycle.* *I would suggest you review this daily in your escalation meetings as a means to spot any immediate safety concerns.* In reviewing agendas provided since this email was issued we noted: • West and East QSEEL meetings did not have HARMS on their agenda; • Central QSEEL included only the email at its meeting of the 3rd October 2018 under Agenda Item *20181003.10 – For Information*; • Regional Services QSEEL meetings of 10th September and 1st October 2018 both have HARMS dashboard as an agenda item; 10th September 2018 - Minute 20180910.4 states *"Reviewed and agreed that all inpatient services for RSS are captured."*; 1st October 2018, Agenda Item 20181001.5.5 – HARMS dashboard has no paper included.	

Recommendation	Priority level
The Director of Mental Health & LDS ensures all QSEEL meeting Chairs comply with the instruction from the Director of Nursing that HARMS dashboard forms part of their monthly cycle of business.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Director of Nursing MHLD has written to all chairs of the governance sub-groups clearly outlining expectations in terms of content and submission timescales in advance of QSEEL meetings. As part of this process, a template report has been developed for locality QSEEL meetings which identifies HARMS dashboard as a specific reportable item. In addition, the HARMS dashboard is discussed daily at each Acute Care meeting, with a summary discussed at the weekly TWC meetings, reported weekly to Divisional TWC.	Director of Nursing MHLD Complete

Finding - ISS.7 – Performance (Operating effectiveness)	Risk
We could not see divisional reporting and consideration of the division specific performance data incorporated within the Health Board's Integrated Quality and Performance Report (IQPR).	Consistency over performance reporting and scrutiny is not evident.

Recommendation	Priority level
The Director of Operations and Service Delivery considers the suite of performance measures for formal reporting and scrutiny and whether the IQPR set of measures should be subject to formal monthly review.	Medium
Management Response	**Responsible Officer/ Deadline**
Divisional Performance Reports continue to be hosted on the Performance Directorate SharePoint site where they are available to divisional staff at any time. Divisional reports include the KPIs defined within the NHS Wales Delivery Framework that are relevant to the division along with agreed local KPIs. The latest validated position is formally reported to the monthly F&P meetings for discussion, which supports actions to be taken to improve future performance and informs the exception reporting processes of BCUHB IQPR which is also hosted on the Performance Directorate SharePoint site.	Director MHLD Complete

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.

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

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Health Board

Corporate Legislative Compliance

Nurse Staffing Levels (Wales) Act 2016

Final Report

BCU 2018/19

April 2019

NHS Wales Shared Services Partnership

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

Disclaimer notice - Please note:

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1. Introduction and Background

In March 2016, the Nurse Staffing (Wales) Act was enacted. The purpose of the Nurse Staffing (Wales) Act 2016 (Act) is to ensure minimum safe nurse staffing levels are in place on acute wards in LHB's and NHS Trusts. The Health Board must take all reasonable steps to maintain the nurse staffing level; ensure there are systems in place to review and record data. Responsibility for decisions relating to the maintenance of nurse staffing levels rests with the Health Board.

The Act consists of 5 sections:

- 25A refers to the Health Board's overarching responsibility to have regard to providing sufficient nurses in all settings, allowing the nurses time to care for patients sensitively;
- 25B requires the Health Board to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards. The Health Board's is also required to inform patients of the nurse staffing level on those wards;
- 25C requires the Health Board to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards;
- 25D relates to the statutory guidance released by the Welsh Government;
- 25E requires the Health Board to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward.

The responsibility for meeting the requirements of the Act applies to all staff from ward to Board with the Board and Chief Executive Officer being ultimately responsible for ensuring compliance.

Specific members of the Board are required under sections 25B and 25C to provide evidence and professional opinion to the Board to assist in decision making in relation to calculating and maintaining the nurse staffing level (NSL).

The Board is required to:

- designate a person to be responsible for calculating the nurse staffing level in settings where section 25B of the Act applies;
- to determine which wards meet the definitions in the Act;
- receive and agree reports from the designated person on the nurse staffing level for each designated ward at a public Board on an annual basis and at any other time if the designated person deems it to be required;
- ensure there are systems in place to record and review every occasion when the number of nurses deployed varies from the planned roster;
- And agree the operating framework.

In line with the Act the Health Board is expected to use a triangulated approach when calculating the nurse ward staffing level for each ward by using qualitative and quantitative information incorporating:

- Professional judgement;

- Patient Acuity;
- Quality indicators.

The Health Board adopted an action plan to meet its statutory duties, in preparedness for the implementation of the law in April 2018. To enable this it formed a Nursing Safety and Efficiency Group to ensure the Nurse Staffing Operational guidance and Guiding principles were adopted and implemented across the Health Board (not applicable in Mental Health & Learning Disabilities) and to ensure the roll-out and implementation of the Safecare programme monitoring e-roster efficiency for safe rosters.

2. Scope and Objectives

The overall scope of the audit was to review the evidence that the Nurse Staffing Levels (Wales) Act 2016 Action Plan had been implemented and to validate a number of tasks, which were live for completeness and accuracy.

The system objectives reflect the requirements of the Act and the tasks identified in the preparation for the Nurse Staffing (Wales) Act Action Plan for April 2018 and the working Action Plan identified in the Health Board papers dated 5th April 2018, and considered the following:

- Under Section 25B specific members of the Board have been identified to provide evidence, professional opinion and to assist the Board with decision making to calculate and maintain nurse staffing levels on the designated wards;
- A designated person has been identified and is responsible for calculating the nurse staffing level in settings where Section 25B of the Act applies and provide reports at a public board on an annual basis or any other time as if deemed required;
- The Board has identified the adult acute medical and surgical wards that meet the definitions in the Act;
- To ensure the Board has systems in place to record and review every occasion when the number of nurses deployed varies from the agreed planned roster;
- To ensure the Board has agreed an operational framework to provide systems and processes that have been implemented across the Health Board specify the decision making process and the actions to be taken to ensure all reasonable steps are taken in relation to maintaining the nurse staffing level and specify the arrangements by which patients are informed of the nurse staffing level on each ward along with the date agreed by the Board ensuring this complies with Welsh language standards;
- To ensure a triangulated approach is used and evident to calculate the nurse staffing levels incorporating the factors noted in the Act.

The review also considered:

- The implementation of Safe care, quality and updating of relevant policies noted in the Preparation Action plan;

- Monthly exception reporting within the Quality and Performance report noting the extent to which nurse staffing levels have been maintained within the Act;
- Six monthly Board reporting for compliance with section 25E.

3. Associated Risks

The risks of non-compliance with the Nurse Staffing (Wales) Act 2016 identified at the outset are as follows:

- Specific members of the Board may not have not been identified to provide evidence, professional opinion and to assist the Board with decision making to ensure compliance with the Act;
- A designated person may not have not been identified to calculate the staffing levels as per the requirements of the Act;
- Wards may not have been identified in line with the Act;
- The Health Board may not have consulted on the guidance provided by Welsh Ministers for Sections 25B and C of the Act and are not compliant with the requirements;
- Systems may not have not been put in place to ensure nurse staffing levels provide appropriate safe care is delivered to patients and therefore are unable to secure the provision of nursing services, undertake workforce planning, education and training of nurses;
- The Health Board is not accurately or efficiently reporting the level of compliance with the Act in respect of the maintenance of nurse staffing levels and the impact of non-compliance in accordance with Complaints regulations and /or an increase in incidents of harm; and
- Safe care has not been adopted across acute wards as defined in the Act and exposes patients to risk.

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 Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 review is Limited assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Designated person (Section 25B)			✓	
2	Board responsibility (section 25B)		✓		
3	Triangulated approach			✓	
4	Operational Framework		✓		
5	Six monthly Board reporting (Section 25E)			✓	
6	Identification of wards in line with the Act (Section 25B and C)			✓	
7	Ward compliance with the Act		✓		
8	Health Board reporting systems		✓		

Assurance Summary					
9	Monthly Exception reporting		✓		

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as having a weakness in the control design for Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016.

Operation of System/Controls

The findings from the review have highlighted seven issues that are classified as weaknesses in the operation of the designed system for Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016.

6. Summary of Audit Findings

The Nurse Staffing Levels (Wales) Act 2016 became law in Wales from 2016 and was implemented in April 2018. The Act requires Health Service bodies to make appropriate provision for nurse staffing levels wherever nursing services are required and to ensure they provide sufficient nurses to ensure patients are treated sensitively.

Person designate

Section 25B (1) (a) requires the Health Board to designate a person with sufficient seniority to be responsible for the calculation of nurse staffing levels. The Health Board has assigned this role to the Executive Director of Nursing and Midwifery within the governance framework of the Health Board [on behalf of the Chief Executive].

Board responsibilities

Under Section 25A of the Act the Board have a responsibility to ensure compliance with the Act. Under Section 25B and 25C of the Act the Executive Directors of Nursing, Finance, Workforce and Operations have a responsibility to provide evidence and professional opinion to the Board regarding nurse staffing levels. We have been advised that some responsibilities have been transferred to the Director of Secondary Care however this officer is not an Executive Director [as required by the Act].

Board responsibilities were noted in the following reports presented to the Health Board:

- Health Board meeting, 21/9/17 (Section 5.1; 17/207);
- Health Board meeting, 5/4/18 (Section 3.5; 18.113);
- Health Board meeting 1/11/18 (Section 2.6; 18.242);

We were unable to confirm job descriptions of Executive members are reflective of Nursing Staffing Levels responsibilities.

We are aware the operational Scheme of Reservation and Delegation is currently being refreshed to reflect changes in executive portfolio.

Triangulated approach

The Acute Skill Mix Review for Secondary Care dated December 2017 ensured compliance with the Chief Nursing Officer All Wales Nursing Act 2016 use of a triangulated approach to the calculation of nurse staffing levels in line with Welsh Government requirements.

Operational Framework

Operational Guidance is in place supporting Statutory Guidance and legislation. Our review of the Health Board's Nurse Staffing Level (NSL) and Escalation Plan: Acute Services Policy identified that the Policy has not been updated to reflect the reallocation of the roles and responsibilities following changes to the senior corporate management structure. We found that the policy does not clearly provide guidance on documenting the occasions when the Nursing Staffing Levels do not meet minimum standards.

Board Reporting

There is evidence of six monthly staffing reviews to comply with the Act and Health Board requirements. Papers attached to Board papers dated 5.4.18 reported there was sufficient budget within current ward establishments to ensure compliance with the Act and Chief Nursing Officer guiding principles based on agreed funded beds.

Papers reported to the Board on 1.11.18 reported there is continuous pressure to meet operational demands with escalated beds, Registered Nurse vacancies and unscheduled care pressures.

Identification of Wards

We established that the Health Board has identified twenty-one adult acute medical and seventeen surgical inpatient wards in line with the requirements of Section 25B of the Act.

Ward Compliance with the Act

A sample of six wards were reviewed across the three District General Hospital's (DGH'S) and included both medical and surgical wards. The following findings were noted:

- 5 wards provided evidence that Act guidance was available;
- Safecare training was up to date for wards reviewed in Ysbyty Gwynedd (YG) and Ysbyty Glan Clwyd (YGC);
- Staffing levels had been calculated and agreed by the Board in December 2017 and reviewed as part of the bi-annual audits of NSL;
- A number of wards were not populating the e-rostering system with the approved NSL or using the shift times used to calculated the staffing levels;

- The Board papers dated 5.4.18 indicated that there was sufficient ward budget within the current ward establishments to ensure compliance with the Act and Chief Nursing Officer (CNO) guiding principles based on the number of funded beds. No further review was undertaken of ward budgets;
- We have been informed that notice boards based on a national template have been delivered to all wards in September 2018; staff have been informed the Act only requires the agreed NSL to be declared. The notice boards also provide Welsh language translation;
- Policy does not provide clear guidelines on the use of Safecare. Information generated from the Safecare system for the period 10.6.18 to 7.7.18 and reviewed by Internal Audit, identified a number of missing entries; reported breaches of the NSL but no corresponding information noted as the professional judgement taken to address the breach; a patient fall that had not been reported on Safecare as a result of unsafe staffing levels but was not evident on the Breach report with information taken directly from Datix (incident reporting system); harms as a result of unsafe NSL noted on the West Area Breach report but not recorded on Safecare;
- Inconsistent approach to the level of information input to support action taken to address variances;
- One ward noted 4 major breaches in July 2018 (not date specific) on the Breach report. All were NSL related but had not been recorded on Safecare as Red flag events and no mitigation or professional judgement was evident. Red flag events are those occurrences stipulated by NICE (July 2014) which may be an indicator that the quality of care has declined and patients are being made vulnerable;
- One ward noted a Red flag event on the Safecare system on the 17th June 2018 noting a patient fall. This fall was not on NSL Breach report (we were given to understand this information was taken directly from Datix);
- Safe Staffing Breach reports collated by area do not present consistent levels of information. Ysbyty Glan Clwyd (YGC)/Abergele Central Safe Staffing Breach reports provide a summary of the impact that not maintaining nurse staffing levels has had on care provided to patients by nurses in accordance with Complaints Regulations or by reference to an increase in incidents of harm. Ysbyty Gwynedd (YG) and the Wrexham Maelor Hospital (YWM) Safe Staffing Breach reports do not provide a summary. They do however note each episode of harm.

Health Board Reporting Systems

Audit sample testing of information from e-rostering, identified a number of the wards were not using the nurse staffing levels approved by the Board or the shift times used to calculate the nurse staffing levels.

The audit identified inconsistent and in some cases incomplete input of information on the Safecare system. It was also noted that the Nurse Staffing Levels and Escalation Policy for Secondary Care did not provide clear direction on the use of Safecare.

Fleming and Evington Wards in the Maelor Hospital were not using Safecare at the time of our review.

Monthly Exception Reporting

Monthly Performance reporting identifying safe staffing is not ward specific; this was a requirement on the NSL Action Plan dated June 2018.

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	**5**	**2**	**1**	**8**

Finding - ISS.1 - Executive responsibilities and update of Escalation policy and Schemes of Reservation and Delegation (Operating effectiveness)	**Risk**
The NSL and Escalation Plan: Acute Services Policy noted that the Chief Operating Officer (COO) is responsible for the operational framework, escalation policy and business continuity. The policy has not been updated to reflect changes to management structure. Audit have been informed some Act responsibilities have been transferred to the Director of Secondary care who is not an Executive Director as required by the Act. Audit are aware the Operational Schemes of Reservation and Delegation are currently being refreshed to reflect changes in executive portfolio.	Health Board policy does not reflect the current status of Executive responsibilities.
Recommendation	**Priority level**
The NSL and Escalation Plan and Schemes of Reservation and Delegation should be updated to reflect current responsibilities and consideration given to the appropriateness of the transfer of responsibilities to the Director of Secondary Care, in line with the requirements of the Act.	**High**
Management Response	**Responsible Officer/ Deadline**
The NSL and Escalation Plan: Acute Services Policy is due for review in May 2019. The newly appointed Nurse Director for Secondary Care has recently reviewed the policy and had opportunity to comment. The Deputy Director of Nursing and Associate Director of Nursing have also recently reviewed and changes to the	Associate Nurse Director Secondary Care Nurse Director By end May 2019

<table>
<tr>
<td>policy will include
• core policy for Act requirements
• revised responsibilities to reflect Executive portfolios
• localisation of policy to BCU
• clarity on SafeCare requirements as wider implementation across BCUHB
• adult acute medical and surgical section initially with other speciality specific sections e.g. MHLD and Paediatrics as they are included within the Act

The Nurse Staffing Levels Act has been added to the latest version of the Schemes of Reservation and Delegation (SORD)

Extract from updated SORD:
<table>
<tr><th>DELEGATED MATTER</th><th>DELEGATED TO</th><th>OPERATIONAL RESPONSIBILITY</th></tr>
<tr><td>53.Nurse Staffing Levels Act (Wales) 2016</td><td>Chief Executive</td><td>Executive Director of Nursing & Midwifery</td></tr>
</table>
The Board Secretary has approved the inclusion and it will be confirmed at the May Audit Committee, after which the SORD will be circulated again with an extra column for Divisions inclusion of the next person in the hierarchy with responsibility for NSL Act requirements.

Inclusion of Act responsibilities will be reviewed, including transfer of responsibilities to the Executive Director of Nursing</td>
<td>Office of Board Secretary – May 2019

Executive Director of Nursing</td>
</tr>
</table>

Finding - ISS.2 – Nurse Staffing Levels and Escalation Plan and Recording of breaches on Safecare (Operating effectiveness)	Risk
The Nurse Staffing Levels and Escalation Plan: Acute Services Policy does not provide clear guidelines on what constitutes a marginal or major breach of the Act; nor does it provide guidelines on whether a major breach should be reported on Datix as well as Safecare. Examples of inconsistent methods of reporting breaches and associated patient harms were noted during the course of the audit that included: • Ward 5 YGC Breach reports for Quarter 1 and 2 recorded major breaches of nurse staffing levels on Datix but these had not been recorded on Safecare red flag events; • Ward 1 YGC recorded a red flag event noting a breach of staffing levels and a patient fall but the incident had not been recorded on the Breach report (information taken from Datix); • Enlli Ward in YG noted 4 major breaches of the NSL on the quarterly Breach reports but nothing had been recorded on Safecare. The Escalation policy requires major breaches of the NSL to be recorded on Safecare Red Flags noting mitigation; We were unable to reconcile breach reports to Safecare for Fleming and Evington wards in the Maelor Hospital as they were not using Safecare at the time of the review.	Policy is not clear and could impact on the accurate recording of breaches of the Act.
Recommendation	**Priority level**

The NSL and escalation Plan should be reviewed to provide clear instruction on what constitutes a marginal and major breach of the NSL and any associated harms and should clearly state which system(s) should be used to record breaches.	**High**
Management Response	**Responsible Officer/ Deadline**
The Nurse Staffing Levels (Wales) Act 2016, and the All Wales Operational Guidance (2018) (and updated draft Feb 2019) (attached), do not reference a major or marginal breach. The Act sections 13 – 17 outlines the steps Health Boards must take, the systems and reporting requirements when the number of nurses deployed varies from the planned roster. The NSL and escalation Plan will therefore be updated in line with the proposed revised all Wales guidance, with local agreement, approved by the Executive Director of Nursing and Midwifery as to the reporting of non-compliance across Secondary Care as outlined on page 22 and 23 of the guidance.	Secondary Care Nurse Director End April 2019
Variation from the planned roster must be entered into Safe Care and on Datix and the NSL policy will be updated to articulate this, with required communication to staff. The E Roster team have confirmed there is the option to add notes to the current SafeCare system, which can be used to record the Datix number so the red flag system and Datix correlate	Assistant Director Workforce/E Roster Manager End April 2019
The All Wales Nurse Staffing group have approved the recommendations within the report (attached) which outlines changes to the complaints and incident management processes	Secondary Care Governance Teams/ Head of Risk Management

COMPLAINTS SBAR FOR AWNSG FEB 201	End April 2019

Finding - ISS.3 - Reporting to the Board and QSE (Operating effectiveness)	**Risk**
Monthly Performance of NSL is noted on the Safe Staffing report and is reported to the Board and Quality and Safety Executive Committee but does not report on individual ward performance. The NSL Action Plan requires NSL levels to be reported and to show the extent to which the NSL within the Act are being maintained. It is acknowledged that nurse staffing levels are reviewed and reported biannually to the Board in line with the Act.	The Board are presented with information on Nurse Staffing Levels that does not show compliance with legislation.
Recommendation	**Priority level**
Whilst Nurse Staffing Level monthly Board reporting is not required under legislation, consideration should be given to separately reporting the Nurse Staffing levels on Act wards within the Safe Staffing report in line with the requirements of the Health Board Action Plan. This could be achieved by using Safecare and e-rostering data.	**Low**
Management Response	**Responsible Officer/ Deadline**

Secondary Care Nurse Directors are currently reviewing reporting for the Act for the Secondary care Nurse Director. This will include separately reporting the Act within the monthly Integrated Quality and Safety report	Secondary Care Nurse Director End May 2019

Finding - ISS.4 - Quarterly reporting of Harms and Breaches of the Nurse Staffing Levels (Operating effectiveness)	**Risk**
Audit identified an inconsistent approach to the quarterly reporting of Harms and Safe staffing generated from the Datix Incident reporting system. There was evidence of omissions in respect of monthly information required in the West area quarter 1 report. The level of detail provided in the reports differed across the areas.	Inconsistent information and incomplete reporting to the Health Board.
Recommendation	**Priority level**
There should be complete, clear and consistent reporting of the impact of Nurse Staffing levels and associated harms across the Health Board.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Secondary Care Nurse Directors are currently reviewing reporting for the Act. This will include the agreed reporting format across the three secondary care sites that is complete, clear and consistently reports of the impact of Nurse Staffing levels and associated harms across the Health Board. There are several reports available from the E Roster system and Allocate (the system suppliers) are developing further reports based on Secondary Care	Secondary Care Nurse Director End May 2019

feedback that will be available in later versions of the system. There is no confirmed launch date by Allocate for the upgraded system (10.8.3) which can only be supported on the most recent internet browser platforms. The browser systems are not currently available across BCU due to other system capabilities however IT are working on this over the next few months.	

Finding - ISS.5 - Safecare Training and Operational guidance for Nurse staffing levels (Operating effectiveness)	**Risk**
At the time of the review, staff on the wards selected for review in YGC (Wards 1 and 5) and YG (Enlli and Aran) had been adequately trained to use Safecare. However only 63% of staff were trained on Evington Ward and 82% on Fleming Ward in the Maelor hospital. At the time of the audit Nurse Staffing Levels Operational Guidance was not available on Ward 1 YGC and had not been discussed with staff.	Lack of understanding of the requirements of the Act and the Safecare system.
Recommendation	**Priority level**
All Ward staff to be fully trained to use Safecare in line with the requirements of Operational Guidance.	**High**
Management Response	
Safe care was in the process of being implemented in Wrexham at the time of the audit, which included training of staff. Overall training compliance for Wrexham is 77%, including Evington 63% and Fleming is 82%. In Evington of	Assistant Director Workforce/E Roster Manager End March 2019

the 3 staff not trained two work predominately nights and 1 has been off long term sick. Two staff outstanding in Fleming of which one is predominately nights and the other on maternity leave. Where the E Rostering team have been unable to cascade the training to staff, wards have been able to do this. The E Roster team will continue to provide training in the use of Safe Care. The Heads of Nursing will undertake a spot check audit of staff understanding and application in practice on a day to day basis of the Safe Care system. This will be monitored through secondary care accountability meetings	Secondary Care Nurse Director End May 2019

Finding - ISS.6 - Nurse staffing levels and shift times (Operating effectiveness)	**Risk**
Information provided from the E Rostering system identified that the planned and actual WTE nurse staffing levels (including Health Care assistants) for 5/6 wards under review were not in line with the workforce establishment approved by the Board and calculated in line with the requirements of the Act. In addition a number of wards were not using the shift times used to calculate the workforce establishment.	Non-compliance with the Act and approved workforce establishment and shift times.
Recommendation	**Priority level**
Wards comply with the workforce establishment and shift times approved by the Board to meet the requirements of the Act.	**High**
Management Response	**Responsible Officer/ Deadline**

The E Rostering team have been working with Secondary Care Nurse Directors to ensure the E Roster templates comply with the workforce establishment and shift times approved by the Board to meet the requirements of the Act. All templates have now been updated in the system to reflect the staffing numbers agreed by the Board in October 2018. There remain discrepancies with the shift times actually worked by the wards versus the hours they are budgeted for which are being addressed by the Nurse Roster Optimisation project. As this is a Health Board wide project, formal consultation on the proposals is necessary, which will occur end March 2019. Subject to the necessary executive approvals, the planned changes, would come into effect on the 4th August Roster due to the 6 week in advance shift approval requirements and the time required for the E Roster team to make the changes in the system The revised NSL policy will include a section on agreeing and changing templates.	Secondary Care Nurse Director/ E Roster Manager End February 2019 Secondary Care Nurse Director/E Roster Manager August 2019

Finding - ISS.7 - Populating Safecare and Datix Incident reporting (Operating effectiveness)	**Risk**
We found inconsistent and incomplete use of red flag events and professional judgement on Safecare across those wards subject to review. We identified an example where Safecare recorded a patient harm, however the incident had not been recorded on Datix.	Inconsistent and incomplete recording of nurse staffing levels and breaches in line with the Act and incident reporting

There were also examples of missing Safecare entries across some of those wards subject to review.	
Recommendation	**Priority level**
Management ensure Safecare is used in accordance with guidance and red flag events and harms are recorded appropriately.	**High**
Management Response	**Responsible Officer/ Deadline**
Secondary Care Site nurse directors will ensure all staff aware of the requirements to ensure SafeCare is used in accordance with guidance. This will be via Heads of Nursing, Matron, Ward Manager meetings and daily staffing huddle. The Guidance for SafeCare will be re-circulated and reinforced by E Rostering team in training events, that red flag events and harms are recorded appropriately. The E Roster team continue to provide training for new staff and wards are able to cascade the training to staff that the E Rostering team have been unable to directly provide this too. User guides are also available on the E Roster website.	Secondary Care Nurse Director End March 2019 Assistant Director Workforce/E Roster Manager End March 2019

Finding - ISS.8 - Funding and Staffing Strategy (Control design)	**Risk**

The review identified an example where a ward was regularly using escalated beds. These were not funded and not incorporated into the calculations for the workforce establishment for that particular ward. The Acute Skill Mix Review for Secondary Care [dated December 2017] noted that "the number of escalated beds that are not funded should have a plan to reduce them and the bed base realigned to meet the demand."	Funding and staffing may not be adequate to ensure patient needs are met.
Recommendation	**Priority level**
Management to review escalation bed management to ensure compliance with the Health Board policies and operational requirements	**Medium**
	Responsible Officer/ Deadline
Secondary Care Hospital Directors in conjunction with Secondary Care Site Nurse Directors to review their bed escalation polices to ensure core bed base and escalated bed base staffing to meet Act requirements are included.	Secondary Care Hospital Directors/ Secondary Care Nurse Director End May 2019

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.

Audit Committee
30.5.19

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Interim Accountability Framework
Report Author:	Dr. Jill Newman, Director of Performance
Responsible Director:	Mr Mark Wilkinson, Executive Director of Strategy
Public or In Committee	Public
Purpose of Report:	The purpose of this report is to make the Audit Committee aware of the change adopted in the Board's accountability framework as confirmed via the Finance and Performance Committee of the Board.
Approval / Scrutiny Route Prior to Presentation:	In January 2019, the Finance and Performance Committee received and accepted the interim accountability framework, acknowledging that this replaced the previously ratified framework from December 2017.
Governance issues / risks:	The Accountability Framework forms part of the Board Assurance Framework and requires ratification via the Audit Committee following scrutiny via the Finance and Performance Committee of the Board.
Financial Implications:	A sound accountability framework supports good financial governance and decision making throughout the organization and supports proactive performance management to promote effective decision-making, cost avoidance and operational efficiency.
Recommendation:	The Committee are asked to ratify this framework following the support given to it by the Finance and Performance Committee and to note: • the connectivity of the framework to the operational plan and objective setting, • the transition to health economy accountability; and • the interim nature of the framework, designed to support learning from its application so as to inform the development of a framework suited to the 3 year business planning and delivery cycle of the Health Board.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	√

2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life	√	3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper The governance arrangements of the Board is part of the Special Measures Improvement Framework and therefore the Accountability Framework forms an element of this..			
Equality Impact Assessment: Not required for this type of report.			

Betsi Cadwaladr University Health Board

Interim Accountability Framework and Processes

Summary

- Interim accountability review arrangements to run in 2019 with intent to learn from process and adapt and adopt for 2019-2022 planning period.
- Delivering our plans requires a team focus.
- Accountability is exercised via a) the Board and committees, b) individual objective setting, and c) quarterly accountability review meetings.
- Health Economy based accountability reviews (three economies: west central and east) with the performance of divisions and areas as a 'subset' of geographic economy based performance.
- Escalation framework mirroring Welsh Government framework of tiered escalation.

Purpose

This paper sets out the proposed interim accountability framework for the Health Board and aims to replace the current framework approved by the Finance and Performance Committee in December 2017. It will run for the bulk of 2019 with a view to learning from the quarter 3 process, adapting and adopting as the framework for the 2019-2022 health board's three year plan.

Flowing from the plan and this accountability framework the integrated performance reporting framework arises. This reporting framework will be the subject of a further paper setting out the arrangements proposed from team/site to board.

Background

The current framework requires review following the change of Executive portfolios and reflections on changes needed to support the organisation achieve strategic and operational objectives.

As part of our duties the NHS Wales planning framework requires all Health Boards in Wales to produce 3 year Integrated Medium Term Plans (IMTPs), or Annual Plans explaining how they will meet their objectives and deliver improvements with pace and purpose.

In order for the Health Board to be assured that we are on track to deliver this improvement, the performance management process needs to be effective. Performance assurance, performance management and performance improvement are dependent on a clear framework of accountability with teams and individuals clear as to the expectations placed on them, the resources available to them to deliver and awareness of the consequences of non-delivery.

Principles

Best practice shows that in order to ensure an organization assesses performance across all aspects of business, it is vital that different perspectives are captured to provide a fully integrated view of performance across the Health Board – delivering our plan is a team responsibility.

The key objective of the accountability framework is to ensure that information is available which enables the Board and senior management teams to understand, monitor, and assess the quality and performance of the organization, enabling appropriate action to be taken when performance against set targets deteriorates.

The accountability framework needs to support the organization in delivering:

a) The strategy set out by the Board through the our plans.
b) Operational ownership of the key organisational priorities.
c) Clarity of expectations as to level of performance expected.
d) Opportunity for accountable officers to discuss support needed to achieve expected levels of performance
e) Challenge to accountable officers through a holding to account mechanism for areas where performance falls below expectations.

To do this effectively, information must be timely, accurate, consistent and complete.

Proposed Accountability Arrangements

It is proposed that existing arrangements for accountability are strengthened in the following ways:

a) The Board through its meetings and committees will hold the Executive responsible for areas within their portfolios. **BOARD AND COMMITTEES**
b) The Chief Executive will through objective setting and personal performance reviews hold Executives to account for the performance management of their portfolios - the executive sponsor of each of the indicators within the National Outcome Framework will be assigned to a named Executive. **SETTING OBJECTIVES**
c) Each Executive Director will through objective setting and personal performance reviews hold direct line reports to account for delivery of agreed objectives. There will be a matrix management approach; this means that Divisional Directors will have objectives to meet which fall within an Executive Portfolio outside of their Executive Line Management. **SETTING OBJECTIVES**
d) The Executive Management Group (EMG), chaired by the CEO is responsible for performance monitoring of the indicators within the NHS Wales Delivery Framework. **ACCOUNTABILITY REVIEWS**
e) The Chief Executive will monitor performance across geographically defined health economies on a quarterly basis to support delivery of integrated health care. **ACCOUNTABILITY REVIEWS**

The remainder of this paper proposes a new approach to accountability reviews.

The Chief Executive will chair quarterly performance reviews. This process will be led by the Executive Director of Planning and Performance, with support from the Director of Performance.

Crucially, the Divisions will also have the opportunity to raise issues where support or discussion is required.

The scope of the reviews will be performance achievements and challenges against the 2018/19 core delivery priorities (January and April 19), and the operating plan from July 19 onwards.

The accountability review will have a formal agenda, be minuted and the outcomes from the discussion including the overall assessment will be communicated to the divisional directors in a timely fashion. Within these meetings individual directors will normally assume overall responsibility for reports from within their own portfolio.

Discussions relating to individual performance will be conducted on a 1:1 basis by individual directors in accordance with normal line management arrangements. (see above)

The information provided within the reviews will align to the indicators used by the Board through the operational planning and integrated quality and performance reporting processes, reflected in a disaggregated manner through the Health Economy performance reports. Divisional performance reports will continue as sub-sets of the Health Economy performance report. The Divisional Governance structure will mirror that of the Board and its committees with Divisional Directors responsible for holding their direct reports accountable for delivery of quality and performance at a disaggregated level, with escalation as appropriate from the Division to the Executive.

In order to have a single version of the truth validated and submitted information will be used and this will be locked down 7 days prior to the meeting to ensure all participants are sighted on the same information.

The focus of the accountability reviews will be geographically health economy based performance with the performance of divisions and areas as a subset of these as described above.

There will be three in-depth performance reviews held on a quarterly basis for the place based systems:

- West and Ysbyty Gwynedd
- Central and Ysbyty Glan Clwyd
- East and Wrexham Maelor Hospital

The hosted services will be discussed under the host placed based review e.g. palliative care services will be discussed in the East and YGC health economy meeting with the East Area team accountable.

Mental health and learning disability services, North Wales Clinical Services and Womens services will be discussed in each health economy review with information disaggregated where possible to each of the health economies.
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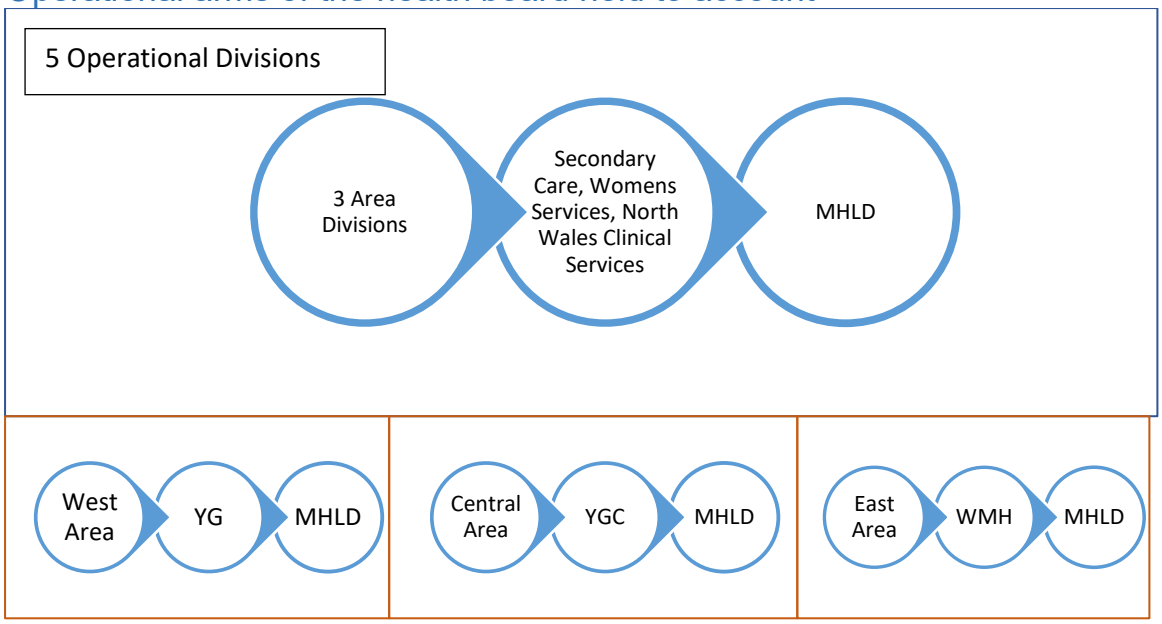
Operational arms of the health board held to account



A typical format will be scheduled for around 2 hours and would generally include:

- Health Economy based responsibilities:
  - Mental health and learning disability services
  - Secondary care, womens and N.Wales managed clinical services
  - Area responsibilities

The format will enable the health economy to present its current position and challenges against the core health board priority areas and discussion to be framed in relation to those indicators themed to:

  - Quality and Safety
  - Performance
  - Use of Resources – Finance, Workforce, Estate
  - Organisational development and learning

Attendance is required from respective Area, Secondary care, Womens, North Wales Managed Clinical Services and Mental health and LD directors to cover the agenda items. Usually attendees will include:

- Secondary care, Area, and Mental health and LD Directors
- Area and Secondary Care Medical Directors
- Area and Secondary Care Nurse Directors

All executive directors will be requested to prioritise this process.

Following the review day the Executives will confirm outcomes and determine escalation levels. Escalation processes will be in line with the WG framework and designed to ensure issues of concern are given increased support to improve performance within an agreed timeframe.

Escalation is possible on individual issues of concern, divisional responsibilities within the health economy or across the whole health economy. The escalation process within the performance framework is based on the outputs and outcomes against the core priorities and may not be directly aligned to performance of individuals.

The escalation levels will be triangulated with individual personal development and PADRs. Assessment of individual performance against agreed objectives will not necessarily be consistent with the level of Departmental escalation (an area could be progressing well against a target but individual progress against objectives could need improvement and vice versa).

Initiation of the process

The process will commence in January 2019 and reviewed in a collaborative manner at the end of Quarter 4 with a view to adapting based on learning and adopting formally for use throughout the 3 year operational plan period 2019-2022.

Appendix 1: Escalation Framework

The levels of escalation are shown below:

Governance arrangements

The overall results for each of the Health Economy Reviews will be presented to the EMG and the Finance and Performance Committee of the Board.

Audit Committee

30.5.19

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Title:	Clinical Audit – the proposed way forward
Author:	Dr Melanie Maxwell SAMD/1000 Lives Clinical Lead
Responsible Director:	Dr Evan Moore, Executive Medical Director Mr Adrian Thomas, Executive Director of Therapies & Health Sciences
Public or In Committee	Public
Strategic Goals	

1. Improve health and wellbeing for all and reduce health inequalities	X
2. Work in partnership to design and deliver more care closer to home	
3. Improve the safety and outcomes of care to match the NHS' best	X
4. Respect individuals and maintain dignity in care	
5. Listen to and learn from the experiences of individuals	
6. Use resources wisely, transforming services through innovation and research	X
7. Support, train and develop our staff to excel.	

Approval / Scrutiny Route	Principles discussed at Executive Team meeting.
Purpose:	This paper seeks to address concerns raised by the Audit Committee at its meeting on 14th March 2019 and in doing so, strengthen the arrangements for Clinical Audit within the organisation and ensure that a robust plan of action is presented to the next meeting in order to satisfy the requirements of both the Annual Governance and Annual Quality Statements.
Significant issues and risks	• National audits do not always reflect local priorities and lack synergy with organisational quality risks • Audit resources are limited, and do not support the entire patient pathway. There is very little digital support. • There is a lack of robust planning for Tier 2 audits • There is a lack of clinical engagement in audit with moves to Quality improvement activity; this may impact on the effectiveness of audit.

Special Measures Improvement Framework Theme/ Expectation addressed by this paper	Leadership and Governance
Equality Impact Assessment	An equality impact assessment is not considered necessary for this type of report.
Recommendation/ Action required by the Committee	The Committee is asked to: (1) endorse the proposed way forward in terms of managing the clinical audit function; (2) endorse the proposals in relation to the clinical audit plan for 2019/20 acknowledging that the plan will be further refined over coming months to provide assurance against risks to the Quality Improvement Strategy by September 2019. (3) agree the proposal in relation to future reporting via QSE and Audit Committee as outlined, and as a consequence stands down the JAQS meeting in November 2019.

Clinical Audit – The Proposed way forward

1. Purpose of report

This paper seeks to address concerns raised by the Audit Committee at its meeting on 14th March 2019 and in doing so, strengthen the arrangements for Clinical Audit within the organisation and ensure that a robust plan of action is presented to the next meeting in order to satisfy the requirements of both the Annual Governance and Annual Quality Statements.

2. Introduction/Context

The Wales Audit Office Structured Assessment 2017 recommended that the Health Board's programme of clinical audit needed to align with the priorities and risks identified in the Health Board's Quality Strategy, be more explicit in regards to patient/quality outcomes to understand the added value of clinical audit. This recommendation was repeated in the structured assessment 2018 as the expected progress had not been made within the timeframe. Furthermore the Joint Audit and Quality and Safety Committee (JAQS) meeting in November 2017 and 2018 had raised concerns in relation to improving assurance of the effectiveness of clinical audit and echoed the concerns raised within the Structured Assessment.

Clinical audit is an integral part of the quality framework, providing information to support quality planning and delivering quality assurance; the results of clinical audit help determine quality improvement priorities. However, it must be recognised that significant resource is used to support nationally mandated clinical audit, these are predominantly within secondary care and therefore may not fully align with the Health Board's Quality Improvement Strategy. Furthermore, resources are used to collect and submit the audit data, with little capacity for action planning and change.

The Health Board has agreed that there will be a structured process for planning clinical audit based on the analysis of clinical risk and aligned to the Health Board's Quality Improvement Strategy by September 2019.

3. Clinical Audit – Leadership and Resources

Following internal discussions, it has been agreed by the Chief Executive that responsibility for clinical audit at Board level will be under the Executive Leadership of the Medical Director. This decision was taken at the end of March 2019, and as a consequence work now needs to be undertaken to implement it.

This will include reviewing roles and responsibilities of staff within the Clinical Audit Team, ensuring they have the capacity, skills and resources to deliver clinical audit activities across the Health Board that address the key organisations risks to the quality improvement strategy priorities.

4. Clinical Audit Plan

Within the Health Board there are three levels of Clinical Audit:

Tier 1 – National: These are nationally mandated by the Welsh Government's National Clinical Audit and Outcome Review Advisory Committee and are drawn from the UK National Clinical Audit and Patient Outcomes Panel (NCAPOP) under the auspices of the Health Quality Improvement Partnership (HQIP) and mainly administered by the Royal College's. These audits usually measure services against national standards and/or are performed to allow national provision of a service to be understood and benchmarked. The Welsh Government specify an annual list of the projects mandated for all Health Boards within the National Clinical Audit and Outcome Review Plan (NCAORP). These are predominantly based within secondary care, have identified clinical leads on each site and are supported by the corporate audit team; however, there is inequity in how these are resourced.

Tier 2 – Corporate: These are the BCUHB wide audits that the organisation has made the decision to undertake to support its service improvement plans and/or agreed priorities and so are based on risk. These clinical audits should be aligned to the priorities set out within the Health Board's Quality Improvement Strategy. The Audit Committee is responsible for approving the clinical audit plan identified at this level to support risk management and service improvement. These are currently supported by the corporate audit team.

Tier 3 – Divisional: These are clinical audits that should form part of a prioritised programme at a local level; whether this be divisional, individual department or specialty level. Often, these cover topics that clinicians have chosen to support a local specialist service or personal interest aligned to further education. These audits may be more important in some specialist areas where there are no mandated national audits, or there is a key risk.

Clinical audit should be used as a key part of professional/service development recognising that this may cover a wider clinical network for example Dermatology. These projects are not usually supported by the corporate audit team.

An outline plan for Tier 2 projects was agreed by the Corporate Quality and Safety Group on 13th March 2019. However, the plan requires further development and whilst work is on-going to progress key risk based audits (consent/ record keeping) there is further work to do. The plan will be reviewed following completion of the Annual Plan and three year outlook scheduled to be represented to the Health Board in July 2019. It is envisaged that a renewed audit plan will be presented in September 2019. The draft document can be made available to members on request.

The Annual Clinical Audit Plan going forward will be based upon the key priorities and risks and include tier 1 &2 audits. The focus of the plan will be to review gaps in assurances as directed by the accountable management as well as meeting mandated requirements. This will no longer include the additional quality improvement projects supporting delivery of the QI strategy that will be reported elsewhere.

The governance for Tier 3 audits needs to be held at the service level and only by exception be reported to the Corporate Quality & Safety Group

A policy will need to be developed and implemented to ensure all staff are clear about the organisational expectations relating to clinical audit.

5.	**Actions from the Joint Audit and Quality, Safety and Experience (JAQS) Committee**

Set out in Appendix 1 is the combined summary action log from the JAQS meetings in November 2017 and 2018. This provides the latest update position with regard to each of the actions including providing narrative to explain where actions have been superseded or have been progressed through another means.

6.	**Role of Audit Committee, Quality, Safety and Experience (QSE) Committee**

In relation to Clinical Audit relevant extracts from the Audit and QSE Committees terms of reference are detailed below:-

Audit Committee – '… work with the Quality, Safety and Experience Committee to ensure that there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer.'

Quality, Safety and Experience Committee – 'ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that: sources of internal assurance (including clinical audit) are reliable;'

It is equally important to note that it is not the role of the Audit Committee to establish and maintain processes for governance, risk management and internal control. This is the responsibility of Executive Directors and the Accountable Officer. The Audit Committee should review all reliable sources of assurance (i.e. Internal and External Audit, self-assessment) and feel satisfied with the course of action being taken by the Executive, and that the sources of assurance demonstrate that controls in place are effective. In relation to internal audit plans (including clinical audit), the Audit Committee need to be satisfied that audit work programmes are aligned to the Health Boards Risk Register. It is proposed that in relation to Clinical Audit, the roles of the two committees are summarised as;

- Quality, Safety and Experience Committee – Being assured there is an effective audit function, adequately resourced, that delivers robust audit supporting quality planning and assurance; leading to safe high quality services.
- Audit Committee – Provide assurance to the Board that the function is effective and that the annual clinical audit plan prioritises key risks and supports delivery of the quality improvement strategy.

Over recent years the value of having a separate annual JAQS meeting has been questioned. Clearly there are merits of bringing together the two Committee in terms of gaining assurance that the clinical audit plan is fit for purpose. An option going forward is to invite those Members of QSE (not already Members of Audit Committee) to attend Audit Committee for a combined discussion at the appropriate point in the business cycle.

Set out below is a simple annual cycle of reporting activity designed to illustrate the role, involvement and interaction of the Audit Committee and the Quality Safety & Experience Committee in relation to clinical audit.

Item	**Quality, Safety and Experience Committee Action**	**Audit Committee Action**	**Frequency**
Clinical Audit Annual Plan		Approval at Audit Committee with QSE Members invited for relevant part of the meeting	Annually in March each year.
Progress against Tier 1 & 2 clinical audit plan	Summary assurance report from QSG		Quarterly
Clinical Audit Annual Report	Approval at QSE		Annually in July each year
Formal Internal & External Audit Reports relating to Clinical Audit function		Formal receipt of reports and monitoring of implementation of recommendations via TeamMate.	Each meeting as appropriate

The Quality and Safety Group will provide overview and scrutiny for the tier 1 & 2 audits agreed in the clinical audit plan.

7. Assessment of risk and key impacts

Key risks are:

- National audits do not always reflect the priorities of the local organisation but are mandated and so supported by the corporate audit services. The impact of this is the perceived lack of synergy between organisational risk and audit.
- Lack of resources to undertake audit. Most audit activity supported by the corporate team relates to secondary care; there is limited information about audit in other BCU services. The impact of this is quality assurance may not be as visible for services outwith the hospitals and does not go across whole pathways.
- Lack of robust audit planning for Tier 2 audits. The plan is predominantly re-audit work undertaken by the corporate audit team; with no transparent

planning process. This needs to be addressed within the clinical audit policy and process going forward.

- Lack of clinical engagement in developing and implementing a new framework with increased accountability for closing the audit cycle and delivering change (capacity and capability for quality improvement). This may hamper the transition from quality planning to quality improvement and subsequent service improvements.
- Lack of resources to support a robust governance system – including IT infrastructure to capture all audit activity and subsequent action plan monitoring. This will lead to lack of assurance that audit is effective.

8. Equality Impact Assessment

An equality impact assessment is not considered necessary for this type of report.

8. Conclusions / Next Steps

The Board has raised concerns about the robustness and effectiveness of the clinical audit process in terms of providing assurance or leading to quality improvement activity. There is concern that the annual plan does not reflect organisational risks to delivering the Quality Improvement Strategy.
To facilitate and improve this, the clinical audit function has now moved to the Executive Medical Director's portfolio and will be aligned to the developing Quality Improvement hub.

Key next steps are to:

- review the current corporate audit resource capacity and deployment
- review the annual audit plan and ensure it is aligned to provide assurance against the key quality risks by September 2019.
- ensure the audit process is effective (see logic diagram attached at Appendix 2) by April 2021

7. Recommendations

That the Committee:-

(1) endorses the proposed way forward in terms of managing the clinical audit function;

(2) endorses the proposal in relation to the clinical audit plan for 2019/20 acknowledging that the plan will be further refined over coming months to provide assurance against risks to the Quality Improvement Strategy by September 2019.

(3) agrees the proposal in relation to future reporting via QSE and Audit Committee as outlined, and as a consequence stands down the JAQS meeting in November 2019.

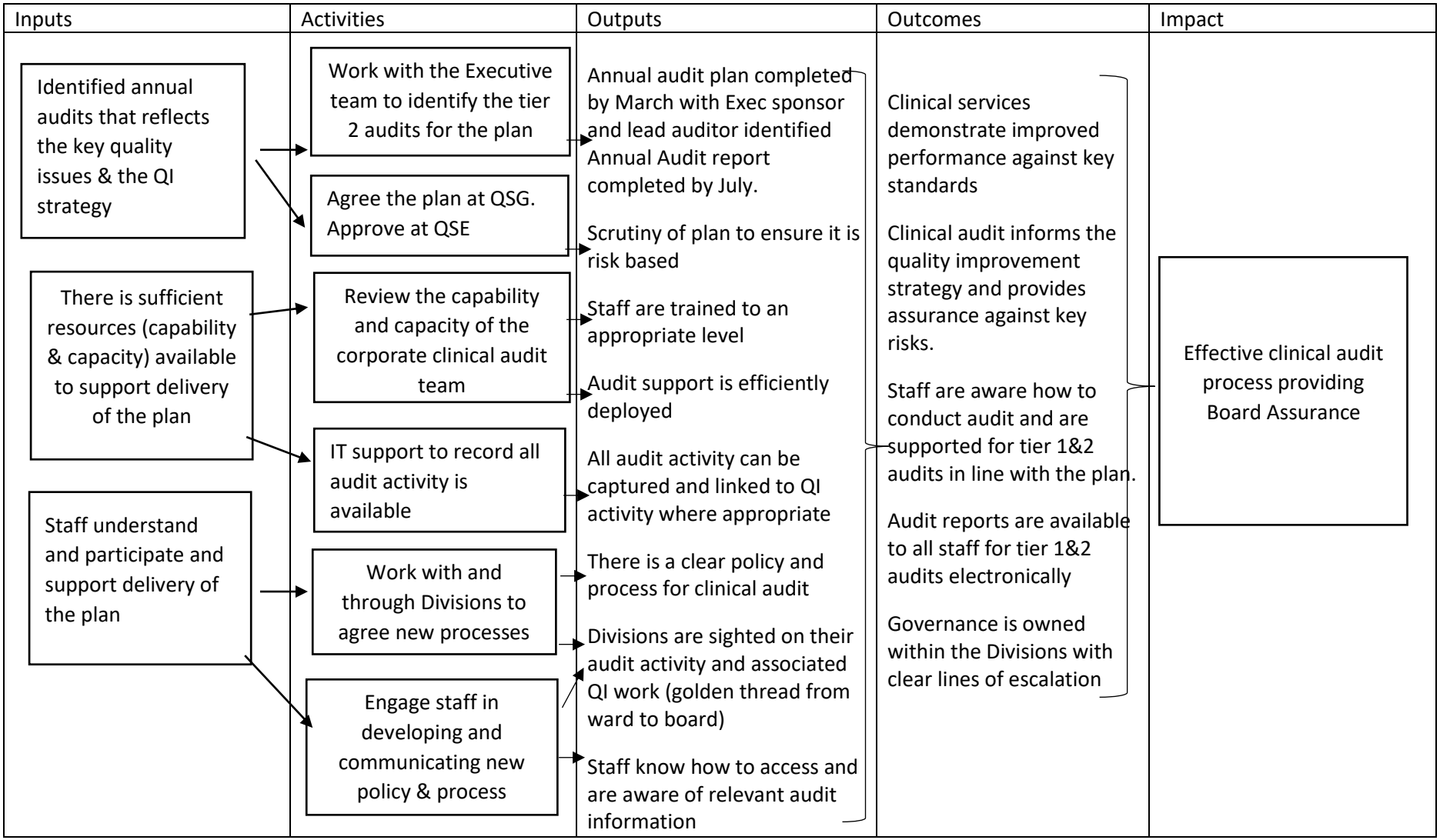
Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Actions from meeting held on 9.11.17				
Adrian Thomas	JAQS 17/5 Clinical Audit Report – Future reports to take on board the suggestions put forward by the Committee namely:- • Future plans to have a unique identification number against each project • Intended outcomes to be captured as well as progress on specific recommendations • Summary of main headlines to be captured for reporting to the Board. • RAG rating system to be adopted and whether recommendation was implemented and within timeframe • Trajectory showing whether improvements are being made year on	November 2018	All these suggestions will be considered during the development of a clinical audit policy and template for a clinical audit annual report. The development of assurance for clinical audit will be an iterative process. Some of these actions will need to take place at divisional level or below and through reporting mechanisms and we will seek to ensure the suggestions are addressed. The audit reporting needs to be concise and provide assurance on both the audit process and value/outcome of activity undertaken. Where actions require an electronic solution – such as tracking action plans, investment may be required. Commissioned services will be monitored through the contracts system and will not be incorporated into the annual report. It should be noted that some services already participate in nationally mandated audits.	Close

	year • Indicators to show whether all leads within a particular area are working to the same level • Consideration to be given to whether commissioned services should be included within future Audit Plans • Emphasis to be placed on reflective learning and examining the results of audits in conjunction with performance data in order to provide effective triangulation;			
Gill Harris/Adrian Thomas	JAQS 17/5 Clinical Audit Report – GH &AT to discuss highest risk factors outside the meeting.	December 2017	Revised interim plan includes risk assessment - this will be strengthened going forward (Sept 2019)	Close
Adrian Thomas – Dawn Sharp	JAQS 17/5 Clinical Audit Report – Future Audit Committee to give consideration to how recommendations from Clinical Audits are followed up.	November 2018	. This will be included within the new clinical audit policy and process	Close

Gill Harris	JAQS 17/5 Clinical Audit Report – Areas of concern noted around stroke. GH agreed to liaise with MD Radiology re forthcoming report on Stroke.	December 2017	Action superseded. Subsequent reports presented to QSE Committee.	Close
Adrian Thomas	JAQS 17/5 Clinical Audit Report – Dementia Strategy to be cross checked against clinical audit plan	November 2018	This will be considered as part of the revised annual plan (Sept 2019)	Close
Adrian Thomas	JAQS 17/5 Clinical Audit Report – good news stories to be included in future reports	November 2018	This will form part of the reporting system to be developed (QSE reports)	Close
Adrian Thomas	JAQS 17/6 Clinical Audit Plan – AT to give further consideration to the process around inclusion of individual clinical audits within the plan and review the arrangements for the tracking of clinical audit recs with a view to adopting a similar system to that in place for internal and external audit recs.	November 2018	. This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources.	Close
Dawn Sharp	JAQS17/7 – Quality Assurance Frameworks and Governance Arrangements – report to be presented to the December 2017 QSE	December 2017	This will be reviewed as part of the development of the clinical audit policy and process.	Close
Dawn Sharp	JAQS17/8.1 – Chair's assurance report – to be prepared.	December 2017	Actioned. Complete.	Close

Dawn Sharp	JAQS17/8.2 – consideration be given to holding an additional meeting prior to November 2018 should the need arise.	November 2018	No additional meeting required	Close
Actions from JAQS meeting 6.11.18				
Dawn Sharp	JAQS18/4 – action log to be prepared and updated to reflect the progress of those actions not yet complete from last meeting	March 2019	Complete	Close
Adrian Thomas	JAQS18/9&10 – Clinical Audit and Outcome Review Plan and update reports – ET re-examine the BCU elements of the clinical audit plan and the process going forward including future presentation, tracking and follow up of recommendations arising, with input from Internal Audit as appropriate.	March 2019	This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources.	Close

Effective Clinical Audit – theory of change **Appendix 2**



Audit Committee 30.5.19	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Title:	**Committee Annual Reports**
Author:	**Dawn Sharp, Assistant Director and Deputy Board Secretary**
Responsible Director:	**Grace Lewis-Parry, Board Secretary**
Public or In Committee	Public
Purpose of the Report:	All Committees of the Board are required to provide written annual reports to the Board on their work with an assessment of progress against the Committee's annual objectives/work plan. The Committee is asked to consider the final submission of the reports prior to submission to the Board. Attachments are as follows:- • Appendix 1 - Quality, Safety and Experience (QSE) Committee • Appendix 2 - Finance and Performance Committee • Appendix 3 - Strategy, Partnerships and Population Health Committee • Appendix 4 - Remuneration and Terms of Service Committee • Appendix 5 - Mental Health Act Committee • Appendix 6 - Local Partnership Forum Advisory Group • Appendix 7 - Healthcare Professionals Forum Advisory Group • Appendix 8 - Stakeholder Reference Advisory Group • Appendix 9 – Audit Committee • Appendix 10 – Information Governance and Informatics Committee With regards to the Charitable Funds Committee, the Charitable Funds Committee produces a very detailed combined Annual Report and Accounts. This has to be submitted to the Charities Commission by 31st January each year. The Audit is scheduled to take place in July/August 2019, with the Annual Report (and Accounts) due to be submitted to the September 2019 Charitable Funds Committee.
Approval / Scrutiny Route Prior to Presentation:	All of the Committee Annual Report were reviewed by a workshop held by Audit Committee Members on 14th May. Members' used the reports to help inform the Audit Committee Annual Report.
Governance issues/risks:	As identified within the individual reports.
Financial Implications:	None

Recommendation:	To recommend to the Board the suite of Committee annual reports including the proposed changes in Terms of Reference as outlined within the Audit Committee Annual Report.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3.Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and Governance			
Equality Impact Assessment Not required for an update paper of this nature.			

Committee Annual Report 2018/19

1. Title

Quality, Safety & Experience Committee

2. Name and role of person submitting this report:

Mrs Gill Harris, Executive Director of Nursing & Midwifery

3. Dates covered by this report:

01/04/2018-31/03/2019

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

The Committee was routinely scheduled to meet 12 times plus an annual joint meeting with the Audit Committee (and otherwise as the Chair deemed necessary) however the frequency of meetings was amended in-year from monthly to bimonthly. During the reporting period therefore it met on 10 occasions including 1 extraordinary in-committee meeting. Attendance at meetings is detailed within the table below:

INDEPENDENT MEMBERS	24.4.18	22.5.18	26.6.18	24.7.18	25.9.18	6.11.18 (Joint with Audit)	29.11.18	22.1.19	28.2.19 (extra ordinary)	19.3.19
Cheryl Carlisle	A	√*	√	√	√	√	A	√*	√	√
Margaret Hanson (Chair)	√	√	◆	◆	◆	◆	◆	◆	◆	◆
Peter Higson (Interim Chair)	◆	◆	√	◆	◆	◆	◆	◆	◆	◆
Jackie Hughes	◆	◆	√	√	√	√	√	√	√	√
Lyn Meadows (Chair July-Sept)	√	√*	√	√	√	√	A	√*	√	√
Lucy Reid (Chair Sept-March)	◆	◆	◆	◆	√*	√	√	√	√	√

Directors and Officers in Attendance	24.4.18	22.5.18	26.6.18	24.7.18	25.9.18	6.11.18 (Joint with Audit)	29.11.18	22.1.19	28.2.19 (extra ordinary)	19.3.19
Sue Green Executive Director of Workforce & OD	◆	◆	◆	◆	◆	√	A	√	√	√
Gill Harris Executive Director of Nursing & Midwifery	√	√	A	√	√	√	√*	√	√	A
Evan Moore Executive Medical Director	√	√	A	√	√	√	√*	√	A	√*
Morag Olsen Chief Operating Officer	A	A	A	◆	◆	◆	◆	◆	◆	◆
Teresa Owen Executive Director of Public Health	√	√	√	√	√*	√	√*	√*	√	√
Michael Rees Chair of Healthcare Professionals Forum	A	√*	A	A	√	A	A	√	A	◆
Chris Stockport Executive Director of Primary & Community Services	◆	◆	◆	◆	◆	◆	◆	A	√*	√
Adrian Thomas Executive Director of Therapies & Health Sciences	√	√	√	√	√	√	√	√	√	√

Key:

√ Present A Apologies/Absent

√* Part meeting ◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. These include the Associate Director of Quality Assurance, Staffside Chair, Senior Associate Medical Director, Director of Performance and the Community Health Council Vice-Chair/Chair. For a full list of attendance, please see the detailed Minutes which can be accessed on the Health Board's website via the following link:- http://www.wales.nhs.uk/sitesplus/861/page/88168

5. Assurances the Committee is designed to provide:

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

- Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning.
- Ensure the adequacy of safeguarding and infection, prevention and control arrangements.
- Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations or as part of a partnership arrangement.
- Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience.
- Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:
    - Sources of internal assurance (including clinical audit) are reliable
    - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis
    - Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.
- Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements.
- Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).
- Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR.
- Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.
- Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate.
- Receive periodic updates in respect of the workforce flu vaccination *(note – this requirement only added to terms of reference from February 2019 onwards)*

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference V4.0 which were operative from March 2018 to January 2019 and V5.0 operative from February 2019. The terms of reference are appended at Appendices 1 and 2.

An integral part of the process is the requirement for the Committee to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management Group (CBMG) who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year.

At a workshop of the Audit Committee held on the 15th May 2018 members reviewed each of the Committee and Advisory Group's annual reports for 2017-18 with the aim of providing evidence on the scope and effectiveness of Committees and of their evaluation of the sources of assurance available to them. At the system of Board Assurance continued to be refined, Audit Committee members made the following comments specific to the QSE Committee:-

That QSE should monitor clinical audit outcomes in-year on a more regular basis	Reflected within cycle of business
Future reports would benefit from the inclusion of examples of learning from concerns.	Meeting held between Committee Chair, Community Health Council Chair and report authors to scope and inform future Listening & Learning Reports.
Ensure that future Annual Reports include a specific explanatory comment if no assurance was received by the Committee	Completed for 2018-19
Ensure that future Annual Reports include detailed narrative of actions being taken against any red or amber levels of assurance	Completed for 2018-19
Encourage improvement to both IM and Executive attendance levels	2017-18 IM attendance was 77% Exec attendance was 72% 2018-19 IM attendance was 85% Exec attendance was 84%

In addition, Audit Committee members made the following generic comments pertaining to the Committee and Advisory Group Annual Reporting process:-

Recurring themes around the need for training for members in respect of specific Committee responsibilities, and concerns around the volume of work some Committees were dealing with.	A full review and refresh of the cycle of business has been undertaken with the Committee Chair and Lead Executive. Meeting duration has been extended to allow for full discussion of items. Committee members have also increased their skillset through the wider Board Development and Workshop programme. Other specific training has also been provided eg risk management, equality, safeguarding and continuing health care.
Externally commissioned/produced reports e.g. Deanery/Royal Colleges should be centrally logged.	Central logging now in place within Office of the Board Secretary.

Chairs assurance reports to in future confirm actions being taken to address key risks identified.	Template amended in July 2018
Template for future Committee Annual reports to be amended to detail ”focus for the year ahead” at the end of the report.	Completed (see section 9)
Any difficulties in identifying sources of assurance to be included as a key focus for the year ahead.	Completed (see section 9)
In respect of internal or external audit reports individual committees are asked to review and provide commentary within their annual report on whether the implementations of the recommendations arising from audits relevant to their remit have led to overall qualitative improvements.	The Committee will need to address this point in 2019-20
Ensure new assurance map addresses quality of primary care and quality of commissioned services.	Completed as part of ongoing development of Board Assurance Framework
Sources of assurance document to be updated as follows:- • Outcome findings of local clinical audit work to be included (ACS 21A) • Systems of internal control to be included (ACS 11A) • Team Central Tracker aligned to Audit Committee to be included (ACS66). • Delete RAG colour coding from document.	Completed as part of ongoing development of Board Assurance Framework

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

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

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	**Supporting narrative (Please provide detail for all actions showing amber or red assurance levels in terms of actions being taken to address these issues).**
Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning.	Green	Amber	Clinical Audit and Organisational Learning to be strengthened and prioritised within committee business.
Ensure the adequacy of safeguarding arrangements.	Green	Amber	Gaps in assurance have been articulated in the reports provided.
Ensure the adequacy of infection prevention and control arrangements.	Green	Green	
Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations or as part of a partnership arrangement.	Amber	Amber	The development of a range of Stakeholder Groups. Strengthening of patient stories. Embedding revised arrangements for patient experience. Refresh the approach to Listening & Learning reports. Rollout of Patient Advocacy Service to Wrexham.
Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience.	Amber	Red	Report submitted. Escalation to corporate risk register. Amended executive portfolios.

			Establish H&S Committee.
Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that: • Sources of internal assurance (including clinical audit) are reliable • Recommendations made by internal and external reviewers are considered and acted upon on a timely basis • Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.	Amber	Amber	Paper on clinical audit due March 2019. Clinical Audit plan was not received in-year. Improvements to be made on organisational learning.
Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements.	Green	Amber	Committee input into AQS development
Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).	Green	Amber	HIW report due 19.3.19
Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR.	Green	Green	
Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.	Amber	Amber	Committee sighted on concerns around endoscopy, ophthalmology and children's services
Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate.	Red	Red	Reflect QIA in ongoing development of the Three Year Plan.
Receive periodic updates in respect of the workforce flu vaccination.	Green	Green	

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

Standing Items

- Chair's assurance report from the Quality Safety Group
- Integrated Quality Performance Reports
- Policies for approval
- Chair's assurance report from HASCAS & Ockenden Improvement Group (from Sept 2018 onwards)
- Executive briefings (from January 2019 onwards)

Regular Items

- Infection Prevention and Control / Safe Clean Care Updates
- Listening and Learning from Patient Experience reports
- Committee Risks from Corporate Risk and Assurance Framework
- Mortality updates
- Accessible Healthcare Standards annual report
- Putting Things Right annual report
- Service development reports from Mental Health Learning & Disabilities Division
- Continuing Health Care assurance reports
- Equalities annual report
- Health and Safety reports
- Annual Quality Statement
- Quality Assurance reports (evolving into CLIC – Complaints, Litigation, Incidents and Coroner) reports
- Integrated Resilience (Winter) Plan
- Flu vaccination uptake reports
- Shared patient experience discussions with Wales Ambulance Services NHS Trust
- Updates against quality Improvement Strategy
- Prison health updates
- Healthcare Inspectorate Wales inspection updates
- Public Services Ombudsman Wales annual letter
- Safeguarding reports
- Health Protection Team annual report
- Tissue and Organ Donation annual report
- Pharmacy and Medicines Management annual report
- Re-introduction of Patient Stories
- Quality and Safety reports from Primary Care
- Clinical Audit report

Ad-Hoc

- Feedback from Chief Dental Officer on the BCUHB Update against National Oral Health Plan
- Presentation from Cemlyn Ward, Cefni Hospital on good practice examples / psychology programme
- Presentation on child health

- Briefing on Older People's Commissioner review into care homes
- Reports of the Organisational Development project into Women's Services
- Stroke services update
- Updates on Pressure Ulcer collaborative
- Ward accreditation dashboard and nurse staffing reports

Governance Items

- Review of minutes and actions
- Committee annual report
- Review of special measures expectations
- Radiation Protection sub-group annual report
- Minutes and briefings from Welsh Health Specialised Services Committee's Quality & Patient Safety Committee
- Review and refresh of Committee terms of reference

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

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

Meeting Date	Key risks including mitigating actions and milestones
24.4.18	• Correlation between nurse staffing levels and incidents of harm such as patient falls and hospital acquired pressure ulcers. Controls/Actions - monitoring through IQPR, development of dashboards • Delays in responding to the Public Accounts Committee (PAC) hospital catering and patient nutrition action plan. Control/Actions – taken forward through Quality Safety Group
22.5.18	• Challenges in meeting the target for smoking cessation with pregnant women. Controls/Actions – continued monitoring through IQPR. • Concerns regarding nurse staffing levels. Controls/Actions - monitoring through IQPR, development of dashboards. • The Committee was keen that the seasonal/winter plans for 2018-19 be drawn up much earlier than in previous years. Controls/Actions – highlighted to Board and relevant officers.
26.6.18	• Lack of organisational accountability for performance in relation to compliance with Accessible Healthcare Standards (AHCS). Controls/Actions – resulting action plans from audits to be acted upon and incorporated into PADRs; extension of audits into primary care; completion of "easy wins" by all operational areas; incorporation into ward accreditation programme; re-establish the AHCS Steering Group. • Low levels of participation in training, development and awareness of AHCS. Controls/Actions – mandatory completion of sensory loss e-learning for all staff; rollout toolkit to all operational areas.

	) Sensory loss fields within primary care systems not being completed. Controls/Actions – ensure that all managed practices record communication needs within practice management systems; encourage patients and third sector representatives to request their GP to record communication needs; develop agreed reference values within Welsh Patient Administration System (WPAS); ensure communications needs are checked and entered into WPAS for each contact with BCU. (*Note – when the Committee Chair's report was submitted to the Board on 2.8.18, the Board requested clarification as to whether this risk was a national or BCU issue. A note was circulated to board members on 21.8.18)*) More transparent RAG rating better supported by trend data within performance reports. Controls/Actions - Director of Performance led on refresh of IQPR in-year.) Ward staffing levels remained of concern. Controls/Actions - Associate Director of Quality Assurance to look at an enhanced reporting functionality for future Integrated Quality Performance Reports to ensure that wards not necessarily listed by the Ward Staffing Act were appropriately monitored.) Numbers of catastrophic adverse incidents noted within the Putting Things Right report. Controls/Actions – the Deputy Director of Contractor Services would provide a refreshed coversheet for submission to the July Health Board.) The implications of Gosport investigation. Controls/Actions - exception assurance report to be provided to September meeting.) Corporate safeguarding support to the MHLDS. Controls/Actions – the next planned safeguarding report to clearly set out assurances and actions.) Health & Safety Annual Report. Controls/Actions – report to be to developed report further and resubmitted to a subsequent Health Board meeting.
24.7.18	No risks identified
25.9.18	) Potential adverse implication of an amended process for influenza vaccine distribution to primary care. Controls/Actions – ongoing monitoring.) Deteriorating position in respect of pressure ulcers. Controls/Actions - improvement collaborative established with update report due to next meeting.) Deteriorating position in terms of delayed transfers of care (specifically Gwynedd and Wrexham. Controls/Actions - Chief Executive wrote to the respective Local Authority Chief Executives; launch of amended process in terms of care home of choice.) Timeframe for addressing issues with 24 hour on-call services for Section 136 (Child Adolescent Mental Health Services). Controls/Actions - interim measure to be implemented ahead of longer solution of service redesign.) Paediatric middle grade cover in the West. Controls/Actions - Executive Medical Director to provide an update on mitigating actions in November and the Executive Director of Primary Care & Community Services to provide a paper early in 2019 on governance and escalation processes for this service.) The need for risks within HMP Berwyn report to be rated or scored. Controls/Actions – Executive Director of Primary Care & Community Services to take forward with the HMP Berwyn team.

29.11.18	) Rate of closure for incidents. Controls/Actions - an exception report to the next meeting.) Child Adolescent Mental Health Services (CAMHS) performance. Controls/Actions - prioritisation of longest waiting patients; internal deep dive ahead of a national review; use of external funding to address backlog.) Initial risk scores and risk appetite for a range of corporate risks. Controls/Actions - to be followed up at the Board Workshop 20.12.18.) Lack of evidence to explain the proposed reduction in risk score for CRR13 (mental health). Controls/Actions- Director of MHLDS to provide briefing note.) Format and content of Listening and Learning from Experience reports to the Committee. Controls/Actions - small task group to be established.) Lack of assurance around how the Quality Safety Group reported the closing down of Healthcare Inspectorate Wales actions. Controls/Actions - Committee Chair to write formally to the QSG.
22.1.19	) Continued concern at the level of pressure ulcers. Controls/Actions – measures to ensure staff were aware of correct reporting processes; work closely with the Ambulance Trust to reduce the risk of pressure ulcers resulting from long waits in ambulances.) Format of the assurance report for HASCAS & Ockenden. Controls/Actions - continue to refine format to more clearly map progress made against each of the recommendations.
19.3.19	• The Committee were unable to gain assurance from the Clinical Audit report and endorsed the feedback from the Audit Committee regarding the content, quality and scope of the paper. Controls/Actions - action agreed with the Executive Team and the Audit Committee on how this was to be addressed and the urgency of the timescales. • The Committee continued to be concerned at the performance against the key mental health measures and the need to ensure that learning from incidents and Healthcare Inspectorate Wales feedback was clearly evidenced within the reporting and governance arrangements. Controls/Actions - the Committee supported a review of the reporting process with the division to provide assurance on action being taken to address areas for improvement. • The Committee received an update on the Hospital Acquired Pressure Ulcer collaborative and noted the increase in numbers reported. This increase was anticipated as a result of a change in reporting arrangements and the work of the collaborative improving incident reporting. Controls/Actions - the report provided details of the interventions being tested by identified cohorts and the benefits and challenges to date and supported the continued focus in this area. • The Committee received a verbal update (as part of the in-committee meeting) on the review of the Endoscopy waiting list and the actions being taken to address the risks identified. Controls/Actions - the Committee has requested regular updates on progress to address the concerns identified.

9. Focus for the year ahead:

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

- Organisational learning
- Responding to HASCAS / Ockenden
- Impact of systems and processes on patient experience
- Clinical audit
- Children's services
- Priorities from the Quality Improvement Strategy

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 3.

***Key:*

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

Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

1 INTRODUCTION

1.1 The Board shall establish a committee to be known as the **Quality, Safety and Experience Committee (QS&E).** The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2 PURPOSE

2.1 The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to quality, safety, patients and service user experience of health services.

3 DELEGATED POWERS

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

3.1.1 ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;

3.1.2 ensure the adequacy of safeguarding and infection, prevention and control arrangements;

3.1.3 provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

3.1.4 seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

3.1.5 ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

- Sources of internal assurance (including clinical audit) are reliable
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis

- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.1.6 Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

3.1.7 Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.1.8 Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.9 Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

3.1.10 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

4 AUTHORITY

4.1The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

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

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

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

5 SUB-COMMITTEES

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

6 MEMBERSHIP

6.1 Members

Four Independent Members of the Board.

6.2 In attendance

Executive Director of Nursing and Midwifery (Lead Executive)
Executive Medical Director
Executive Director of Therapies and Health Sciences
Chief Operating Officer
Executive Director of Public Health
Associate Director of Quality Assurance
Senior Associate Medical Director / 1000 Lives Clinical Lead
Chair of Healthcare Professionals Forum -Associate Board Member
Representative of Community Health Council
Staff Side Representative

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. The Mental Health & Learning Disabilities Division will attend as per scheduled items on the cycle of business.

6.3 Member Appointments

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

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

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

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

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

7 COMMITTEE MEETINGS

7.1 Quorum

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

7.2 Frequency of Meetings

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

7.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

8.5 Receive assurance and exception reports from the Quality and Safety Group (QSG)

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

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

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

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

Quorum

11. REVIEW

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

Date of approval:
Audit Committee 9.2.18
Health Board 5.4.18

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

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3.1.2 ensure the adequacy of safeguarding and infection, prevention and control arrangements;

3.1.3 provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

3.1.4 seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

3.1.5 ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

- Sources of internal assurance (including clinical audit) are reliable
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis

- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.1.6 Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

3.1.7 Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.1.8 Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.9 Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

3.1.10 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

3.1.11 to receive periodic updates in respect of the workforce flu vaccination.

4 AUTHORITY

4.1The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

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

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

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

5 SUB-COMMITTEES

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

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Executive Medical Director
Executive Director of Therapies and Health Sciences
Executive Director of Primary Care & Community Services
Director of Performance
Executive Director of Workforce & Organisational Development
Executive Director of Public Health
Associate Director of Quality Assurance
Senior Associate Medical Director / 1000 Lives Clinical Lead
Chair of Healthcare Professionals Forum -Associate Board Member
Representative of Community Health Council
Trade Union Partners

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. The Mental Health & Learning Disabilities Division will attend as per scheduled items on the cycle of business.

6.3 Member Appointments

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

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

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

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

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

7 COMMITTEE MEETINGS

7.1 Quorum

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

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

7.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

8.3.2 sharing of information

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

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

8.5 Receive assurance and exception reports from the Quality and Safety Group (QSG)

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:
9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;
9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

Quorum 11. REVIEW

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

Date of approval:
QSE Committee 29.11.18
Board 24.1.19

V5.0

QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER last updated 23/05/2019 18:40

Part 1 – Annual Recurring Business

Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Accessible Healthcare Standards Annual Report	*Peter Morris*			X			
Annual Quality Statement	*Ali White*		X draft	X final			
Children's Services	*Teresa Owen*			X			X
CLIC / Quality Report to include section on progress against HIW recommendations; quality aspects of Welsh Risk Pool reports (the value aspect goes to Audit); PSOW?	*Shan Kennedy Barbara Jackson*	X		X		X	
Clinical Audit – monitoring of outcomes from clinical audit plan	*Adrian Thomas*		X				Via JAQS meeting
Committee Annual Report (inc Review of Terms of Reference and Approval of Cycle of Business)	*Kate Dunn*		X final				
Community Health Council joint priorities					X		
Continuing Health Care Assurance Report (for information)	*Marianne Whalmsley*	X		x		X	
Corporate Risk Assurance Framework (QSE Risks)	*Peter Barry*			X			X
Dashboard (hams/quality) exception report as required and/or through Associate DQA reports		X	X	X	X	X	X
Equality Annual Report (for info)	*Sally Thomas*				X		
Executive Quality & Safety Updates **In Committee** (To sight the Committee on current issues around complex complaints, never events, key risks, Regulation 28s and any significant quality & safety issues	*All Execs*	X	X	X	X	X	X

QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER last updated 23/05/2019 18:40

Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Healthcare Inspectorate Wales Annual Report					X		
Health & Safety (including Corporate Health at Work updates – agreed at CBMG 10.1.19)	*Sue Green*	X	X	X	X annual report	X	X
Health Protection (PHW Report)	*Teresa Owen*	X					
Improvement Group (HASCAS & Ockenden) Chair's Assurance Report	*Gill Harris*	X	X	X	X	X	X
Infection Prevention & Control	*Tracey Cooper*	90 day plan update	Full report	90 day plan update	Full report	90 day plan update	Full report
Integrated Quality Performance Report	*Ed Williams Jill Newman*	X	X	X	X	X	X
Listening & Learning Report (focusing on patient experience and what has changed or is planned as a result of their feedback)	*Peter Morris Barbara Jackson*		X		X		X
Medicines Management	*Berwyn Owen*		X ann rep			X key risks	
Mental Health Service Development (CBMG 10.1.19 advised that papers to QSE need to focus on quality improvement aspects, with updates against the strategy going to SPPH)	*Steve Forsythe*		X		X		X
Mortality & Morbidity (inc lessons learnt from casenote reviews) Frequency to be determined	*Melanie Maxwell*						
Nurse Staffing Report (as required by Wales Act 2016)	*Trevor Hubbard*		X			X	
Patient Stories		X	X	X	X	X	X

QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER last updated 23/05/2019 18:40

Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Policies for Review (as required)	*Varies*	X	X	X	X	X	X
Primary Care Quality Assurance Report	*Chris Stockport*		X			X	
Prison Health	*Chris Stockport*		X			X	
PSOW Annual Letter	*PSOW*						X
Putting Things Right Annual Report (inc link to PSOW Annual Report)	*Barbara Jackson*			X			
Quality Improvement Strategy 2017-2020	*Deborah Carter*				X update		
Quality Safety Group – assurance report	*Deborah Carter Caroline Williams*	X	X	X	X	X	X
Radiation Protection – Annual Report of Sub Group GH to speak to AT regarding timeliness and scheduling	*Peter Hiles Helen Hughes Adrian Thomas*						
Safeguarding GH to discuss with M.Denwood	*Michelle Denwood*		X		X Ann Rep		X
Standing Items – Opening Business (apologies, declarations of interest, minutes)		X	X	X	X	X	X
Standing Items – Closing Business (items discussed in committee, documents circulated, issues of significance, any other business, date of next meeting)		X	X	X	X	X	X
Tissue & Organ Donation Annual Report	*David Southern*	X					
Wales Interpretation & Translation Service (WITS) Annual Report	*Eleri Hughes Teresa Owen*					X	
Welsh Health Specialised Services Committee – Quality & Patient Safety	*Cathie Steele WHSCC*	X	X	X	X	X	X

QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER last updated 23/05/2019 18:40

Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Committee Minutes and/or Chair's Reports (held in public) *obtained from WHSCC website*							
Welsh Risk Pool Services and Legal & Risk Services Annual Review	*Barbara Jackson*		X				

Committee Annual Report 2018/19

1. Title

Finance and Performance Committee

2. Name and role of person submitting this report:

Mr Russ Favager, Executive Director Finance

3. Dates covered by this report:

01/04/2018-31/03/2019

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

The Committee was routinely scheduled to meet 10 times. During the reporting period an additional meeting was scheduled in August and also an InCommittee meeting in December 2018, therefore it met on 12 occasions. Attendance at meetings is detailed within the table below:

Independent Members	26.4.18	24.5.18	28.6.18	26.7.18	23.8.18	25.9.18	25.10.18	22.11.18	21.12.18 (InCommittee)	17.1.19	26.2.19	26.3.19
Mrs Marian Wyn Jones Chair to 31.8.18	✓	✓	✓	✓	✓	◆	◆	◆	◆	◆	◆	◆
Mr Mark Polin Chair wef 1.9.18	◆	◆	◆	◆	◆	✓	✓	✓	✓*	✓	✓	A
Mr John Cunliffe Vice Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mrs Bethan Russell Williams Member to 31.8.19	✓	✓	✓	✓	A	◆	◆	◆	◆	◆	◆	◆
Cllr Cheryl Carlisle Member to 31.8.18	A	✓	A	A	✓	◆	◆	◆	◆	◆	◆	◆
Ms Helen Wilkinson Member wef 1.9.18	◆	◆	◆	◆	◆	✓	✓	✓	✓*	A	✓	✓
Mrs Lyn Meadows Member wef 1.9.18	◆	◆	◆	◆	◆	A*	✓	A	✓	✓	✓	✓

Directors in attendance (ia)	26.4.18	24.5.19	28.6.19	26.7.19	23.8.19	25.9.18	25.10.18	22.11.19	21.12.18 (InCommittee)	17.1.19	26.2.19	26.3.19
Mr Russ Favager Executive Director of Finance	✓*	✓	A	✓	✓	✓	✓	✓	✓	✓*	✓	A
Ms Morag Olsen Chief Operating Office ia to	A	A	A	◆	◆	◆	◆	◆	◆	◆	◆	◆
Mrs Sue Green Executive Director Workforce & Organisational Development	✓	✓	✓	A	✓	A	✓	✓	A	✓	✓	✓
Mr Geoff Lang Turnaround Director wef May 2018 Executive Director Strategy to May 2018	✓	✓*	✓*	✓*	✓*	✓	✓	✓	✓	✓*	✓	✓
Mrs Sally Baxter Interim Executive Director Strategy wef to	◆	✓	✓	✓	✓	✓	✓	◆	◆	◆	◆	◆
Mr Mark Wilkinson Executive Director Planning and Performance Wef 22.11.18	◆	◆	◆	◆	◆	◆	◆	✓	✓	✓	✓	P
Dr Evan Moore Executive Medical Director Wef 1.9.18	◆	◆	◆	◆	◆	A*	✓	✓	✓*	✓	✓	✓
Mrs Gill Harris Executive Director Nursing & Midwifery Wef 1.9.18	◆	◆	◆	◆	◆	A*	A	A	A	✓*	A	A
Mrs Deborah Carter Acting Executive Director Nursing & Midwifery Wef March 2019	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	A

Key:

✓ Present — A Apologies/Absent

✓* Part meeting — A* Apologies as attending QSE Committee meeting previously scheduled in diary for same date

◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. These include the Finance Director ~ Operational Finance / Provider services, Performance Director. For a full list of attendance, please see the detailed minutes which can be accessed on the Health Board's website via the following link:- http://www.wales.nhs.uk/sitesplus/861/page/85397

5. Assurances the Committee is designed to provide:

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

Financial Management

- seek assurance on the Financial Planning process and consider Financial Plan proposals
- monitor financial performance and cash management against revenue budgets and statutory duties
- consider submissions to be made in respect of revenue or capital funding and the service implications of such changes including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial Instructions
- receive assurance with regard to the Health Board Turnaround programme progress and impact/pace of implementation of organisational savings plans.
- receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual directorates, divisions and sites
- to determine any new awards in respect of Primary Care contracts

Performance Management and accountability

- approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required)
- ensure detailed scrutiny of the performance and resources dimensions of the Integrated Quality and Performance Report (IQPFR)
- monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets
- review in year progress in implementing the financial and performance aspects of the Integrated Medium Term Plan (IMTP)
- review and monitor performance against external contracts
- receive assurance reports arising from Performance and Accountability Reviews of individual teams
- receive assurance reports in respect of the Shared Services Partnership

Capital Expenditure and Working Capital

- approve and monitor progress of the Capital Programme

Workforce

- monitor performance against key workforce indicators as part of the IQPR
- monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans
- receive quarterly assurance reports in relation to workforce, to include job planning under Medical and Dental contracts for Consultants and Specialist and Associate Specialist (SAS) doctors and the application of rota management for junior doctors, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and Allied professionals
- to consider and determine any proposals from the Primary Care Panel (via the Executive Team) in relation to whether the Health Board should take on responsibility for certain GP Practices

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference V3.0 which were operative from March 2018 to August 2018 and V4.0 operative from September 2018. The terms of reference are appended at Appendices 1 and 2.

[1] Added to terms of reference from September 2018 onwards :

Remove references to Informatics and Information Governance, Communications and Technology Programmes
Include requirement re Turnaround Extend reference to performance and accountability reviews to directorates, divisions and sites.
Remove reference to Upholding Professional Standards in Wales
Remove reference to ongoing monitoring in relation to staff survey results. Staff induction and updates on employee safehaven.
Amend membership to remove COO, Add Executive Director of Nursing & Midwifery, Add Executive Director of Primary & Community Services, Add Executive Director of Planning & Performance, and add Director of Turnaround (for relevant items pertaining to finance and savings)
Clarify members can be reappointed to the committee for up to 8 years maximum.

At a workshop of the Audit Committee held on the 15th May 2018 members reviewed each of the Committee and Advisory Group's annual reports for 2017-18 with the aim of providing evidence on the scope and effectiveness of Committees and of their evaluation of the sources of assurance available to them. As the system of Board Assurance continued to be refined, Audit Committee members made the following comments specific to the F&P Committee:-

• Attendance of both independent members and executives could be improved. It can be noted in the attendance summary provided within the 2018/19 report that regular attendance has been achieved.

In addition, Audit Committee members made the following generic comments pertaining to the Committee and Advisory Group Annual Reporting process:-

Recurring themes around the need for training for members in respect of specific Committee responsibilities, and concerns around the volume of work some Committees were dealing with.	A full review and refresh of the cycle of business has been undertaken with the Committee Chair and Lead Executive. Meeting duration has been extended to allow for full discussion of items. Committee members have also increased their skillset through the wider Board Development and Workshop programme. Other specific training has also been provided eg risk management, contracting, equality, safeguarding and continuing health care.
Externally commissioned/produced reports e.g. Deanery/Royal Colleges should be centrally logged.	Central logging now in place within Office of the Board Secretary.
Chairs assurance reports to in future confirm actions being taken to address key risks identified.	Template amended in July 2018
Template for future Committee Annual reports to be amended to detail ”focus for the year ahead” at the end of the report.	Completed (see section 9)
Any difficulties in identifying sources of assurance to be included as a key focus for the year ahead.	Completed (see section 9)
In respect of internal or external audit reports individual committees are asked to review and provide commentary within their annual report on whether the implementations of the recommendations arising from audits relevant to their remit have led to overall qualitative improvements.	
Ensure new assurance map addresses quality of primary care and quality of commissioned services.	Completed as part of ongoing development of Board Assurance Framework
Sources of assurance document to be updated as follows:-) Outcome findings of local clinical audit work to be included (ACS 21A)	Completed as part of ongoing development of Board Assurance Framework

• Systems of internal control to be included (ACS 11A) • Team Central Tracker aligned to Audit Committee to be included (ACS66). • Delete RAG colour coding from document.	

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

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

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	Supporting narrative
Seek assurance on the Financial Planning process and consider Financial Plan proposals			Finance review commissioned
Monitoring financial performance and cash management against revenue budgets and statutory duties			Monthly finance reports.
Consider submissions to be made in respect of revenue or capital funding and the service implications of such changes including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial Instructions			As and when business cases are provided for scrutiny (e.g. vascular business case)
Receive assurance with regard to the progress and impact/pace of implementation of organisational savings plans.			Monthly finance reports.
Receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual teams.			Annual reporting is scheduled in Cycle of Business
Determine any new awards in respect of Primary Care contracts			
Approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).			As required
Ensure detailed scrutiny of the performance and resources dimensions of the Integrated Quality and Performance Report (IQPFR)			Monthly reporting.
Monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets			Monthly reporting.
Review in year progress in implementing the financial aspects of the Integrated Medium Term Plan (IMTP)	**Not applicable – IMTP not in place for 2018/19**		

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	Supporting narrative
Review and monitor performance against external contracts			Quarterly contracts reports.
Receive assurance reports arising from Performance and Accountability Reviews of individual teams.			Reports on performance issues are considered by the Committee
Receive assurance reports in respect of the Shared Services Partnership.			Update reports provided to Committee
Approve and monitor progress of the Capital Programme			Monthly reports provided
Monitor performance against key workforce indicators as part of the IQPR			Monthly and adhoc reporting
Monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans.			Further work is required in this area
Receive quarterly assurance reports in relation to workforce, to include job planning under Medical and Dental contracts for Consultants and Specialist and Associate Specialist (SAS) doctors and the application of rota management for junior doctors, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and Allied professionals.			Update reports are provided to Committee
Consider and determine any proposals from the Primary Care Panel (via the Exec Team) in relation to whether the Health Board should take on responsibility for certain GP Practices			This is reviewed by the Committee as required
Committee reviews risk assigned to it.			Twice per annum

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

Standing Items

- Monthly Finance report
- Monthly Capital Programme report
- Monthly Turnaround report
- Integrated Quality Performance Reports
- Policies for approval:
    - All Wales no purchase order no pay Policy
    - Capability Policy and procedure
    - BCUHB additional leave purchase scheme procedure
    - Lease Car policy

Regular Items

- Interim Financial Plan update
- Accountable Budget Holder letter
- Savings schemes update
- Registration and Revalidation updates : Health Care Professions Council, General Pharmaceutical Council Wales, General Medical Council
- Unscheduled Care programme report
- External Contracts updates
- Workforce quarterly reports
- Referral to Treatment (RTT) reports
- Junior Doctors Rotation Management report
- Locum Governance update
- Budget setting framework and timetable (2019/20)
- Financial Planning
- 3 year plan
- Until establishment of Information Governance and Informatics Committee:
    - Information Governance update report
    - Informatics Operational plan
    - Issues of significance of the Information Governance Group reports

Ad-Hoc

- Proposed interim arrangements for Continuing Healthcare and Free Nursing Care Fee charges for 2018/19
- Employment Relations Case Management update
- Workforce metrics report development
- Senior Medical Job Planning
- Primary Care reporting arrangements
- Ysbyty Glan Clwyd File Library Business Continuity plans
- Multi agency adult substance misuse service bases at Holyhead and Shotton
- Caldicott outturn report 2018
- Operational Programme and Projects
- Update on change capacity
- Deep dive high risk spend area consideration
- Development of the performance report
- Outline Business Case – North Denbighshire Community Hospital
- Workforce Strategy development
- Paybill review
- Resident Critical Care tier at Ysbyty Glan Clwyd Business case
- Countess of Chester Hospital contract
- Benefits realisation: Llangollen Primary Care Centre
- Amendments to the procedural manual for managing capital projects
- Performance Accountability Framework updates

Governance Items

- Review of minutes and actions
- Committee annual report
- Committee Risks from Corporate Risk and Assurance Framework
- Special Measures - review of expectations allocated to the Committee

- Shared Services Partnership Committee assurance reports
- Review and refresh of Committee terms of reference
- Review and refresh of Cycle of Business
- Establishment of Finance and Performance Sub Committee : Savings Programme Group

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following link:-

In addition the following items were considered in InCommittee session :

- Ysbyty Glan Clwyd Redevelopment updates
- Gateway Review SURNiCC
- Medical and Dental Agency Locum monthly reports
- Tender approval for submission to the Board
- Requests to assign/transfer various leases
- Dental service commissioning
- Mental Health and Learning Disability Divisional reports
- MHLD Benchmarking report
- Employee Case Management update
- Upholding Professional Standards (until transferred to RaTs Committee)
- Finance Delivery Unit presentation response
- Providing additional bed capacity in Ysbyty Glan Clwyd to facilitate the creation of the North Wales Vascular Network and support Unscheduled / Planned care across the Health Board.
- Redevelopment of the Mental Health inpatient unit at YGC strategic outline case
- Renal Dialysis Tender
- Financial position
- Draft Financial Plan 2019/20
- Draft Interim Financial plan
- 3 year plan
- Additional Discretionary Capital
- Blood Gas Analyser managed service contract
- Appointment of Construction Consultant Frameworks
- Organisational and governance structure for quality and cost improvement/transformation.
- Development of 2019/20 annual work programme
- North Denbighshire Community hospital
- 3 year outlook and 2019/20 annual plan

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

Meeting Date	Key risks including mitigating actions and milestones
26.4.18	Key risks: • The Committee noted that finance and performance were both the subject

	of targeted intervention by WG J Financial position and forecast outturn J Performance on unscheduled care and RTT trajectory J Ysbyty Glan Clwyd capital scheme J SuRNICC phase 2 expected completion date was being addressed with the providers J Planned schedule of USC work supported by PwC Key assurances included: ▪ Actions taken to address the financial position and actions taken to address improvements required in unscheduled care and RTT performance
22.5.18	J The Committee received a paper and presentation on the unscheduled care programme in conjunction with Pricewaterhouse Cooper. Disappointment was expressed that the processes and systems put in place in Ysbyty Glan Clwyd remained fragile with the potential for them not to be sustained longer term. The Committee were also keen to see value for money in terms of the investment in the project but accepted that there were limitations to what could be achieved. The Committee would wish to see the positive elements of the YGC work consolidated and sustained across the wider patch, and evidence of how it had led to improvements. J The discussion on the paper on external contracts highlighted a new risk to the organisation relating to the Countess of Chester's intention to move away from tariff, and a potential cost pressure of £4m. This would however be an unusual change to the payment mechanism and would not be supported by the Health Board. J The Committee were extremely concerned to note a £0.6m variation from plan at Month 1. The Executive Director of Finance indicated that the main areas contributing to this would be familiar to the Committee – ie; unscheduled care, medicines management, mental health and continuing health care packages. The Director of Mental Health & Learning Disabilities would be asked to attend the next meeting to provide further detail regarding the Division's financial performance. J The Committee were concerned at the impact that the current gaps in senior and executive teams would have upon finance and performance. J The Committee noted that the budget for the Ysbyty Gwynedd Emergency Department project was under pressure and requested a short exception report against the contingency resources to be prepared. J The Committee were disappointed to note that the 100% job planning target had not been met by the end of March as planned, however, acknowledged that significant improvement had been made. The Executive Medical Director indicated that there was a genuine desire within operational teams to engage fully with the job planning process, however, recent and ongoing competing pressures had affected their ability to do so.
28.6.18	J Achievement of the forecast deficit of £35 million was dependent on delivery of the full savings programme as well as the continued application of enhanced grip and controls introduced in the second half of 2017/18 across the Health Board. The Turnaround Director had been appointed with a number of work streams in process to reduce expenditure.

	Recovery plans had been requested from all overspending divisions, and Secondary Care and MHLD senior management teams were in weekly escalation meetings with members of the Executive Team. Performance on unscheduled care and RTT trajectory was being managed through weekly Access meetings and there were ongoing discussions with Welsh Government regarding the funding which was yet to be agreed.) Medical Agency spend continued to rise for the 3rd successive month. Control systems were in place to manage bookings in excess of framework rates approved by the Executive Team, ongoing recruitment was being undertaken to try and reduce the reliance on agency doctors.) Mental Health packages of care and Continuing Health Care (CHC) were areas of particular concern. Actions had been agreed with Executives and monitored on a weekly basis.
26.7.18	Financial Stability The year to date deficit of £10.3m was £0.2 million worse than plan. Although savings schemes of £45.3m had been identified, there remained a gap in fully worked up savings of £3.5m and there was a step up of £1m per month additional savings from August. Current forecast for MHLD was breakeven, although there were significant financial risks to this as the division had an overspend of £0.5m at Month 3. Mitigating actions : Financial Recovery Plans requested from MHLD and each of the hospital sites. Secondary Care / MHLD were in weekly escalation meetings with Execs. Forensic review of Area/Secondary Care Budgets & CHC/ Mental Health packages of Care. Increased focus on the delivery of savings and management of budgets through financial recovery meetings with Divisions, the Executive Director of Finance and the Director of Turnaround were working together to ensure recovery plans were being implemented and progress tracked. Future Turnaround reports to the Committee would provide exception reporting against key deliverables and milestones. Integrated Quality and Performance Report Access & Delivery Unscheduled Care (USC) Risk: Deteriorating USC performance on all three sites with a continuing shift in patient acuity. Mitigating actions include: Embedding learning from PwC work at YGC to WM & YG Focus on improvement trajectory to 80% firstly. New Emergency Department Management at Wrexham Maelor had agreed a phased improvement plan. Appointment of Advanced Nurse Practitioners to maintain flow of minors. USC redesign work led by sponsor group to complete high level benefits quantification. Trajectories agreed for 2018/19 and presented to Welsh Government. Referral to Treatment Large numbers of patients experiencing waits of over 36 weeks for treatment

	with initial forecasts reporting a deteriorating position for Q2. Mitigating Actions/milestones include: Monthly additional internal activity plans being implemented. Theatre productivity confirmed and monitored by Transformation Group Outsourcing capacity overseen by contracting department, subject to WG approval. Secondary Care & Area Teams continue to oversee delivery of cohort. Health Board were continuing to work towards improved Q2 position with 3 scenarios presented to WG for year end plan.
23.8.18	Risk - Financial Stability The Health Board's Financial forecast, which remained at £35 million, is at risk as the year to date deficit deteriorated by £0.5 million more than projected and there was a requirement of a step up in savings delivery from August. Mitigating Actions: • Financial Recovery Plan produced by MHLD to recover the overspend, outlining actions under consideration to achieve breakeven, whilst mindful of the risks to service delivery, quality and reputation. • Additional controls and grip with YGC and WM key areas of focus in Secondary Care. Discussions were taking place around Health Economy based control totals. • Additional Savings Stretch Targets being explored to mitigate potential non delivery of current identified savings. Risk - Access & Delivery Challenging performance of Unscheduled Care which struggled to meet KPI's despite much additional work and support. Mitigating Actions: • Joint area & hospital site accountability meetings had been established with clear actions and delivery timescales. • Focus on detailed breach analysis, by types of patients, time of day & common themes. • Introduction of zero tolerance for paediatric breaches and improvement plan. • Operational structure reviewed with WG funding to boost management capacity. Risk - Referral to Treatment RTT remained a key risk with current operational forecast for Q2 showing an increase in 36 week breaches, with Medical staffing constraints in Urology, Endocrinology and loss of Ophthalmic capacity in Centre. Mitigating Actions: • Operational structure review increasing managerial capacity to support improvement and pathway management.
25.9.18	Risk of delivery of savings targets – the proportion of high risk remained consistent at 155 with the amber risk reducing from 35 to 33%. The risk profile was a cause for concern as BCU moves towards midpoint of the year with further action required to improve confidence of delivery or identify alternative cost savings to bridge any gaps.

25.10.18	£10m risk of delivery of the £35m financial control total. Achievement of the savings targets was a key factor in delivering the plan – the proportion of high risk schemes had reduced by £1.7m to £5.0m and amber schemes reducing by £3.3m to £11.6m. Whilst the risk profile had improved, it remained a cause for concern as BCU moves into Q3. Further action was required to improve confidence of delivery or identify alternative cost savings to bridge any gaps. RTT delivery was also a risk, currently on trajectory but remained a risk as we progress into the winter months. This was being closely monitored through the weekly Access meetings. The Unscheduled Care Performance remained very challenging and below target. The first 90 day cycle of the Unscheduled Care Plan would be closely monitored to assess the impact.
22.11.19	£10m risk of delivery of the £35m financial deficit control total. Financial recovery schemes of £6.75m having been identified, which left a potential gap of £3.4m. Mental Health recovery was very high risk and that the turnaround pay recovery schemes were amber. Therefore the current gap to delivering the £35m was between £3.4m to £8m and £40m was a realistic assessment of the current forecast Achievement of the savings targets was a key factor in delivering the plan. Further action was required to improve confidence of delivery or identify alternative cost savings to bridge any gaps. RTT delivery was also a risk, currently on trajectory but remained a risk as we progress into the winter months. This was being closely monitored through the weekly Access meetings. The Unscheduled Care Performance remained very challenging and below target. The first 90 day cycle of the Unscheduled Care Plan would be closely monitored to assess the impact.
17.1.19	Forecast outturn had been increased to £42m deficit and Welsh Government had been notified. Additional financial controls had been implemented to control the expenditure run rate and further scrutiny of the savings programme. Savings schemes were forecast to achieve £38.8m, a potential gap of £6.2m against the £45m target and the turnaround schemes had not delivered against the £7.7m schemes outlined in September. Both Secondary Care and MH and LD were forecasting a significant overspend against budget and mitigating actions were being scrutinised through both CE Escalation and the Accountability Review meetings.

	RTT delivery was a significant risk, against the target for 31 March 2019. This was being closely monitored through the weekly Access meetings. The Unscheduled Care Performance remained very challenging and below target.
26.2.19	Forecast outturn had been maintained at £42m deficit and the additional financial controls had been implemented to control the expenditure run rate and further scrutiny of the savings programme. Savings schemes were forecast to achieve £38.9m, a slight improvement on Month 9 but there was still a gap of £6.1m against the £45m target and the identification of schemes for 2019/20 needed to be accelerated. Both Secondary Care and MH and LD were forecasting a significant overspend against budget and mitigating actions were being scrutinised through both CE Escalation and the Accountability Review meetings. RTT delivery was a significant risk, against the target for 31 March 2019 and actions to improve data quality needed to be progressed. This was being closely monitored through the weekly Access meetings. The Unscheduled Care Performance remained very challenging and below target.
26.3.19	Forecast outturn had been maintained at £42m deficit but there were risks around the clawback of RTT funding, CHC, English contract income, drugs, HRG4+ and GMS. The expected delivery of savings had reduced by £0.6m against Month 10 and there was a shortfall of £6.7m against the £45m in the annual plan. The Savings Sub Group will meet for the first time in April and will provide greater scrutiny and challenge around the savings programme. Both Secondary Care and MH and LD continue to forecast a significant overspend against budget and mitigating actions were being scrutinised through both CE Escalation and the Accountability Review meetings. RTT delivery remained a significant risk, against the target for 31 March 2019 and actions to improve data quality need to be progressed. This was being closely monitored through the weekly Access meetings. The Unscheduled Care Performance remained very challenging and below target.

9. Focus for the year ahead:

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

- Control and Scrutiny of the annual plan, reconciling:
  - Financial performance
  - Savings delivery
  - Workforce
  - Quality
  - Activity

The Committee will need to establish a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. The 2018/19 COB is attached as Appendix 3 for reference.

***Key:*

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

V1.0

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

FINANCE AND PERFORMANCE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as Finance and Performance Committee (F&P). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance and delivery. This includes the Board's Capital Programme, Informatics and Information Governance, Communications and Technology Programmes and Workforce matters.

3. DELEGATED POWERS

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

3.1.1 Financial Management

- seek assurance on the Financial Planning process and consider Financial Plan proposals
- monitoring financial performance and cash management against revenue budgets and statutory duties;
- consider submissions to be made in respect of revenue or capital funding and the service implications of such changes including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial Instructions;
- receive assurance with regard to the progress and impact/pace of implementation of organisational savings plans.
- receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual teams.

3.1.2. Performance Management and accountability

- approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).
- ensure detailed scrutiny of the performance and resources dimensions of the Integrated Quality and Performance Report (IQPFR);

- monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets;
- review in year progress in implementing the financial and performance aspects of the Integrated Medium Term Plan (IMTP);
- review and monitor performance against external contracts
- receive assurance reports arising from Performance and Accountability Reviews of individual teams.
- Receive assurance reports in respect of the Shared Services Partnership.
- Consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.

3.1.3 Capital Expenditure and Working Capital

- approve and monitor progress of the Capital Programme.

3.1.4 Informatics and Information Governance

- approve and monitor progress of the Informatics Operational plan including performance against the annual Informatics Capital Programme;
- monitor performance and delivery of the rollout of the core national IT systems, in particular
    - Patient Administration
    - Emergency Department
    - Community Care Information Systems
    - Welsh Clinical Portal

- To review other major IT systems developments which could have significant impact on the Health Boards operational services to monitor performance including access timeframes, efficiency measures and other performance improvement measures, including local targets.
- To provide assurance that the Health Board is discharging its functions and meeting its responsibilities with regard to Information Governance, including Caldicott and Health Care Records;

3.1.5 Workforce

- Monitor performance against key workforce indicators as part of the IQPR;
- Monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans.

- Receive quarterly assurance reports in relation to workforce, to include job planning under Medical and Dental contracts for Consultants and

Specialist and Associate Specialist (SAS) doctors and the application of rota management for junior doctors, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and Allied professionals

- Ongoing monitoring in relation to staff survey results. Staff induction and updates on employee safehaven.

4. AUTHORITY

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

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
- other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

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

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

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

5. SUB-COMMITTEES

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

5.2 The Financial Recovery Task and Finish Group will report to the Committee.

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board

6.2 In attendance

Executive Director of Finance (Lead Director)
Chief Operating Officer
Executive Director of Workforce and Organisational Development
Executive Director of Strategy

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

6.3 Member Appointments

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

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

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

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

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

7. COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, this should include either the Chair or the Vice-Chair of the Committee. In the interests of effective governance it is expected that a minimum of two Executive Directors will also be in attendance.

7.2 Frequency of Meetings

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

7.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

8.3.2 sharing of information

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

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the

presentation of an annual report;

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

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

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

11. REVIEW

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

Date of approval :
Audit Committee 9.2.18
Health Board 5.4.18

V3.0

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

FINANCE AND PERFORMANCE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as Finance and Performance Committee (F&P). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance and delivery. This includes the Board's Capital Programme and Workforce matters.

3. DELEGATED POWERS

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

3.1.1 Financial Management

- seek assurance on the Financial Planning process and consider Financial Plan proposals
- monitor financial performance and cash management against revenue budgets and statutory duties;
- consider submissions to be made in respect of revenue or capital funding and the service implications of such changes including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial Instructions;
- receive assurance with regard to the Health Board Turnaround programme progress and impact/pace of implementation of organisational savings plans.
- receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual directorates, divisions and sites.
- to determine any new awards in respect of Primary Care contracts

3.1.2. Performance Management and accountability

- approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).
- ensure detailed scrutiny of the performance and resources dimensions of the Integrated Quality and Performance Report (IQPFR);

- monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets;
- review in year progress in implementing the financial and performance aspects of the Integrated Medium Term Plan (IMTP);
- review and monitor performance against external contracts
- receive assurance reports arising from Performance and Accountability Reviews of individual teams.
- Receive assurance reports in respect of the Shared Services Partnership.

3.1.3 Capital Expenditure and Working Capital

- approve and monitor progress of the Capital Programme.

3.1.4 Workforce

- Monitor performance against key workforce indicators as part of the IQPR;

- Monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans.

- Receive quarterly assurance reports in relation to workforce, to include job planning under Medical and Dental contracts for Consultants and Specialist and Associate Specialist (SAS) doctors and the application of rota management for junior doctors, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and Allied professionals

- To consider and determine any proposals from the Primary Care Panel (via the Executive Team) in relation to whether the Health Board should take on responsibility for certain GP Practices.

4. AUTHORITY

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

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

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

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

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

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

5. SUB-COMMITTEES

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

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board

6.2 In attendance

Executive Director of Finance (Lead Director)
Executive Director of Nursing & Midwifery
Executive Director of Workforce and Organisational Development
Executive Director of Primary & Community Services
Executive Director of Planning & Performance
Director of Turnaround (for relevant items pertaining to finance and savings)

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

6.3 Member Appointments

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

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

6.4 Secretariat

Secretary – as determined by the Board Secretary.

6.5 Support to Committee Members

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

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

7. COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, this should include either the Chair or the Vice-Chair of the Committee. In the interests of effective governance it is expected that a minimum of two Executive Directors will also be in attendance.

7.2 Frequency of Meetings

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

7.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

8.3.2 sharing of information

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

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

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

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

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

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

11. REVIEW

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

Date of approval by the Board 6.9.18

Reported to Committee ……
V4.0

Cycle of Business 2018/19 2.02 updated 24.10.18

Agenda Item	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV		JAN	FEB	MAR
NB Consent items will be determined on a meeting by meeting basis												
Opening Business / Standing items												
Previous Minutes and Action Plan	x	x	x	x	x	x	x	x		x	x	x
Declaration of any Interests	x	x	x	x	x	x	x	x		x	x	x
Finance and Planning												
Finance Report	x	x	x	x	x	x	x	x		x	x	x
Financial Plan 2019-2020 (inc sign off of budgets)					-						x	x
Financial Planning	x	x	x	x	x	x	x	x		x	x	x
Turnaround reports wef June 2018			x	x			x	x		x	x	x
External Contracts Update *(for information only – with exception of presentation in November)*		x			x			X Presentation			x	
Annual Budget Principles and Budget Management Strategy								*x*				

Agenda Item	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV		JAN	FEB	MAR
Capital Programme Report	x	x	x	x	x	x	x	x		x	x	x
Approval of the draft annual Discretionary Capital allocation programme												x
Benefits Realisation / Gateway Reviews – *as arise*	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆
Any Estates / Capital Business Cases for approval prior to Board ratification – *as arise*	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆
Performance and Contracting												
Integrated Quality and Performance report and supporting KPI indicator presentation	x	x	x	x	x	x	x	x		x	x	x
Unscheduled Care report	x	x	x	x	x	x	x	x		x	x	x
RTT report	x	x	x	x	x	x	x	x		x	x	x
Workforce												
Workforce Intelligence report		X Mar data			X June data			X Sept data			X Dec data	
BCUHB Medical Locum Governance Update including Junior Doctors rota compliance				x								

Agenda Item	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV		JAN	FEB	MAR
Registration and Revalidation Updates ⁾ Nursing & Midwifery ⁾ HCPC and Pharmacy (Health Care Professionals Council and Pharmacy) ⁾ Medical & Dental *(followed up by assurance report to RaTs Committee)*		NM HCP C MD										
Review of Corporate Risks Assigned to Finance & Performance Committee (CRR = Corporate Risk Register)		x						x				
Agree CoB for coming year												x
Committee Annual Report inc review of ToR	x											x
Policies (relating to area of responsibility)		x										
Shared Services Partnership Committee Assurance Report	x			x			x			x		
Special Measures												
Special Measures – Committee expectations					x		x			x		x
Agenda Item	**APR**	**MAY**	**JUN**	**JULY**	**AUG**	**SEP**	**OCT**	**NOV**		**JAN**	**FEB**	**MAR**
Closing Business												
Summary of In Committee Board business to be reported in public (Only if in committee meeting the previous month)	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆
Issues of Significance to Inform Chair's Report	x	x	x	x	x	x	x	x		x	x	x

Agenda Item	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV		JAN	FEB	MAR
InCommittee												
Medical and Dental Agency Locums monthly reports	x	x	x	x	x	x	x	x		x	x	x
Performance Assurance Progress Report				x								
Carry forward to future years:												
2020/21 : Review of Performance Management Framework (as required by ToR) *to be addressed in 3 year cycle)*					x							

◆ = Items to be considered if arise

Committee Annual Report 2018/19

1. Title

Strategy, Partnerships and Population Health Committee

2. Name and role of person submitting this report:

Mr Mark Wilkinson, Executive Director of Planning and Performance

3. Dates covered by this report:

01/04/2018-31/03/2019

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

The Committee was routinely scheduled to meet 8 times (and otherwise as the Chair deemed necessary) however the frequency of meetings was amended in-year to bimonthly. During the reporting period therefore it met on 7 occasions. Attendance at meetings is detailed within the table below:

INDEPENDENT MEMBERS	12.4.18	10.5.18	5.7.18	9.8.18	9.10.18	4.12.18	5.2.19
Bethan Russell-Williams (Vice Chair)	✓	✓	A	✓	A	✓	✓
Margaret Hanson (Chair to June 2018)	✓	A	◆	◆	◆	◆	◆
Marian Wyn Jones (Chair wef October 2018)	◆	◆	◆	◆	✓	✓	✓
Medwyn Hughes	✓	A	✓	✓	✓	✓	A
Lyn Meadows	✓	✓	✓	✓	◆	◆	◆
Helen Wilkinson	◆	◆	◆	◆	✓	✓	✓

Directors and Officers in Attendance	12.4.18	10.5.18	5.7.18	9.8.18	9.10.18	4.12.18	5.2.19
Geoff Lang Executive Director Strategy (Lead Director)	✓	✓	◆	◆	◆	◆	◆
Sally Baxter Acting Executive Director Strategy (Lead Director)	In attendance	In attendance	✓	A	✓	In attendance	◆
Mark Wilkinson Executive Director of Planning and Performance (Lead Director)	◆	◆	◆	◆	◆	✓	✓
Sue Green Executive Director of Workforce & OD	✓	A	A	✓	✓	✓	✓
Teresa Owen Executive Director of Public Health	✓	✓	A	✓	✓	✓	✓
Chris Stockport Executive Director of Primary & Community Services	◆	◆	◆	◆	✓	✓	✓
Rob Nolan Finance Director ~ Commissioning and Strategy	◆	◆	✓	✓	✓	✓	✓
John Darlington Assistant Director Planning	✓	✓	✓	✓	✓	✓	✓

Key:

√ Present

√* Part meeting

A Apologies/Absent

◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. For a full list of attendance, please see the detailed Minutes which can be accessed on the Health Board's website via the following link:- http://www.wales.nhs.uk/sitesplus/861/page/88168

5. Assurances the Committee is designed to provide:

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

Ensure that current and emerging service strategies adhere to national policy and legislation, the priorities of the Health Board and are underpinned by robust population health needs assessment, workforce and financial plans and provide for sustainable futures;

Advise and assure the Board in discharging its responsibilities with regard to the development of the Health Board's Medium and long term plans, together with the Annual Operating Plan;

Ensure the Health Board's response to new and revised legislative requirements in relation to service planning and delivery, providing assurance that statutory duties will be appropriately discharged, ensuring strategic alignment between partnership plans developed with Local Authorities, Universities, third sector and other public sector organisations;

Receive regular performance and assurance reports from the Public Service Boards and Regional Partnership (Social Services and Partnership part 9 Board and Mental Health Partnership Board).

Ensure that the Health Board meets its duties in relation to prison health, Welsh language, civil contingencies legislation and emergency preparedness;

Ensure the alignment of supporting strategies such as Workforce, Capital Planning, Estates infrastructure and Information, Communications and Technology (ICT) in the development of the Strategic Plans;

Ensure that the partnership governance arrangements reflect the principles of good governance with the appropriate level of delegated authority and support to discharge their responsibilities; and monitor sources of assurances in respect of partnership matters ensuring these are sufficiently detailed to allow for specific evaluations of effectiveness.

Ensure appropriate arrangements for continuous engagement are in place; and review assurances on Consultation feedback.

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference V3.0 which were operative from March 2018 to November 2018 and V4.0 operative from December 2019. The terms of reference were amended as below and are appended at Appendices 1 and 2.

Amendment of Lead Director title: Executive Director Strategy to Executive Director Planning and Performance
Addition of Executive Director Primary and Community Services (new post)

An integral part of the process is the requirement for the Committee to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management Group (CBMG) who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year.

CBMG actions agreed:

- 2.8.18 SPPHC to move to meeting every other month
- Workforce planning issues to remain with SPPHC
- CBMG discussed the proposal to move staff welfare issues to Remuneration and Terms of Service Committee (RaTS) and it was agreed that SPPH should retain this aspect in order to ensure that RaTS agendas remained as streamlined and technically-focused as possible.
- A planned paper on University collaboration had been deferred several times. It was confirmed that the Executive lead would be the Executive Director of Therapies and Health Sciences but there were shared implications for several individuals who would be asked to input into the paper which would be taken to the October 2018 meeting
- The Committee would need to receive a follow up paper regarding A Healthier Wales.
- 10.1.19 re-examine meeting structure and reintroduce workshops in the month between formal meetings, particularly in the second half of the financial year.
- Monitoring against Annual Operational Plan (AOP) and clarity regarding Key Performance Indicators will create challenge to redesign monitoring framework which in turn will result in changes to COBs. Oversight of strategic change – SPPHC responsible for planning and performance elements with Finance and Performance Committee having responsibility for finance, resources and change. SPPHC Chair and Board Secretary to discuss future oversight arrangements to ensure coherent reporting and monitoring arrangements via Committees in place.
- Ensure Public Health Annual Report on Board COB and presented to SPPHC prior to Board.

At a workshop of the Audit Committee held on the 15th May 2018 members reviewed each of the Committee and Advisory Group's annual reports for 2017-18 with the aim of providing evidence on the scope and effectiveness of Committees and of their evaluation of the sources of assurance available to them. As the system of Board Assurance continued to be refined, Audit Committee members made the following comments specific to the SPPH Committee:-

Business continuity – arrangements need to be made to address the weaknesses identified by the audit.	The Committee has approved the business continuity plan for 2019/20 and will receive progress updates as set out in the cycle of business.
Consistency (with other Committee Annual Reports) to be applied in terms	Completed for 2018-19

of attendance key.	

In addition, Audit Committee members made the following generic comments pertaining to the Committee and Advisory Group Annual Reporting process:-

Recurring themes around the need for training for members in respect of specific Committee responsibilities, and concerns around the volume of work some Committees were dealing with.	A full review and refresh of the cycle of business has been undertaken with the Committee Chair and Lead Executive. Meeting duration has been extended to allow for full discussion of items. Committee members have also increased their skill set through the wider Board Development and Workshop programme. Other specific training has also been provided e.g. risk management, equality, safeguarding and continuing health care.
Externally commissioned / produced reports e.g. Deanery / Royal Colleges should be centrally logged.	Central logging now in place within Office of the Board Secretary.
Chairs assurance reports to in future confirm actions being taken to address key risks identified.	Template amended in July 2018
Template for future Committee Annual reports to be amended to detail ”focus for the year ahead” at the end of the report.	Completed (see section 9)
Any difficulties in identifying sources of assurance to be included as a key focus for the year ahead.	Completed (see section 9)
In respect of internal or external audit reports individual committees are asked to review and provide commentary within their annual report on whether the implementations of the recommendations arising from audits relevant to their remit have led to overall qualitative improvements.	The business continuity recommendation from 2018 has served to catalyse the work of the Committee in this respect. It’s currently too early to say whether it has led to overall quality improvements. Staffing improvements in this area with the recent appointment of a substantive Head of Emergency Preparedness and Resilience and planned recruitment to the now vacant manager post have had as great an impact on our capacity.
Ensure new assurance map addresses quality of primary care and quality of	Completed as part of ongoing development of Board Assurance

commissioned services.	Framework
Sources of assurance document to be updated as follows:- • Outcome findings of local clinical audit work to be included (ACS 21A) • Systems of internal control to be included (ACS 11A) • Team Central Tracker aligned to Audit Committee to be included (ACS66). • Delete RAG colour coding from document.	Completed as part of ongoing development of Board Assurance Framework

In addition, The Committee welcomed the BCU Translation Team to SPPH Committee meetings to pilot the Team's simultaneous translation service which was being developed. The Committee Chair encouraged members who were able to speak in the Welsh language to do so in order to maximise the WL Team's opportunities to practice this skill.

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

The overall RAG status is GREEN.

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

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	**Supporting narrative (Please provide detail for all actions showing amber or red assurance levels in terms of actions being taken to address these issues).**
Ensure that current and emerging service strategies adhere to national policy and legislation , the priorities of the Health Board and are underpinned by robust population health needs assessment, workforce and financial plans and provide for sustainable futures;			Living Healthier Staying Well Strategy development effectively overseen by the Committee
Advise and assure the Board in discharging its responsibilities with			Regular reports were provided as

regard to the development of the Health Board's Medium and long term plans, together with the Annual Operating Plan;			part of core cycle of business
Ensure the Health Board's response to new and revised legislative requirements in relation to service planning and delivery, providing assurance that statutory duties will be appropriately discharged, ensuring strategic alignment between partnership plans developed with Local Authorities, Universities, third sector and other public sector organisations;			Regular reports were provided as part of core cycle of business relating to partnership work eg PSBs, Regional Partnership Board Further work required on Collaboration with the Higher Education sector
Receive regular performance and assurance reports from the Public Service Boards and Regional Partnership (Social Services and Partnership part 9 Board and Mental Health Partnership Board).			In place at the end of the year
Ensure that the Health Board meets its duties in relation to prison health, Welsh language, civil contingencies legislation and emergency preparedness			Regular reports were provided as part of core cycle of business ****Prison Health is now monitored via QSEC therefore an amendment to Terms of Reference is recommended*
Ensure the alignment of supporting strategies such as Workforce, Capital Planning, Estates infrastructure and Information, Communications and Technology (ICT) in the development of the Strategic Plans			Details and alignment considered as part of the development of the 3 year plan
Ensure that the partnership governance arrangements reflect the principles of good governance with the appropriate level of delegated authority and support to discharge their responsibilities; and monitor sources of assurances in respect of partnership matters ensuring these are sufficiently detailed to allow for specific evaluations of effectiveness.			Progress made in year to align partnership working with Committee business.

Ensure appropriate arrangements for continuous engagement are in place; and review assurances on Consultation feedback.			Regular updates on the approach to engagement with staff and public, including feedback reports from engagement activity.

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

Standing Items

- Annual Operational Plan monitoring reports

Regular Items

- Living Healthier, Staying Well Strategy : End of programme report
- Review of the Committee's allocated risks extracted from the Corporate Risk Register
- The Well-being of Future Generations (WBFG) (Wales) Act 2015 : Well-being Objectives and Annual Report
- Update on public engagement activity
- Civil Contingencies and Business Continuity Annual Report 2017/18
- Fairness, Rights and Responsibilities Annual Equality Report 2017 -2018
- Welsh Language Services Annual Monitoring Report 2017-2018
- Welsh language standards update
- North Wales Regional Partnership Board updates
- North Wales Mental Health Strategy update
- Draft Annual Operational Plan 2018/19
- BCUHB Volunteers Annual report 2016/17
- North Wales Regional Partnership Board Annual report 2017/18
- Development of the Integrated Medium Term Plan 2019/22
- Mental Health Strategy update
- Learning Disability Strategy update – Engagement activity
- Well North Wales Annual report 2017/18
- North Wales Area Planning Board ~ Substance Misuse update
- Wrexham Maelor hospital campus redevelopment programme
- Staff Engagement - NHS Survey 2018 – Draft Organisational Improvement plan and Divisional Improvement plans
- Reconnecting with the Public –public engagement update
- EU Exit Transition planning

Ad-Hoc

- Strategic Change Programmes – update on partner organisations
- North Wales Public Service Boards : Well-Being plans
- Strategic Change Programmes: Hywel Dda UHB – Our big NHS change
- Future Fit : Consultation on improving hospital services for people in Shropshire, Telford & Wrekin and Mid Wales

- North Wales Community Dental Services Strategy document - Working for Smiles
- "A healthier Wales: Our plan for health and social care"
- North Wales Integrated Resilience Planning
- Equality and Human Rights Strategic Forum Terms of Reference and operating arrangements
- Corporate Health Standard Gold Revalidation and Platinum Assessment
- North Wales Safer Communities Board update July 2018
- Collaborative working with Universities
- North Wales Carers Strategy
- Draft Enabling Strategies supporting the 3 year plan – Estate, and Workforce
- BCUHB – Main Budget Changes – Additional funding 2019/20

Governance Items

- Health Board wide procedure : Using Welsh internally
- Draft SPPH Committee annual report 2017/18
- Special Measures : Review of expectations allocated to the SPPH Committee
- Review of minutes and actions
- Committee annual report
- Review of Cycle of Business

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following link:- http://www.wales.nhs.uk/sitesplus/861/page/85403

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

Meeting Date	Key risks including mitigating actions and milestones
12.4.18	The Committee noted concerns regarding the capacity to ensure effective clinical engagement in the next phase of the strategy work
10.5.18	The Committee noted concerns regarding increased risk rating of CRR01 Improving Population Health
5.7.18	Concern was raised regarding workforce engagement, head space and affordability of the NW Mental Health strategy implementation. It was agreed that an updated robust operational delivery plan with clear milestones would be provided to the October Committee meeting. The need to develop capacity and capability in the development of business cases needed to be addressed in moving forward as well as ensuring a read across to the Board's Annual Operating Plan. Disappointment was expressed regarding the 57% completion rate of the Annual Operating Plan actions achieved and the requirement to provide further explicit detail regarding incomplete actions. Robust development of business plans consistently across North Wales was noted as being partially rolled out and would need to be improved on, noting that a reconciliation of

	incomplete actions would be moved forward into the 2018/19 AOP. The need to address project, business plan and clinical management skills were highlighted to improve performance going forward. The Committee acknowledged the criticality of attaining AOP grip, and a framework, in a timely manner, and at pace, to ensure the Minister's expectation for significant improvement by the Autumn. RTT work was progressing, although funding had yet to be agreed with WG, to ensure there was no fall back in performance.
9.8.18	In questioning whether the Seasonal Resilience Plan would be prepared in time for submission to the September Health Board, it was confirmed that an update would be presented and incorporate the Committee's feedback. The risk of non-inclusion of service users, parents and carers within development of the LD Strategy had been mitigated via embedding participation within the process and also consideration of a specialist company to support this. The IMTP timetable required further work to ensure that key milestones and priorities were identified/amended and to enable effective monitoring by the Committee.
9.10.18	Disappointment was expressed regarding the completion rate of the Annual Operating Plan achieved in Quarter 1. Verbal updates on Quarter 2 performance highlighted the need to address project, business plan and clinical management skills to improve performance going forward, with a need for timely reporting to Committee. Where milestones were not met, remedial actions were identified. The Capacity to implement the Mental Health Strategy remains a challenge, with little dedicated programme support, pace of delivery remains slow. The development of the IMTP is a critical organisational requirement which will require engagement across the organisation to ensure successful and timely delivery. There were financial risks associated with a number of Well North Wales programme areas where aspects of specific initiatives are subject to short-term funding arrangements.
4.12.18	The development of the Three year Plan is a critical organisational requirement which will require significant work and engagement to complete within the required timescale.
5.2.19	The Committee noted the significant work remaining to develop the Board's 3 year Plan 2019/22, requiring engagement across the organisation to ensure timely delivery.

9. Focus for the year ahead:

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

- Overseeing the service strategy development work in accordance with the annual plan and stakeholder expectations.
- Encouraging the development of health economy approaches to planning to inform the BCU wide plan for 2020/21.
- Developing our awareness of partnership working focusing on public service boards and the regional partnership board.
- Gaining assurance on our engagement with statutory partnership fora and that targeted investment (eg transformation funding) is delivering the anticipated benefits.
- Receiving updates on key enabling strategies including workforce / engagement, and estates.

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 3.

***Key:*

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

V2.0

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

STRATEGY, PARTNERSHIPS AND POPULATION HEALTH COMMITTEE

1 INTRODUCTION

1.1 The Board shall establish a committee to be known as the Strategy, Partnerships and Population Health Committee (SP&PH). The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2 PURPOSE

2.1 The purpose of the Committee is to provide advice and assurance to the Board with regard to the development of the Health Board's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales. The Committee will do this by ensuring that strategic collaboration and effective partnership arrangements are in place to improve population health and reduce health inequalities.

3 DELEGATED POWERS

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

3.1.1 ensure that current and emerging service strategies adhere to national policy and legislation , the priorities of the Health Board and are underpinned by robust population health needs assessment, workforce and financial plans and provide for sustainable futures;

3.1.2 advise and assure the Board in discharging its responsibilities with regard to the development of the Health Board's Medium and long term plans, together with the Annual Operating Plan;

3.1.3 ensure the Health Board's response to new and revised legislative requirements in relation to service planning and delivery, providing assurance that statutory duties will be appropriately discharged, ensuring strategic alignment between partnership plans developed with Local Authorities, Universities, third sector and other public sector organisations;

3.1.4 Receive regular performance and assurance reports from the Public Service Boards and Regional Partnership (Social Services and Partnership part 9 Board and Mental Health Partnership Board).

3.1.5 Ensure that the Health Board meets its duties in relation to prison health, Welsh language, civil contingencies legislation and emergency preparedness;

3.1.6 Ensure the alignment of supporting strategies such as Workforce, Capital Planning, Estates infrastructure and Information, Communications and Technology (ICT) in the development of the Strategic Plans;

3.1.7 Ensure that the partnership governance arrangements reflect the principles of good governance with the appropriate level of delegated authority and support to discharge their responsibilities; and monitor sources of assurances in respect of partnership matters ensuring these are sufficiently detailed to allow for specific evaluations of effectiveness.

3.1.8 Ensure appropriate arrangements for continuous engagement are in place; and review assurances on Consultation feedback.

4 AUTHORITY

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

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
- other committees, sub-committee or group set up by the Board to assist it in the delivery of its functions.

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

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Strategy, Partnerships and Population Health matters.

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

5 SUB-COMMITTEES

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

6 MEMBERSHIP

6.1 Members

Four independent members of the Board

6.2 In attendance

Executive Director of Strategy (Lead Director)
Executive Director of Public Health
Executive Director of Workforce and Organisational Development
Chair of Stakeholder Reference Group

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

6.3 Member Appointments

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

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

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

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

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

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

7. COMMITTEE MEETINGS

7.1 Quorum

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

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

7.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the

organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

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

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

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

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

11. REVIEW

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

Date of approval by the Board 21.9.17
Reported to Committee 30.10.17

V3.0

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

STRATEGY, PARTNERSHIPS AND POPULATION HEALTH COMMITTEE

1 INTRODUCTION

1.1 The Board shall establish a committee to be known as the Strategy, Partnerships and Population Health Committee (SP&PH). The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2 PURPOSE

2.1 The purpose of the Committee is to provide advice and assurance to the Board with regard to the development of the Health Board's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales. The Committee will do this by ensuring that strategic collaboration and effective partnership arrangements are in place to improve population health and reduce health inequalities.

3 DELEGATED POWERS

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

3.1.1 ensure that current and emerging service strategies adhere to national policy and legislation , the priorities of the Health Board and are underpinned by robust population health needs assessment, workforce and financial plans and provide for sustainable futures;

3.1.2 advise and assure the Board in discharging its responsibilities with regard to the development of the Health Board's Medium and long term plans, together with the Annual Operating Plan;

3.1.3 ensure the Health Board's response to new and revised legislative requirements in relation to service planning and delivery, providing assurance that statutory duties will be appropriately discharged, ensuring strategic alignment between partnership plans developed with Local Authorities, Universities, third sector and other public sector organisations;

3.1.4 Receive regular performance and assurance reports from the Public Service Boards and Regional Partnership (Social Services and Partnership part 9 Board and Mental Health Partnership Board).

3.1.5 Ensure that the Health Board meets its duties in relation to prison health, Welsh language, civil contingencies legislation and emergency preparedness;

3.1.6 Ensure the alignment of supporting strategies such as Workforce, Capital Planning, Estates infrastructure and Information, Communications and Technology (ICT) in the development of the Strategic Plans;

3.1.7 Ensure that the partnership governance arrangements reflect the principles of good governance with the appropriate level of delegated authority and support to discharge their responsibilities; and monitor sources of assurances in respect of partnership matters ensuring these are sufficiently detailed to allow for specific evaluations of effectiveness.

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- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
- other committees, sub-committee or group set up by the Board to assist it in the delivery of its functions.

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

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Strategy, Partnerships and Population Health matters.

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Executive Director of Public Health
Executive Director of Workforce and Organisational Development
Executive Director Primary and Community Services
Chair of Stakeholder Reference Group

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

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7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

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

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

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

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

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11. REVIEW

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

Agenda Item	**Lead officer**	**Feb 2**	**Apr 2**	**July 4**	**Aug 6**	**Sep 3 work shop**	**Oct 1**	**Nov 12 work shop**	**Dec 3**	**Jan 14 work shop**	**Feb 4**	**Mar 5 work shop**
NB Consent items to be determined on a meeting by meeting basis												
Opening Business (Standing Items)												
Apologies for Absence		x	x	x	x		x		x		x	
Previous Minutes and Action Plan		x	x	x	x		x		x		x	
Governance Matters												
Committee annual report (A) (inc annual review of ToR and Cycle of Business)	Mark Wilkinson		A									
Cycle of Business review	Mark Wilkinson		x	x	x		x		x		x	
Corporate Risk Register – Review of allocated risks	Mark Wilkinson / Peter Barry			x					x			
Special Measures - Consideration of allocated expectations by the SPPH Committee	Mark Wilkinson / Liz Jones		x	x								
Public Health and Partnership Matters												
Partnership Arrangements Mid Wales Health Collaborative 111 Public Health : 1. ACEs 2. Smoking cessation 3. Healthy Weight 4. Well North Wales (Inequalities) 5. Alcohol and APB. 6. Vulnerable groups	Teresa Owen WNW- Glynne Roberts		1	2	3		4		5		6	

Agenda Item		**Feb 2**	**Apr 2**	**July 4**	**Aug 6**	**Sep 3 work shop**	**Oct 1**	**Nov 12 work shop**	**Dec 3**	**Jan 14 work shop**	**Feb 4**	**Mar 5 work shop**
Public Service Boards – Area Director updates			FfJ	RS	BJ		RS		FfJ		TBA	
NW Regional Partnership Board - Minutes as available – Including update on Transformation funding		x	X TF: Community services	X TF	X TF		X TF		x		x	
Planning Board – Substance Misuse				x			x					
Strategic Matters												
3 year Plan – refresh including Estates Strategy and major project reports	Mark Wilkinson	x	x		x			x			x	
3 year Plan - Development	Mark Wilkinson	x	x			x	x	x	x	x	x	x
Living Healthier, Staying Well Strategy - refresh and supporting strategies Clinical Services strategy (CSC)	Mark Wilkinson Evan Moore (CSC)		CSC	CSC	CSC	LHSW CSC	LHSW CSC	LHSW CSC	LHSW CSC	LHSW CSC	LHSW CSC	LHSW CSC
Key enabler Strategy updates: Workforce [W] ICT [i] Estates [E] Quality Improvement [Q]	Sue Green Chief Information Officer Neil Bradshaw Deborah Carter		E	E	E Q	E	E	E	E	E	E	E
Staff Survey	Sue Green	x					x					
Engagement - updates	Katie Sargent	x		x		x	x	x	x	x	x	x

Agenda Item		**Feb 2**	**Apr 2**	**July 4**	**Aug 6**	**Sep 3 work shop**	**Oct 1**	**Nov 12 work shop**	**Dec 3**	**Jan 14 work shop**	**Feb 4**	**Mar 5 work shop**
Civil contingency and business continuity progress and end of year update (E)	John Darlington		Plan	End of year update			Mid Year monitor		x			
Winter Resilience Planning - TBC	Meinir Williams											
Equalities: Strategic Equalities plan and Annual Report	Sally Thomas			x			x					
Major Strategic Projects (as required)	Wylfa – Wyn Thomas		Wylfa		x		WNW (A)		x		x	
Mental Health Strategy: Together 4 Mental Health Partnership progress	Andy Roach		x		x			x			x	
Learning Disabilities Strategy	Andy Roach		x		x						x	
Carer's Strategy	Chris Stockport / Ffion Johnstone				A							
Third Sector Strategy	Mark Wilkinson / Sally Baxter		x									
Volunteering Strategy incl Annual report (A)	Gill Harris			A								
Welsh Language Strategic Reports (A) Annual Monitoring report	Eleri Hughes-Jones	x		A								
Closing Business (Standing Items)												
Summary of In Committee business to be reported in public (as appropriate)		x	x	x	x		x		x		x	
Issues of Significance to Inform Chair's Report to Board		x	x	x	x		x		x		x	

Agenda Item		**Feb 2**	**Apr 2**	**June 11**	**Aug 6**	**Sep 3 work shop**	**Oct 1**	**Nov 12 work shop**	**Dec 3**	**Jan 14 work shop**	**Feb 4**	**Mar 5 work shop**
Date of Next Meeting		x	x	x	x		x		x		x	
Exclusion of press and public (as appropriate)		x	x	x	x		x		x		x	
In Committee Items and Minutes (as appropriate)												
As appropriate		x	x	x	x		x		x		x	
Adhoc items for consideration (as appropriate)												
Consultation responses (as appropriate)		x	x	x	x		x		x		x	
Legislation & National Policy (as required)		x	x	x	x		x		x		x	
Policy approval as appropriate		x	x	x	x		x		x		x	
Social Services and Well-being Act (as appropriate)		x	x	x	x		x		x		x	
Well-being of Future Generations Act (as appropriate)		x	x	x	x		x		x		x	
Corporate Health at Work		x			x						x	
Workforce Strategic Developments (as arise)												

Remuneration & Terms of Service Committee Annual Report 2018/19

1. Title of Committee:

Remuneration & Terms of Service (R&TS) Committee

2. Name and role of person submitting this report:

Sue Green, Executive Director of Workforce & Organisational Development.

3. Dates covered by this report:

01/04/2018-31/03/2019

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

The Committee was required by its terms of reference to meet at least once a year. During the 2017/18 reporting period the Committee met on five occasions, comprising four meetings held in public followed by an in committee section of the agenda when sensitive or confidential information was discussed in private, plus one extraordinary in committee meeting.. Attendance at meetings is detailed within the table below:

Members of the Committee	30.4.18	11.6.18 Extraordinary	30.7.18	26.11.18	14.1.19
Mrs M Hanson	✓	◆	◆	◆	◆
Dr P Higson	✓	✓	✓	◆	◆
Mrs J Hughes	◆	◆	✓	✓	✓
Mr M Hughes	◆	◆	◆	✓	✓
Mrs MW Jones	◆	✓[co-opted]	✓	✓	✓
Mrs L Meadows	✓[co-opted]	◆	◆	◆	◆

Mr M Polin	◆	◆	◆	✓	✓
Mr C Stradling	x	✓	✓	◆	◆
In attendance	30.4.18	11.6.18	30.7.18	26.11.18	14.1.19
Mr G Doherty	✓	✓	x	✓	**✓
Mrs S Green	✓	✓	✓	✓	✓

◆ Not a Committee member at this time
** Part meeting.

5. Assurances the Committee is designed to provide:

The Committee is designed to provide

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

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

- to perform certain, specific functions as delegated by the Board and listed in the terms of reference.

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference – version 3.0 being operative between 1.4.18 and 6.9.18, and version 4.0 being operative between 7.9.18 to 31.3.19. The terms of reference are appended at Appendix 1 and Appendix 2.

An integral part of the process is the requirement for the Committee to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office, with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management Group who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year.

Audit Committee Members held a workshop on 15 May 2018 to review and take account of the contents of each of the Board Committees' and Advisory Groups' Annual Reports. The review was intended to provide evidence on the scope and effectiveness of the 'committees' and of their evaluation of the sources of assurance

available to them. Members concluded that overall the Board can be reasonably assured that 'committees' and assurance systems in place for the year have worked efficiently and effectively. The only specific comment made regarding the Remuneration and Terms of Service Committee was that 'future reports should only list attendees who are listed in the committee's terms of reference'. This has been actioned in the current annual report.

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

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

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	**Supporting narrative (Please provide detail for all actions showing amber or red assurance levels in terms of actions being taken to address these issues).**
1. To provide advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by Welsh Government.	Yes - Green	Yes - Green	During the year (at the meetings held on 11.6.18, 30.7.18, 26.11.18), review and realignment of Executive portfolios and also remuneration at individual Director level, have been considered by the Committee. Key assurances provided by the Executive satisfied Committee members that, in respect of Executive portfolio realignment, any consequential impacts on reporting lines below Executive level would be adequately addressed using the organisational change policy and procedures. The Committee was also satisfied that robust arrangements were in place to ensure the appropriateness of senior individuals' job descriptions and remuneration (to maintain robustness of arrangements, at the time of writing, an extraordinary R&TS Committee meeting was scheduled. The purpose of this meeting would be to focus on mitigating any potential risk of remuneration arrangements for very senior managers not being

			appropriate and therefore giving rise to retention issues with key individuals). The Board was advised of the assurances provided via Chair's Assurance Reports following each meeting throughout the reporting period.
2. To provide assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales.	Yes - Green	Yes - Green	During the reporting period (at the meetings held on 30.7.18, 26.11.18, 14.1.19), the Committee considered, and was assured on the steps being taken to ensure that systems, including recruitment procedures, were in place to continue to reduce the number of staff receiving pay protection. The Committee was also assured on job planning progress, and that a transition plan would be put in place for fair treatment of staff working in Health Board managed GP practices. In addition, the Committee was satisfied that there were no negative impacts identified from the equality impact assessment on the 2018 pay review.
3.Other specific functions as delegated by the Board: 3.1 Comment specifically upon the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Manager (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied	Yes - Green	Yes - Green	As per objective 1. Covered during Committee discussion during the meetings held on 11.6.18, 30.7.18 and 26.11.18.

consistently.			
3.2 Comment specifically upon objectives for Executive Directors and other VSMs and their performance assessment.	Yes - Green	Yes - Green	As per objective 1. Covered during Committee discussion during the meetings held on 11.6.18, 30.7.18 and 26.11.18. Objective setting and performance review covered on 26.11.18.
3.3 Comment specifically on the performance management system in place for those in the positions mentioned above and its application	Yes - Green	Yes - Green	As per objective 1. Covered during Committee discussion during the meetings held on 11.6.18, 30.7.18 and 26.11.18. Objective setting and performance review covered on 26.11.18.
3.4 Comment specifically on proposals to make additional payments to consultants	Yes - Green	Yes - Green	Waiting list initiative payments discussed as part of consideration of the Remuneration Report at the meeting held on 30.4.18.
3.5 Comment specifically on proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.	Yes - Green	Yes - Green	Arrangements regarding the termination of a very senior manager were discussed by the Committee on 30.4.18.
3.6 Removal and relocation expenses	-	-	No business to discuss during the reporting period in question.
3.7 Consider and approve Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance	-	-	No business to discuss during the reporting period in question.

3.8 Monitor compliance with issues of professional registration	Yes - Green	Yes - Green	Matters relating to professional registration and revalidation were considered at the Committee meetings of 30.4.18 and 14.1.19.
3.9 Monitor and review risk from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.	-	-	No business to discuss during the reporting period in question.
3.10 Investigate or have investigated any activity (clinical and non-clinical) within its terms of reference.	Yes - Green	Yes - Green	An update on a spike in referrals to the NMC was requested, and provided, for the then Chair and CEO following the meeting held on 30.4.18. An internal decision review was considered by the Committee on 26.11.18; this was submitted at the request of the then Chair. The Committee requested at its meeting of 26.11.18 that compliance issues relating to the implementation of the Smoke Free Policy be given further consideration in due course, with input from Public Health. The Committee requested an extraordinary meeting to address appropriate remuneration arrangements for very senior managers, to mitigate retention risks in respect of key individuals.
3.11 Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it	-	-	Not necessary during the reporting period in question.

necessary, in accordance with the Board's procurement, budgetary and other requirements.			
3.12 Consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business including approval of Workforce policies	Yes - Green	Yes - Green	Workforce policies considered and approved at the Committee meetings held on 26.11.18 and 14.1.19.
3.13 Consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.	Yes - Green	Yes - Green	UPSW reports considered by the Committee on 26.11.18 and 14.1.19.

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

Consideration of:

- Draft R&TS Committee Annual Report 2017/18
- Remuneration report
- Nursing & Midwifery Council (NMC) Registration and Revalidation Annual Reports
- Review and realignment of Executive portfolios
- Pay protection reports
- Individual Director's remuneration
- Smoke Free, Managing Attendance and Adverse Weather Conditions & Transport Disruption, Time off in Lieu, NHS Wales Menopause, NHS Wales Organisational Change Policies approved/ratified
- Pay review update with equality impact assessment
- Revised R&TS Committee terms of reference
- Internal decision review
- UPSW reports

- Issues relating to managed GP practices
- Executive and Directors' remuneration.

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

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

Meeting Date	Key risks including mitigating actions and milestones
30.4.18	• Spikes in data for referrals to the NMC in April to June 2016 - further update provided
11.6.18	• Risks associated with realignment of Executive portfolios and the associated reporting lines below Executive level
26.11.18	• Compliance issues relating to the implementation of the Smoke Free policy
14.1.19	• Risks associated with failure to have in place appropriate remuneration arrangements for very senior managers.

9. Focus for the year ahead:

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

- Remuneration, terms of service, objective setting and performance management of Executives and Very Senior Managers

and, as and when required:

- UPSW, pay protection, policies, termination payments, relocation expenses, remuneration report, professional regulation, safehaven, corporate health at work and quality impact assessment of savings schemes.

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached at Appendix 3.

**Key:*

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

Appendix 1 – Terms of Reference operative within the reporting period - between 1.4.18 and 6.9.18

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1. INTRODUCTION

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

2. PURPOSE

2.1 The purpose of the Committee is to provide:

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

3.1.1 comment specifically upon

- the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;

- objectives for Executive Directors and other VSMs and their performance assessment;
- performance management system in place for those in the positions mentioned above and its application;
- proposals to make additional payments to consultants;
- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
- removal and relocation expenses

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

3.1.3 to monitor compliance with issues of professional registration.

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

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

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

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

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

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

3.1.8 Ensure that the Chair of Finance and Performance Committee is sighted on matters delegated to that Committee to monitor.

4. SUB-COMMITTEES

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

5. MEMBERSHIP

5.1 Members

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

5.2 In attendance

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

5.2.1 Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. A Staff side Chair of the Local Partnership Forum will be in attendance at meetings held in public as an ex-officio member.

5.3 Member Appointments

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

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

5.4 Secretariat

5.4.1 Secretary: as determined by the Board Secretary.

5.5 Support to Committee Members

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

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

6. COMMITTEE MEETINGS

6.1 Quorum

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

6.2 Frequency of Meetings

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

6.3 Withdrawal of individuals in attendance

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

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

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

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

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

7.3.2 sharing of information

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

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

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Committee Chair shall:

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

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

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

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

• Quorum

10. REVIEW

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

Date of approval

Audit Committee 14.9.17

Health Board 21.9.17

Reported to RATS 16.10.17

V3.0 approved

Appendix 2 – Terms of Reference operative within the reporting period – between 7.9.18 and 31.3.19

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1. INTRODUCTION

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

2. PURPOSE

2.1 The purpose of the Committee is to provide:

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

3.1.1 comment specifically upon

- the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;

- objectives for Executive Directors and other VSMs and their performance assessment;
- performance management system in place for those in the positions mentioned above and its application;
- proposals to make additional payments to consultants;
- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
- removal and relocation expenses

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

3.1.3 to monitor compliance with issues of professional registration.

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

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

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

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

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

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

4. SUB-COMMITTEES

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

5. MEMBERSHIP

5.1 Members

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

5.2 In attendance

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

Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. A Staff Side Chair of the Local Partnership Forum will be in attendance at meetings held in public as an ex-officio member.

5.3 Member Appointments

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

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

5.4 Secretariat

5.4.1 Secretary: as determined by the Board Secretary.

5.5 Support to Committee Members

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

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

6. COMMITTEE MEETINGS

6.1 Quorum

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

6.2 Frequency of Meetings

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

6.3 Withdrawal of individuals in attendance

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

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

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

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

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

7.3.2 sharing of information

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

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

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Committee Chair shall:

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

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

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

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

• Quorum

10. REVIEW

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

Date of approval

Health Board 6.9.18

Reported to RATS

V4.0

Appendix 3 – Cycle of Business 2019/20

Remuneration and Terms of Service Committee Cycle of Business

Item	April 19	May 19	Jul 19	Nov 19	Jan 20	Notes
Opening Business						
Apologies for Absence	x	x	x	x	x	
Declaration of Interests	x	x	x	x	x	
Previous Minutes and Action Plan	x	x	x	x	x	
Core Agenda Items						
Report on management action regarding pay protection		x		x		
Committee annual report (inc annual review of ToR)	x					
Corporate Health at Work			x			As per new route planner
Whistle-blowing/safehaven			x			CBMG decided that these arrangements would go to R&TS;
Tawel Fan staff issues			x			
Removal and relocation expenses			x			In route planner – note F&P relocation assurance report
Monitoring compliance issues of professional regulation		x		x		

Remuneration Report	x					Need to take Remuneration Report for each financial year prior to submission to May Audit Committee, as part of accounting process
Remuneration and Terms of Service issues : Executives and Very Senior Managers	x	x	x	x	x	
Objective setting arrangements : Executives and Very Senior Managers (every meeting as required)	x	x	x	x	x	
Performance Management : Executives and Very Senior Managers (every meeting as required)	x	x	x	x	x	
Upholding Professional Standards in Wales (*In Committee*)	x	x	x	x	x	Used to be within F&P ToR
Termination Payments incl VERS (every meeting as required)	x	x	x	x	x	
Policies	x	x	x	x	x	
Closing Business (Standing Items)						
Issues of significance to inform Chair's Assurance Report	x	x	x	x	x	
Summary of In Committee Business to be reported in Public	x	x	x	x	x	
Any Other Business (at Chair's discretion)	x	x	x	x	x	
Date of Next Meeting	x	x	x	x	x	

Mental Health Act Committee* Annual Report 2018/19

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

1. Title of Committee:

Mental Health Act Committee (MHAC)

2. Name and role of person submitting this report:

Andy Roach, Director of Mental Health and Learning Disabilities

3. Dates covered by this report:

01/04/2018-31/03/2019

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

The Committee was routinely scheduled to meet four times and otherwise as the Chair of the Committee deemed necessary. During the reporting period, it met on three occasions. Attendance at meetings is detailed within the table below:

The Power of Discharge Sub-Committee also met on four occasions during the year on the same dates and attendance of the core Sub-Committee membership is also detailed below.

Members of the Committee	11th May 2018	21st Sept 2018	3rd Jan 2019	29th Mar 2019
Bethan Russell-Williams	✓	✓	✓	◆
Cheryl Carlise	◆	A	✓	✓
Lyn Meadows	◆	✓	A	✓
Margaret Hanson (Chair)	✓	◆	◆	◆
Marian Wyn Jones (Chair)	◆	✓	✓	✓
Medwyn Hughes	✓	◆	◆	◆

Directors in attendance	11th May 2018	21st Sept 2018	3rd Jan 2019	29th Mar 2019
Alberto Salmoiraghi	✓	✓	A	✓
Andy Roach	A	A	✓	✓
Jen French	A	◆	◆	◆
Jill Timmins	◆	✓	✓	✓
Gill Harris	A	A	A	A
Steve Forsyth	◆	◆	✓	A

◆ Not a member of the Committee at this time.
A Apologies
In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. Additionally, the Committee benefits from Staff Side, Unllais, and Local Authority Social Services Representation attendance and in year has been supported by the regular attendance of nominated Associate Hospital Managers. For a full list of attendance, please see the detailed Minutes which can be accessed on the Health Board's website via the following link:-
http://www.wales.nhs.uk/sitesplus/861/page/88168

Power of Discharge Sub-Committee

Members of the Committee	11th May 2018	21st Sept 2018	14th Dec 2018*	29th Mar 2019
Margaret Hanson (Independent Member – Chair)	✓	◆	◆	◆
Marian Jones (Independent Member – Chair)	◆	✓	✓	✓
Bethan Russell-Williams (Independent Member)	✓	A	A	◆
Lyn Meadows (Independent Member)	◆	✓	A	✓
Cheryl Carlisle (Independent Member)	◆	A	A	✓
Delia Fellowes (Associate Hospital Manager)	◆	✓	A	✓
Diane Arbabi (Associate Hospital Manager)	◆	A	A	A
Frank Brown – Associate Hospital Manager	✓	✓	✓	✓
Shirley Cox- Associate Hospital Manager	✓	A	✓	✓
Ann Owens – Associate Hospital Manager	✓	✓	A	✓
Jacky Parry – Associate Hospital Manager	✓	A	✓	✓

Christine Robinson – Associate Hospital Manager	A	✓	A	✓
Satya Schofield – Associate Hospital Manager	✓	A	✓	✓
John Williams – Associate Hospital Manager	✓	✓	A	A

* This meeting was inquorate

5. Assurances the Committee is designed to provide:

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

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

it necessary, in accordance with the Board's procurement, budgetary and other requirements;

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

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference V3.0 which were operative from March 2018. The terms of reference are attached as Appendix 1.

An integral part of the process is the requirement for the Committee to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management Group who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year.

At the January meeting, members agreed to rationalize the business currently being presented to the Mental Health Act Committee and Power of Discharge Sub Committee.

- Cease submitting separate IMHA, S136 and CAMHS reports as the data is already incorporated into the overarching performance activity report.
- Remove the MHM compliance section from the performance report as this is already presented to QSE.
- HIW updates – only present these to MHAC not the POD. These reports should only be where HIW have specifically made recommendations concerning the Mental Health Act. NB the wider HIW reports are presented to QSE.

The Committee agreed to continue with quarterly meetings. There were no formal changes proposed to the Terms of Reference however, the Cycle of Business for the Mental Health Act Committee and Power of Discharge Sub Committee have been updated and are shown in Appendix 2 & 3.

6. Overall *RAG status against Committee's/Group's/Forum's annual objectives / plan: AMBER

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

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	**Supporting narrative**
Ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities.			Periodic updates provided to the Committee and training
Identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;			Reduction in S136 – 52 in 2017/18 reduced to 20 in 2018/19. Issues remain around detention of U16. There has been a Joint Parliamentary Bid with 6 Local Authorities. Decrease in U18 S136, staff trained at L3 Safeguarding Children, SOP being developed for CAMHS. Issues within Mental Health and Learning Disabilities are similar to those seen in CAMHS. There has been a large increase in the number of referrals but no investment in community services since the implementation of the Measure. Transformation monies will be used to help bridge this gap. The work being done in the ICan Centers across all three sites was hoped to have an impact in reducing the number of referrals
Monitor the use of the legislation and consider local trends and benchmarks;			Improved performance reporting information.
Consider matters arising from the Hospital Managers' Power of Discharge Sub-Committee;			Meetings of the Sub-Committee now held prior to the full Committee in order for the Committee to consider views of the Sub-Committee in a timely manner - effective rescheduling.

Ensure that **all** other relevant associated legislation is considered in relation to Mental Health Act and Capacity legislation;			Mental Capacity Act monitored as part of DoLS reports
Consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review* Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports			Regular reporting to Committee. Process in place to monitor HIW Action Plans: • Local QSEEL • Divisional QSEEL • Corporate QSG
Consider any reports made by the Public Services Ombudsman for Wales			No specific reports made during the year.

regarding complaints about Mental Health Act and Capacity legislation			
Receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors;			Difficulties remain in recruiting Section 12(2) Doctors. Further details are contained under section 8
Consider and approve on behalf of the Board any LHB policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate;			Updating and review of policies taken place.
Receive and review DoLS reports regarding authorisations and associated reasons			Concerns remain around increasing breaches of legislative timeframes. This is a national problem. Training is being provided and Senior Management Teams are being asked to ensure staff attend.
Receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved			Mental Health Measure targets are set by Welsh Government. The Division currently reports by exception to the Board on a monthly basis. There is weekly reporting by county / by service / by target direct to the Locality Managers and their teams. The MHM administration team provide support with guidance, training, reports, data cleanse, data entry on an on-going basis. The MHM team are providing support, training, advice and performance reports/data cleansing to the local management teams. Clinical Network managers are accountable for following local action plans to improve targets monitored through Operational meetings.

Receive and review the results of internal audit reports relating to care and treatment plans, as			Concerns around MH Measure not always meeting the target.

well as any other relevant reports relating to the Mental Health Measure			MHM is presented to QSE with reporting and business cycles.
Receive the results of clinical audits and any other reviews relating to the use of the Mental Health Act and oversee the implementation of recommendations;			No clinical audits which fell within the remit of the Committee.
Consider any other information, reports, etc. that the Committee deems appropriate.			Additional reports including review of best practice elsewhere and benchmarking and national data set considered.
Investigate or have investigated any activity (clinical and non-clinical) within its terms of reference.			Nothing specifically requested by the Committee this year.
Obtain outside legal or other independent professional advice and to secure the attendance of non-members with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;			One training session for Committee and Sub-Committee members held during the year including one facilitated by Dr Sharmi covering Violence & Aggression, MH Act, Dementia and Medication .

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

- Defining a Health Based Place of Safety for young people under age 18 years – MHA Section 136
- Independent Mental Health Advocacy
- Child and Adolescent Mental Health Services (CAMHs) Updates
- Updates on the approval functions for Approved Clinicians & Section 12(2) Doctors in Wales
- For Information - Mental Health Strategy - Together for Mental Health in North Wales
- IMHA Performance Report The report provided an update on the IMHA performance reported to Welsh Government and emerging themes identified by services users
- Health Inspectorate Wales Monitoring Report - The report provided an update in relation to the inspections conducted by Healthcare Inspectorate Wales into Mental Health Division service.
- Standing Orders – Scheme of Delegation – endorsed

- Oversight of the work of the Power of Discharge Sub-Committee
- Mental Health Act / Mental Health Measure Monitoring Data- The report provided an update in relation to the Mental Health Act and Mental Health Measure Activity within the Division
- Membership
- Independent Mental Health Advocacy Performance Report - Analytical Review of S136 in North Wales
- Review Cycle of Business for 2018/19

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

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

Meeting	Key risks and concerns identified
11th May 201	• The Committee continue to remain concerned at the pressure placed on practitioners across all sites with the increasing number of assessment requests. Plans are in place to increase the number of Best Interest Assessors [BIA], once recruited agreement will be required on accommodation. • The Committee again discussed alternative places of safety for young people rather than placing them in a S136 suite. The Committee expressed the opinion that the latter should never be used for children and young people and sought assurance that this is the case. • The Committee were also updated in respect of two significant case developments since presentation of the last DoLs report which can be accessed via the following link: http://www.wales.nhs.uk/siteplus/docu,emts/861/20180511%20Committee%10Agenda%20bundle.pdf [report MHA18.24 refers]
21st Sept 2019	• Notification received from North Wales Police that Force Medical Officers would no longer be available. Requests are being made for consultants to provide a fitness to plead assessment, when the request is refused due to capacity, they are then presented as being suicidal in Accident and Emergency when an assessment has to be carried out. This is putting the consultants under considerable pressure. North Wales Police will be invited to attend December meeting to help resolve the issue. • A further 4 Best Interest Assessors have been recruited and it was anticipated that this could increase the number of Deprivation of Liberty referrals. Still concern around the quality of referrals and the lack of information contained in the forms. Discussions to be held with Senior Staff to see whether further training is required. • A leaflet will be produced providing staff who do not have access to e-learning, detailed information around Deprivation of Liberties. • Concern raised around staff having the appropriate training for dealing with S136 for under 18s. Work being done regarding capacity and demand management, amid concerns around staff retention. Delivery Unit expected to conclude work around Demand and Capacity early 2019, which is hoped will help address challenges in delivering the Measure in CAMHS

	• Mental Health Act Register will not go live until early next year because of delay in the General Data Protection {GDPR] implementation. Further work required to increase the number of Approved Clinicians and Section 12[2] Doctors. Further discussion will take place between Medical Director of MHLD and the Office of the Medical Director before the December meeting.
3rd Jan 2019	• The Committee remained concerned at the pressure placed on practitioners because of the increase in the number of Deprivation of Liberty Assessments being requested when patient has capacity. Although training is provided, there was an increase in the number of people not turning up. The issue needs to remain on the Health Board's Corporate Risk register. • CAMHS performance against the Mental Health Act and Mental Health Measure targets were a cause of concern. Reasons for missing the targets centered around increased demand in CAMHS referrals and reduction in capacity due to sickness, maternity leave and vacancies impacting on the sustainable delivery of targets & driving down performance. Whilst feedback from a two-day visit from Welsh Government to consider Together 4 Children and Young People was awaited, there was concern about internal and external communications. The crisis pathway for young people in distress and Out of Hours access to the emergency bed was an ongoing issue
29th Mar 2019	• Concerns still being raised regarding Section 12[2] doctors, this does not lie within the MHLD Division and work is being done with Office of Medical Director to try and relive some of the pressures. There are cost implications for GPs when they take on section 12[2] work, their indemnity becomes more expensive. Discussions are also being held to look at the fees paid to doctors who carry out this work which has not been increased since first brought in to practice. • The number of inappropriate referrals for Deprivation of Liberty's remains a concern. Training is being offered but there is a very low uptake.

9. Focus for the year ahead:

The primary focus of the Committee over the next twelve months will be scrutinising in particular those areas in paragraph 6 above with a 'Red'/ 'Amber' rating, in addition to monitoring those corporate level risks in the Corporate Risk and Assurance Framework that may be assigned to the Committee during the year (NB there are currently no specific risks assigned to this Committee – risks relating to the wider remit of Mental Health are monitored by the Quality, Safety and Experience Committee).

Drawing these elements out specifically the focus will therefore be on the following areas:-

- Under 18 Section 136
- Continuing to improve the MHA and MHM performance reporting.
- Monitoring of HIW reports and any actions arising therefrom which relate to the Mental Health Act.
- The ongoing difficulties in recruiting Section 12(2) Doctors which is a national problem.
- The position regarding increased challenge of meeting legislative timeframes in respect of DoLS and associated Mental Capacity Act legislation.

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work. This is attached as Appendix 2 with the Cycle of Business for the POD Sub-Committee attached as Appendix 3.

Appendix 1
Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

MENTAL HEALTH ACT COMMITTEE

1. INTRODUCTION

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

2. PURPOSE

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

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

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

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

3. DELEGATE POWERS AND AUTHORITY

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

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

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

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

Sub Committees/Panels

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

3.3 Sub-Committee - In accordance with Regulation 12 of the Local Health Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a Sub-Committee of this Committee, to be known as the Power of Discharge Sub-Committee, terms of reference for which are attached as Annex 2.

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

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

4. MEMBERSHIP

4.1 Members

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

4.2 In attendance

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

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

4.3 Member Appointments

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

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

4.4 Secretariat

4.4.1 Secretary: as determined by the Board Secretary.

4.5 Support to Committee Members

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

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

5. COMMITTEE MEETINGS

5.1 Quorum

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

5.2 Frequency of Meetings

5.2.1 Meetings shall routinely be held on a quarterly basis.

5.3 Withdrawal of individuals in attendance

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

6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

1. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

2. REVIEW

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

Approval:
Audit Committee 14.9.17
Health Board 21.9.17
Reported to MHAC 10.11.17

V3.0 approved

Annex 1

BACKGROUND INFORMATION REGARDING THE ASSOCIATED LEGISLATION

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

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

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

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

Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with associated legislation.

With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the Health Board's
Scheme of Delegation.

Mental Health Measure

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

- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
- making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from

secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extending mental health advocacy provision.

Mental Capacity Act

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

The MCA covers three main issues:

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

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

Annex 2

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

1. INTRODUCTION

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

2. PURPOSE

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

3. DELEGATED POWERS AND AUTHORITY

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

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

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

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

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

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

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

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

4. MEMBERSHIP

4.1 Members

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

4.2 Attendees

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

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

4.3 Member Appointments

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

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

4.4 Secretariat

4.4.1 Secretary: as determined by the Board Secretary.

4.5 Support to Committee Members

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

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

5. SUB-COMMITTEE MEETINGS

5.1 Quorum

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

5.2 Frequency of Meetings

Meetings shall routinely be held on a quarterly basis.

5.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

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

9. REVIEW

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

V3.0 approved

BCU Mental Health Act Committee Cycle of Business 2019-20

Agenda Item	28.06.19	27.09.19	20.12.19	27.03.20
Opening Business				
Apologies	**x**	**x**	**x**	**x**
Declaration of Interests	**x**	**x**	**x**	**x**
Previous Minutes, Matters Arising and Summary Action Plan	**x**	**x**	**x**	**x**
Minutes of previous POD meeting and oral update from the earlier meeting	**x**	**x**	**x**	**x**
For Discussion (Standing Items)				
Deprivation of Liberty Safeguards: Quarterly Report	**x**	**x**	**x**	**x**
Hospital Manager's Update Report (Oral summary only based on feedback from earlier POD meeting)	**x**	**x**	**x**	**x**
Performance Report	**x**	**x**	**x**	**x**
Approval for All Wales Approved Clinicians and Section 12(2) Doctors)	**x**	**x**	**x**	**x**

Consideration of any HIW/Inspection reports/Audit reports etc as appropriate to meetings remit.	x	x	x	x
Governance				
Agree CoB for coming year				x
Committee Annual Report and review of TOR and POD TOR		x		
Closing Business				
Issues of Significance	x	x	x	x
Any Other Business	x	x	x	x
Date of Next meeting(s)	x	x	x	x

BCU Power of Discharge Sub Committee Cycle of Business 2019-20

Agenda Item	28.06.19	27.09.19	20.12.19	27.03.20
Opening Business				
Apologies	x	x	x	x
Previous Minutes, Matters Arising and Summary Action Plan	x	x	x	x
For Discussion (Standing Items)				
Membership updates	x	x	x	x
Performance Report	x	x	x	x
Hospital Manager's Update to include periodic updates on training and appraisals	x	x	x	x
Governance				
Agree CoB for coming year			x	
Committee Annual Report and review TOR	x			x
Closing Business				
Issues of Significance	x	x	x	x
Any Other Business	x	x	x	x
Date of Next meeting(s)	x	x	x	x

Local Partnership Forum Annual Report 2018/19

1. Title of Advisory Group:

Local Partnership Forum.

2. Name and role of person submitting this report:

Ms Sue Green, Executive Director Workforce & Organisation Development.

3. Dates covered by this report:

01/04/2018-31/03/2019

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

The Advisory Group was routinely scheduled to meet 6 times annually and otherwise as the Chair of the LPF deemed necessary. However, part way through the reporting period, it was decided that the Group should reduce the number of meeting to four times annually. During the reporting period, it met on five occasions. Attendance at meetings is detailed within the table below:

Members of the Local Partnership Forum	17/04/18	12/06/18	14/08/18	27/11/18	08/01/19
Mr Gary Doherty Chief Executive	A	✓	✓	✓	✓ **
Mrs Sue Green Executive Director of Workforce and Organisational Development	✓	✓	✓	✓	✓
Mrs Gill Harris Executive Director of Nursing and Midwifery	A Deputy in attendance	A Deputy in attendance	A Deputy in attendance	NP	A
Mrs Jackie Hughes Independent Member (Trade Union)	✓ (as staff side Chair)	✓	✓	✓	✓
Mr Russ Favager Executive Director of Finance	✓	✓	A Deputy in attendance	✓	A

Area Director	Deputy in attendance	NP	A	A	NP
Secondary Care Director	A	Deputy in attendance	NP	Deputy in attendance	Deputy in attendance
Ms Lesley Hall Assistant Director of Workforce & Organisational Development Employment Practices	✓	✓	✓	A	✓
Associate Director of Workforce & Organisational Development	A senior W&OD representative was in attendance at all meetings				
Mr Rod Taylor Director of Estate and Facilities	A	✓	A	✓	NP
Staff Organisations					
GMB – Britain's General Union					
British Association of Occupational Therapists					
BMA - British Medical Association					
British Dental Association	A	✓	A	A	A
British Dietetic Association					
British Orthoptic Society					
Chartered Society of Physiotherapy				✓	✓
Federation of Clinical Scientists					
Royal College of Midwives	✓	(Observer)	✓	✓	✓
Royal College of Nursing	✓ x 3	✓ x 6	✓	✓ x 3	✓ x 2
Society of Chiropodists & Podiatrists					
Society of Radiographers (See Independent Members)	✓	✓	✓	✓	✓
UNISON	✓	✓ x 3	✓ x 5	✓ x 2	✓ x 6 + Chair
UNITE	✓	✓			

	** Part meeting A Apologies received NP Not present ◆ Not a member of the Forum at this time. Recording of attendance has been strengthened for 2019-20 to ensure that it is possible to identify which staff organisations are represented at each meeting. In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Forum as required. For a full list of attendance, please see the detailed Minutes which can be accessed on the Health Board's website via the following link:- http://www.wales.nhs.uk/sitesplus/861/page/88168

5. Assurances the Forum is designed to provide:

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

The purpose of the Local Partnership Forum is to:

- Consider national developments in NHS Wales workforce and organisational strategy and their implications for the board
- Negotiate on matters subject to local determination
- Ensure staff organisation representatives time off and facilities agreement provides reasonable paid time off to undertake their duties and that they are afforded appropriate facilities using A4C facilities agreement as a minimum standard
- Establish a regular and formal dialogue between the Board's executive and the trade unions on matters relating to workforce and service issues
- In addition the LPF can establish Local Partnership Forum sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues. Where these sub-groups are developed they must report to the LPF as per the cycle of business

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

An integral part of the process is the requirement for the Forum to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management Group who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year.

At a workshop of the Audit Committee held on the 15th May 2018 members reviewed each of the Committee and Advisory Group's annual reports for 2017-18 with the aim of providing evidence on the scope and effectiveness of Committees

and of their evaluation of the sources of assurance available to them. As the system of Board Assurance continued to be refined, Audit Committee members made the following comment specific to the LPF – "The membership was considered too broad to be effective and it was suggested that this be reviewed". This was addressed as part of a review of Terms of Reference on the 27.11.18 with amendments agreed to core membership.

In addition, Audit Committee members made the following generic comments pertaining to the Committee and Advisory Group Annual Reporting process:-

Recurring themes around the need for training for members in respect of specific Committee responsibilities, and concerns around the volume of work some Committees were dealing with.	Not applicable to LPF
Externally commissioned/produced reports e.g. Deanery/Royal Colleges should be centrally logged.	Not applicable to LPF
Chairs assurance reports to in future confirm actions being taken to address key risks identified.	Template amended in July 2018
Template for future Committee Annual reports to be amended to detail "focus for the year ahead" at the end of the report.	Completed (see section 9)
Any difficulties in identifying sources of assurance to be included as a key focus for the year ahead.	Completed (see section 9)
In respect of internal or external audit reports individual committees are asked to review and provide commentary within their annual report on whether the implementations of the recommendations arising from audits relevant to their remit have led to overall qualitative improvements.	Not applicable to LPF
Ensure new assurance map addresses quality of primary care and quality of commissioned services.	Not applicable to LPF
Sources of assurance document to be updated as follows:- • Outcome findings of local clinical audit work to be included (ACS 21A) • Systems of internal control to be included (ACS 11A) • Team Central Tracker aligned to Audit Committee to be included (ACS66). • Delete RAG colour coding from document.	Not applicable to LPF

6. Overall *RAG status against Forum's annual objectives / plan: GREEN

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

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	Supporting narrative (Please provide detail for all actions showing amber or red assurance levels in terms of actions being taken to address these issues).
Consider national developments in NHS Wales workforce and organisational strategy and their implications for the board			
Negotiate on matters subject to local determination			
Ensure staff organisation representatives time off and facilities agreement provides reasonable paid time off to undertake their duties and that they are afforded appropriate facilities using A4C facilities agreement as a minimum standard			Facility time agreement in place (currently being reviewed). Concerns raised re some facilities (accommodation) which will be reviewed in 2019 / 20.
Establish a regular and formal dialogue between the Board's executive and the trade unions on matters relating to workforce and service issues			
In addition the LPF can establish Local Partnership Forum sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues. Where these sub-groups are			

developed they must report to the LHB PF as per the cycle of business			

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

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

Received regular updates on:

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

Received updates on:

- Annual Quality Statement 2017/2018
- Corporate Risk Assurance Framework
- Cycle of Business
- Health and Safety Improvement
- Integrated Quality and Performance Report
- Nurse Staffing Act
- Organisational Change Policy
- SafeCare Acuity and Rostering System
- Staff Health and Wellbeing
- Staff Flu Vaccination Programme
- Staff survey
- Stroke Services Review
- Welsh Language Standards
- Working Forward Campaign Update
- Workforce Breastfeeding Provision for Staff
- Workforce Employee Death in Service Guidelines
- Workforce Engagement
- Workforce Issues within the IQPR
- Workforce Metrics Report
- Workforce NHS Wales Menopause Policy
- Workforce Partnership Group
- Workforce Policies and Procedures Working Group
- Workforce Report

Received strategy development presentation on drafts for

- Estate and Facilities – Review of Weekly to Monthly Pay for Staff
- Reimbursement of Travel
- Welsh Union Learning Fund – Proposal to set up a steering group.

- Workforce Issues within the IQPR
- Workforce Working Longer and Sickness Absence Review Group

Approved:

- LPF Annual Report 2017/18 and Cycle of Business

Received for Information:

- Fairness, Rights and Responsibilities Annual Equality Report 2017 - 2018
- Integrated Quality and Performance Report
- Ombudsman Annual Report
- Welsh NHS Confederation Workforce Briefing
- Welsh Partnership Forum Minutes from meeting 02/07/2018
- Workforce Intelligence Report

Discussed items raised by Trade Union Members

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

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

Meeting Date	Key risks including mitigating actions and milestones
17/04/2018	• The Financial report showed a deficit of £35.7m as at month 12. A draft interim financial plan tabled requires approval from the Welsh Government. • The Breastfeeding provision for staff as discussed is the responsibility of the Health Board to support parents returning to work who require this facility – this is a long-standing issue which needs to progress. A task and finish group has been established to take forward and action.
12/06/2018	• The Chief Executive advised members that the Cabinet Secretary has made a statement regarding Special Measures identifying areas where progress is required. • The Executive Director of Finance provided an update on the Health Board's financial position for 2017/18, which is a deficit of £38.8m. The Board's acknowledged planned deficit budget of £35m needs to be accepted by the Welsh Government. • The Deputy Director of Nursing identified two duties that the Health Board is legally obliged to comply with in relation to the Nurse Staffing Act. The Board Nurse Staffing Report needs to be signed off by specific Executive Directors and an operational framework needs to be agreed by the Executive Team. Five levels of care

	will need to be applied to both the SafeCare model and the Nurse Staffing Act bi-annual audit.
14/08/2018	) The Executive Director for Finance provided an update confirming that the Board agreed a deficit plan of £35m and at month 3 the actual deficit was £10.3m, which was £200k above the plan.
27/11/2018	) There is an increase in short and medium term absence requiring action from both managers and trade unions.
09/01/2019	) Mr G Doherty reported that Welsh Government, Wales Audit Office and Healthcare Inspectorate Wales were due to review and assess progress later in January.) Mr G Doherty confirmed that the Health Board was £900k off plan in terms of the month 8 position and that savings plans would have to improve in second half of the year.

9. Focus for the year ahead:

The primary focus of the Forum over the next twelve months will be to support the delivery of the Annual Plan and Year 1 of the Workforce Strategy, in partnership.

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

***Key:**

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

Appendix 1

Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

The Local Partnership Forum

INTRODUCTION

- The BCULHB Local Partnership Forum (LPF) is the formal mechanism through which management and trade unions and professional bodies (hereafter referred to as staff organisations) work together to improve health services for the people of Wales. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.
- All members are full and equal members of the forum and collectively share responsibility for the decisions made. Should any party be in disagreement with decisions taken, a note will be included within the minutes of the meeting.
- The BCU will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply. These principles are attached at Appendix 1.

PURPOSE

The purpose of the Local Partnership Forum, hereafter referred to as "the LPF", is to:

- Consider national developments in NHS Wales workforce and organisational strategy and their implications for the board
- Negotiate on matters subject to local determination
- Ensure staff organisation representatives time off and facilities agreement provides reasonable paid time off to undertake their duties and that they are afforded appropriate facilities using A4C facilities agreement as a minimum standard
- Establish a regular and formal dialogue between the Board's executive and the trade unions on matters relating to workforce and service issues
- In addition the LPF can establish Local Partnership Forum sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues. Where these sub-groups are developed they must report to the LHB PF as per the cycle of business

Appendix 1

GENERAL PRINCIPLES

All members must:

- be prepared to engage with and contribute fully to the Forum's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- comply with their terms and conditions of appointment;
- equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- promote the work of the LPF within the professional discipline he/she represents.

A Code of Conduct is attached as Appendix 2.

DELEGATED POWERS AND AUTHORITY

The Forum will, in respect of its provision of advice to the Board:

- offer advice to the LHB when specifically requested on any aspect of its business
- offer advice and feedback even if not specifically requested by the LHB.

Authority

The LHB may specifically request advice and feedback from the Forum on any aspect of its business, and the Forum may also offer advice and feedback even if not specifically requested by the LHB. The Forum may provide advice to the Board:

- in written advice; and
- in any other form specified by the Board.

Sub Groups

Appendix 1

When it is considered appropriate, the Forum can decide to appoint a sub-group, to hold detailed discussion on a particular issue(s). Nominated representatives to sub groups will communicate and report regularly to the LPF.

The subgroups agreed by LPF are:

- Workforce Partnership Group (WPG)
- Working Longer / Sickness Absence Joint Review Group
- Job Evaluation Programme Team (JEP)
- Policies Group

MEMBERSHIP

- All members of the LPF are full and equal members and share responsibility for the decisions of the LPF.

- Management Representation shall consist of the following postholders:

  - Chief Executive
  - Executive Director of Workforce and OD (or deputy)
  - Executive Director of Nursing and Midwifery (or deputy)
  - Executive Director of Finance (or deputy)
  - Secondary Care Director (or deputy)
  - Area Director (or deputy)
  - Associate Director of Workforce & OD – Human Resources (or deputy)
  - Assistant Director – OD (or deputy)
  - Director of Estates and Facilities (or deputy)
  - Director of Mental Health (or deputy)

- Other Board Level Directors will regularly receive LPF papers and will be required to attend meetings as required, depending upon the nature of business being considered on the agenda.

- All Staff Organisations (Trade Unions and Professional bodies) recognised for the purposes of collective bargaining and representation will be eligible for a seat on the LPF. These are detailed at Appendix 3. The LHB Trade Union Independent Member will be expected to attend the LPF in an ex – officio capacity.

Appendix 1

- The formula for determining the number of representatives for each staff organisation will be one representative for up to 500 members, with further representatives for every 500 members thereafter or part thereof.

- The number of representatives from each organisation will be confirmed by the Executive Director of Workforce and OD on the production of membership numbers by the staff organisation involved. Such information should specify the a) one of the following - role, job title, registered status – registered or unregistered b) work location and c) number of persons.

- Information provided in response to 3.5 above will be held securely by the office of the Executive Director of Workforce and OD and will not be disclosed to other parties.

- In the event of membership numbers not being disclosed as set out in 3.5 above, the staff organisation concerned will be limited to one representative only at meetings of the LPF.

- In the event of any business being concluded by the use of a vote, those present will have proxy voting rights for those not present.

- Staff representatives must be employed by the organisation and accredited by their respective organisations for the purposes of bargaining. If a representative ceases to be employed by the Board or ceases to be a member of a nominating organisation then he/she will automatically cease to be a member of the LPF.

- Members of the Forum who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the Forum.

- Trade unions will determine through their own mechanisms which reps will attend and reserve the right to change the representative as necessary.

- Full time officers of the Trade Unions may attend meetings subject to prior notification and agreement with the Executive Director of Workforce and OD.

Chair, Vice Chair and Officers

- Representatives of Staff organisations elect a secretariat of Chair, Vice-Chair, Secretary and Assistant Secretary annually. No more than two of these positions will be filled by representatives from a single Trade Union or Professional Organisation.

- The Management, and Staff Organisation Chair will chair the LPF. This will be done on a rotational basis.

- In the absence of the Chair(s) the Vice Chair(s) will act as Chair. The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Board's other advisory groups.

Appendix 1

- Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

Secretary

- Each side of the LPF should appoint/elect its own Joint Secretary. The Management, Trade Union Secretary will be responsible for the preparation of the agendas and minutes of the meetings held, and for obtaining the agreement of the Management and Trade Union Chairs.

- The Executive Director of Workforce & OD will ensure the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

Appendix 1

In attendance

- The Board may determine that designated Board members or LHB staff should be in attendance at Advisory Group meetings. The Forum's Chairs may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

Support to Committee Members

The Board Secretary, on behalf of the Chairs, will ensure that the Forum is properly equipped to carry out its role by:

- ensuring the provision of governance advice and support to the Forum Chairs on the conduct of its business and its relationship with the LHB and others;
- ensuring that the Forum receives the information it needs on a timely basis; and
- facilitating effective reporting to the Board enabling the Board to gain assurance that the conduct of business within the Forum accords with the governance and operating framework it has set.

COMMITTEE MEETINGS

Quorum

- Every effort will be made by all parties to maintain a stable membership.
- There should be a minimum of 8 management representatives and 8 Trade Union representatives at a meeting for it to be quorate.
- If a meeting is not quorate no decisions can be made but information may be exchanged.
- Where joint chairs agree, an extraordinary meeting may be scheduled within 7 calendar days' notice.
- Consistent attendance and commitment to participate in discussions is essential. Where a member of the Forum does not attend on 3 consecutive occasions, the Joint Secretaries will write to the member and bring the response to the next meeting for further consideration and possible removal.

Appendix 1

Meeting frequency and arrangements

- Meetings will be held quarterly but this may be changed to reflect the need of either Trade Unions or management.

- The business of the meeting shall be restricted to matters pertaining to Board Wide strategic issues. Local operational issues should be raised at the Sub Local Partnership Forums and will not be considered unless it is agreed that such issues have LHB wide implication.

- The minutes shall normally be distributed 15 working days after the meeting and no later than 7 days prior to meeting. Items for the agenda and supporting papers should be notified to the Management Secretary as early as possible, and in the event at least two weeks in advance of the meeting.

- A summary of actions will be sent out 14 days after the meeting.

- The LPF has the capacity to co-opt others onto the forum or its sub groups as deemed necessary by agreement.

Openness and transparency

The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board therefore requires, wherever possible, the Forum to hold meetings in public unless there are specific, valid reasons for not doing so.

REPORTING AND ASSURANCE ARRANGEMENTS

The Chairs are responsible for the effective operation of the Forum:

- Chairing meetings;

- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating arrangements; and

- Developing positive and professional relationships amongst the Forum's membership and between the Forum and Betsi Cadwaladr University Health Board, and in particular its Chair, Chief Executive and Directors.

Appendix 1

The Chair shall work in close harmony with the Chairs of Betsi Cadwaladr University Health Board other advisory groups, and, supported by the Lead Executive, shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions. Where appropriate and within their area of responsibility, the Forum may be requested by the Health Board to review and comment on draft documents prior to formal approval by the Board.

As Chair of the Forum, they are accountable to the Betsi Cadwaladr University Health Board for the conduct of business in accordance with the governance and operating framework set by the Health Board.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

The Forum's main link with the Board is through the Forum Management Chair's membership of the Board.

The forum shall embed the corporate goals and priorities through the conduct of its business and in so doing and transacting its business shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Wellbeing of Future Generation Act.

The Board should determine the arrangements for any joint meetings between the Betsi Cadwaladr University Health Board and the Forum.

The Health Board's Chair should put in place arrangements to meet with the Forum Chairs on a regular basis to discuss the Forum's activities and operation.

Members of the Forum may be invited to attend other Board Committees / Groups at the discretion of the Health Board Chair.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

REVIEW

These terms of reference and operating arrangements shall be reviewed annually by the Forum with reference to the Board.

Appendix 1

DATE OF ACCEPTING THE TERMS OF REFERENCE AND APPROVAL

Date of approval:

V6.03

Appendix 1 - Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and
- discuss the future plans for the organisation

adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2 - Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all
- individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the member

Appendix 3

The following Staff Organisations (Trade Union and Professional Organisations) are recognised as staff organisations for the purposes of the Local Partnership Forum.

- Britain's General Union (GMB)
- British Association of Occupations Therapists
- British Dental Association
- British Dietetic Association
- British Medical Association
- British Orthoptic Society
- Chartered Society of Physiotherapy
- Federation of Clinical Scientists

Appendix 1

- Royal College of Midwives
- Royal College of Nursing
- Society of Chiropodists & Podiatrists
- Society of Radiographers
- Unison
- Unite

Appendix 2

2

BCUHB Local Partnership Forum Cycle of Business 2019

Agenda Item		Jan	Apr	July	Oct
Standing Items	**Contact**				
Apologies		Y	Y	Y	Y
Minutes of previous meeting		Y	Y	Y	Y
Summary action plan / matters arising		Y	Y	Y	Y
Urgent key issues / AOB		Y	Y	Y	Y
Issues to inform Chair's Assurance report		Y	Y	Y	Y
Corporate Governance					
Update on Special Measures (Gary or rep to present)	Gary Doherty / Liz Jones	Y	Y	Y	Y
LPF Committee Annual Report incl ToRs review (Forward to Dawn Sharp once approved)	Lesley Hall		Y		
Work plan with annual cycle of business	Lesley Hall	Y			
Unscheduled Care Update	Meinir Williams / Claire Brennan		Y		
Welsh Language Standards	Eleri Hughes-Jones	Y		Y	
Health and Safety Management Annual Report	Sue Green		Y		
Finance, Performance and Planning					
Finance Report	Faye Pritchard / Russ Favager	Y	Y	Y	Y
Budget Strategy	Russ Favager	Y			
Corporate Planning Update to include: Corporate Plans, Annual Operating Plan	Mark Wilkinson / John Darlington	Y	Y	Y	Y
Clinical Governance					
Prevention and Control of Infection	Deborah Carter		Y		Y
Annual Quality Statement	Diane Read			Y	
Workforce & Organisational Development Governance					
Workforce Report (F&P report)	F&P papers (change coversheet)		Y		Y
Workforce Policies Group Report	Matthew Winter	Y			
Workforce Partnership Group (former OC&TS)	Kay Hannigan	Y			
Workforce Engagement Update	Nia Thomas				Y
Job Evaluation Programme Report	Alex Tapley	Y	Y	Y	Y
Gender Pay Action Plan	Sally Thomas / Mike Townson		Y		

Appendix 2

Equality & Diversity Annual Report	Sally Thomas			Y	
Health & Wellbeing Annual Report	Sarah Wynne-Jones				Y
Agenda Item		**Jan**	**Apr**	**July**	**Oct**
Issues for Discussion raised by Trade Union Reps					
tba	Jan Tomlinson to confirm	Y	Y	Y	Y
Workshop					
Every Other Meeting	Lesley Hall to confirm		Y		Y
For Information					
Integrated Quality and Performance Report (Board paper link)	Jill Newman / Pull out of Board papers	Y	Y	Y	Y
CRAF – Corporate Risk & Assurance Framework (Board paper link)	Dawn Sharp / Pull out of Board papers	Y		Y	
Welsh Partnership Forum minutes	Caitlin Jenkins caitlin.jenkins008@gov.wales		Y		Y
Annual Audit Report for WAO	Dawn Sharp		Y		
Ombudsman's Annual Report (Board paper link)	Kate Dunn			Y	

FORWARD PLAN FOR AD HOC ITEMS		**Jan**	**Apr**	**July**	**Oct**
Update on escalation policy	Billy Nichols email 11.1.19 requesting an update		X		
Safe staffing information updates	Billy Nichols email 11.1.19 requesting an update. Need to determine with Sue Green if will become a standing item		X		
~~Revised ToR for Workforce Policies & Procedures Working Group~~	~~As agreed at LPF 8.1.19 (Kay Hannigan)~~ ~~Lesley Hall asked for this action to be removed as did not recognise it~~		~~X~~		

Appendix 2

V1.01 live version

Healthcare Professional Forum Annual Report 2018/19

1. Title of Advisory Group:

Healthcare Professionals Forum (HPF)

2. Name and role of person submitting this report:

Prof Michael Rees, Chair of the Forum from July 2015 – February 2019

Mr Gareth Evans, Chair of the Forum from March 2019

Mr Adrian Thomas, Executive Director Therapies and Health Sciences

3. Dates covered by this report:

1st April 2018 to 31st March 2019

4. Number of times the Forum met during this period: 5

The Forum was scheduled to meet five times or otherwise as the Chair of the Forum deemed necessary. During the reporting period, it met on six occasions with one of the dates being an additional workshop (9th November 2018).

Attendance at meetings is detailed within the table below:

Members of the Forum	4th May	6th July	7th Sept	7th Dec	15th Mar
Advisory Group members - Representative group					
Prof Michael Rees – Chair Specialist and Tertiary Care medical representative (Chair to February Meeting)	√	√	√	√	A
Mrs Joanne Kember – Vice Chair (to November Meeting) Community Pharmacists representative – until 7.9.18	√	√	√	◆	◆
Mr Alton Murphy Optometry representative, Deputy – Bryn Jones	√	A	A	√	√

Dr Sandra Sandham Dental representative	√	√	√	√	√
Dr Jay Nankani Primary and Community Care Medical representative	√	√	√	A	√
Mrs Susan Murphy Hospital and Primary Care representative	√	√	√	√	√
Keith Jones – until 07.09.18 Nursing representative	A	A	A	◆	◆
Mrs Mandy Jones – from 7.12.18 Nursing representative	◆	◆	◆	√	√
Mrs Polly Ferguson until 7.12.18 Midwifery representative	A	A	A	A	◆
Mrs Fiona Giraud – from March 2019 Midwifery representative	◆	◆	◆	◆	A
Mr John Day – until 07.09.18 Scientific representative	√	√	√	◆	◆
Mrs Jane Wild – from 07.12.18 Scientific representative	◆	◆	◆	√	√
Mr John Speed – from 07.12.18 Community Pharmacy representative	◆	◆	◆	√	√
Mr Gareth Evans Therapies representative (Vice Chair from December meeting. HPF Chair from March 2019)	√	√	√	√	√
Lead Health Board Officer					
Mr Adrian Thomas Executive Director Therapies and Health Sciences	√	√	√	√	√

D	Deputy		**A**	Apologies		♦	Not a member of the Committee at this time

5. Assurances the Forum is designed to provide:
The Forum is designed to provide advice to the Board on the following key areas as set out in its Terms of Reference in appendix 1.

- Facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the LHB's decision making.

The Audit Committee annual review in 2018 acknowledged the forums concerns regarding representation. Nursing and Midwifery membership had been rectified, however Mental Health representation is lacking, the previous Chair and Lead Director have both spoken to colleagues in Mental Health and Learning Disabilities. The MH&LD team have been contacted again to request membership.

6. Overall *RAG status against Forum's annual objectives / plan: Green

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

Objective as set out in Terms of Reference	Was sufficient assurance provided?	Was the assurance positive?	**Supporting narrative**
	RAG	RAG	
Facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the LHB's decision making.	Green	Green	Meetings have functioned effectively throughout the year, and the group has fulfilled its advisory role to the Health Board.

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

<u>Regular Items and updates</u>

- Corporate Planning – including updates on AOP/IMTP/3 year plan
- LHSW Strategy A Place to Call Home – Impact & Analysis
- Workforce & Organisational Development update
- Annual discussion with CEO
- Membership
- Seasonal Plan update
- North Wales Stroke Services Review
- Update of the Services for Smiles document

Governance and Standing Items

- Chairs written updates
- Members written updates
- Review of minutes and actions
- Committee Annual Report
- Review and refresh of Forums terms of reference
- Minutes Quality, Safety & Experience Committee meetings
- Minutes of Professional Advisory Group meetings
- NJPAC approved minutes
- Team Briefing Updates

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

8. Summary of key advice/feedback for the Board identified by this Forum in-year which have been submitted as part of the Chair's reports to the Board:

Meeting Date	Summary of key advice / feedback for the Board:
4th May 2018	**The Forum were introduced to Sue Green, the Executive Director of Workforce, Organisation and Development (WOD).** A discussion regarding priorities for WOD undertaken and the various areas were noted. Members agreed to have a regular WOD item on the HPF agenda. **Members discussed "A Place to Call Home"**: Impact & Analysis report published on the 23rd January 2018 and received the improvement plan. Members received an update and briefing paper on the improvement plan. Members noted the update endorsed the recommended course of action to ensure implementation of the actions. **Stroke Services**: The Forum received an update on the Stroke Services Review from the Assistant Director for Health Strategy. Members were informed of the comprehensive service redesign that had taken place including engagement with stakeholders and stroke survivors. **Annual Report (HPF) 17/18:** Members received the HPF Annual Report for 2017/18 and approved the report which had been submitted.
6th July 2018	**Corporate Planning Update:** The Forum received an update from the Head of Health Strategy & Planning & the Assistant Director, of Corporate Planning including a presentation regarding the Living Healthier Staying Well Phase 1 - Service review, redesign and transformation. The forum welcomed "Our

	Strategy for the future". Concern had been noted with regards to Dental Health for Children not being incorporated within the public information booklet at an earlier meeting. It was noted that at the point it had been presented it hadn't been possible to change the document however, it was confirmed that it is included in the detailed plan.
7th September 2018	**Corporate Planning Update**: Health Board Planning for 2019-2022. The Forum received a presentation from the Head of Health Strategy and Planning and the Assistant Director, Corporate Planning. A discussion took place regarding "7 day working" to support weekend discharge planning. It was highlighted that seven day working was about transformation over the 7 days, key areas of focus and doing things differently. The Outline Planning Timetable had been noted by the group. The Forum also noted the additional targeted funding from Welsh Government to augment management capacity and requested that the Health Board ensures that new managers have the skills to effectively transform services. **Dental** - "Services for Smiles" draft document. The Forum received an update regarding the Strategy for the Development of Community Dental Services in North Wales for the period 2017 to 2022. SS agreed to update in line with the new Welsh Government Strategy. It was noted that decay rates had risen, models of promotion noted along with closures of various sites. The use of welsh language within medical schools had also been discussed along with highlighting of positive discrimination. The report also explained the Welsh Health Circulars and Reports previously issued which had been influential in determining the Strategy for the North Wales Community Dental Service (CDS). Key actions and service responses were noted along with Good Practice cited by Welsh Government. Oral Health and access to services were also highlighted within the document. **'Together We Care':** Prof Michael Rees presented a synopsis of the All Wales Medical Workforce Strategy 'together we care'. The forum felt that many of the issues dealt within the report were more widely applicable for other professional groups **Therapies:** National Allied Health Professions Day 15th October 2018**.** BCUHB were active participants and undertook a range of events to mark the day. **Vice Chair of the HPF**: The Forum endorsed GE's nomination as Vice Chair. **HPF Workshop**: The workshop had taken place on the 9th November 2018.

7th December 2018	**Workforce and Organisational Planning update** {Sue Green in attendance} SG had received the notes provided from the recent workshop in relation to workforce issues. SG gave an overview to the Forum of the Draft 3 Year Workforce Strategy. **GMC headlines** – MR referred to a recent article published by the GMC in relation to workforce assessment of medical practice. **Timescales to appointing within BCUHB raised**. Issues of skill mix, recruitment and the impact of contract reform were noted in dentistry. Internal progression and the ripple effect this had on the filling of posts was also raised. MJ noted the positive work that was being done with local schools to raise awareness of careers within the health sector. **Representation of the HPF on the newly created Workforce Transformation Group**. It was agreed that updates and highlights from the Workforce Transformation Group would be reported to the HPF. **Corporate Planning Update - BCU Health Board Planning – Working Draft 3 year plan.** {John Darlington in attendance} • The Forum received an update from the Head of Health Strategy, Corporate Planning. JD confirmed that the final report would be submitted to the January Health Board for discussion with key milestones before being amended and submitted to Welsh Government. **Optometry:** Contact Lens provision. AM to update the group at a future meeting with regards to current provision. **Hospital and Primary Care Pharmacy**: SM reported that the Medicines Code MM01 was being consulted on, which would soon become a Policy. **Therapies:** Work in progress to develop an all Wales Therapy Framework. It was also noted that there will be an All Wales Consultant Allied Health Professional for Dementia and BCUHB had expressed an interest in hosting the post. BCUHB to host the advert and recruitment. **Dental:** Consultant Paediatric Dentistry - A meeting had taken place with Liverpool and Cardiff regarding the feasibility of appointing to a shared Consultant in Paediatric Dentistry. The post would be shared across the North West. **Community Pharmacy:** It was noted that pharmacy courses had been oversubscribed and that advanced services were soon to be offered to take pressures off GP's regarding current service

	provisions and common elements. The falsified medicines directive had also been noted. SM confirmed that the item had been recognised upon the departmental risk register. **Nursing:** It was confirmed that new NMC standards for education (for newly trained nurses) within Wales had been adopted with the 1st meeting being undertaken recently. **Chair's report**: "Together We Care" had been presented to the Executive Management Group and had been well received. Findings from 3D events and the struggle to recruit and retain staff raised. The unquantified aspects of Brexit were raised and the unknown impacts. **Multidisciplinary Networking** - MR highlighted the need to reinvent the multidisciplinary networking within cardiology across NHS Wales. The need for networks across various other disciplines had been also been suggested and discussed. **Chair of Forum:** The December HPF Meeting was Professor Michael Rees' last meeting as Chair of the HPF, although he would continue as a member. The HPF thanked Prof Rees for his support, commitment and valuable input to the Forum the role of which has grown and developed during his tenure.
15th March 2019	**Chief Executive Officer – Annual Discussion -** GD acknowledged the significance of health professionals working together in the Forum and the importance of this. He then outlined the BCUHB and NHS environment and challenges, including Special Measures, Workforce, Finance, RTT and Unscheduled care. Following this, he and then took Questions from the forum members and GD encouraged members to email him directly with any further issues that they wished him to note. **Corporate Planning Update – BCUHB Draft Three Year Plan 2019/22 -** The Forum received the presentation from the Head of Health Strategy and Planning, in relation to the BCUHB Draft Three Year Plan 2019/22. **Nursing** - MJ provided a written update for nursing which included: • Ward Accreditation **Pharmacy** - JS reported that: • The first wave of community pharmacist independent prescribers would qualify in Summer 2019, with additional training intakes to continue. An enhanced service is under development to allow these pharmacists to prescribe medications from their pharmacy for some acute conditions that would normally be managed by a GP.

	• Concerns raised regarding supply issues and the potential that the situation will worsen due to Brexit. It was noted that Community pharmacists are being encouraged to be proactive and assist GPs with suggesting alternative drugs to prescribe. **Health Sciences** - JW reported that: • The Primary Care Audiology have been shortlisted in the UK Advancing Healthcare Awards for Innovation in Healthcare Science. The annual Awards event celebrates the contributions of Allied Health Professionals and Healthcare Scientists and will take place on April 12th 2019 • A North Wales Collaborative Care Group for Hearing Loss has been convened. **Therapies** - GE reported that: • The Head of Dietetics in the West had been shortlisted in the "Realising potential through creativity" category of the UK Advancing Healthcare Awards (as above) • The first ever post for a Consultant AHP for Dementia in Wales would be advertised this Spring; BCUHB have declared interest in hosting the post. • The launch of the Allied Health professions framework for Wales, will be held later this Spring. **Dental** - SS reported that: • The target set by Welsh Government for 20% of general dental practices to become involved in the dental contract reform initiative had been achieved. • Access to Pre-Operative Assessment Clinic approved for adult community dental services dental patients requiring general anaesthetic for treatment had been reported as good progression going forwards. • It was noted that funding for paediatric dentistry within North Wales would be sought as part time funding, in conjunction with Liverpool Hospital. **Optometry and Ophthalmology** – AM: • There was discussion regarding the Service Risks of Contact Lens Provision and equipment. **Work Shop time (proposal) – Adrian Thomas** AT proposed the Forum should have some dedicated workshop time to consider, discuss and inform strategies under development. The forum agreed collectively to take this forward. **Vice Chair role** – The role of vice chair is now vacant and expressions of interest are to be sought.

9. Focus for the year ahead:

The primary focus of the Forum over the next twelve months will be *as stated* within Appendix 2 – Cycle of Business for the year 2019/2020.

Strategies under development - Work Shop time (proposal) – Adrian Thomas

There will be some informal workshop time at the meeting to allow the discussion of strategies under development.

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

**Key:*

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

Appendix 1

Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

The Healthcare Professionals Forum

INTRODUCTION

The Healthcare Professionals Forum's role is to provide a balanced, multi disciplinary view of professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of professional terms and conditions of service.

PURPOSE

The purpose of the Healthcare Professionals Forum, hereafter referred to as "the Forum", is to:

- facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the LHB's decision making.

DELEGATED POWERS AND AUTHORITY

The Forum will, in respect of its provision of advice to the Board:

- offer advice to the LHB when specifically requested on any aspect of its business
- offer advice and feedback even if not specifically requested by the LHB.

Authority

The LHB may specifically request advice and feedback from the Forum on any aspect of its business, and the Forum may also offer advice and feedback even if not specifically requested by the LHB. The Forum may provide advice to the Board:

- at Board meetings, through the Forum Chair's participation as Associate Member;
- in written advice; and
- in any other form specified by the Board.

Sub Committees

The Board may determine that the Forum should be supported by a range of sub fora to assist it in the conduct of its work, e.g., special interest groups, or the Forum may itself determine such arrangements, provided that the Board approves such action.

MEMBERSHIP

Chair	nominated from within the membership of the Forum by its members and approved by the Board
Vice Chair	nominated from within the membership of the Forum by its members and approved by the Board
Members	The membership of the Forum reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the Forum shall therefore comprise the following eleven (11) members:

- Welsh Medical Committee
  - Primary and Community Care Medical representative
  - Mental Health Medical representative
  - Specialist and Tertiary Care medical representative
- Welsh Nursing and Midwifery Committee
  - Community Nursing and Midwifery representative
  - Hospital Nursing and Midwifery representative
- Welsh Therapies Advisory Committee
  - Therapies representative
- Welsh Scientific Advisory Committee
  - Scientific representative
- Welsh Optometric Committee
  - Optometry representative
- Welsh Dental Committee
  - Dental representative
- Welsh Pharmaceutical Committee
  - Hospital and Primary Care representative
  - Community Pharmacists representative

Lead Health Board Officer	Executive Director of Therapies and Health Sciences
Secretary	As determined by the Board Secretary
In attendance	The Board may determine that designated Board members or LHB staff should be in attendance at Advisory Group meetings. The Forums Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

Member Appointments

Appointments to the Forum shall be made by the Board, based upon nominations received from the relevant professional group, and in accordance with any specific requirements or directions made by the Welsh Government. Members shall be appointed for a period of no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively.

The ***Chair*** will be nominated from within the membership of the Forum, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Government. The nomination will be subject to consideration by the Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. Their appointment as Chair will be made by the Minister, but it will not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

The Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the Forum. That individual may remain in office for the remainder of their term as a member of the Forum after their term of appointment as Chair has ended.

The ***Vice Chair*** shall be nominated from within the membership of the Forum, by its members by the same process as that adopted for the Chair, subject to the condition that they be appointed from a different clinical discipline from that of the Chair.

The Vice Chair's term of office will be as described for the Chair.

A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the Forum Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Forum Chair will advise the Board in writing of any such cases immediately. The LHB will require Forum members to confirm in writing their continued eligibility on an annual basis. Where a member is unable to attend for 3 consecutive meetings, except in exceptional circumstances, the Chair would request that the member consider their continued membership on the Forum.

Support to Committee Members

The Board Secretary, on behalf of the Chair, will ensure that the Forum is properly equipped to carry out its role by:

- ensuring the provision of governance advice and support to the Forum Chair on the conduct of its business and its relationship with the LHB and others;
- ensuring that the Forum receives the information it needs on a timely basis;
- facilitating effective reporting to the Board; and
- enabling the Board to gain assurance that the conduct of business within the Forum

accords with the governance and operating framework it has set.

COMMITTEE MEETINGS

Quorum

Quorum agreed as 6 members or more and to include Chair or Vice Chair

Frequency of Meetings

- Meetings to take place each quarter consistent with Betsi Cadwaladr University Health Board annual plan of Board Business.
- Additional meetings can be called at the Chair and 2 other members discretion. The Lead Executive may also request additional meetings via the Chair.
- Meetings to be arranged prior to the Full Board meetings so that effective reporting can take place.

Openness and transparency

The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board therefore requires, wherever possible, the Forum to hold meetings in public unless there are specific, valid reasons for not doing so.

REPORTING AND ASSURANCE ARRANGEMENTS

The Chair is responsible for the effective operation of the Forum:

- chairing meetings;
- establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating arrangements; and
- developing positive and professional relationships amongst the Forum's membership and between the Forum and Betsi Cadwaladr University Health Board, and in particular its Chair, Chief Executive and Directors.

The Chair shall work in close harmony with the Chairs of Betsi Cadwaladr University Health Board other advisory groups, and, supported by the Lead Executive, shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions. Where appropriate and within their area of responsibility, the Forum may be requested by the Health Board to review and comment on draft documents prior to formal approval by the Board.

As Chair of the Forum, they will be appointed as an Associate Member of the LHB Board on an ex officio basis. The Chair is accountable for the conduct of their role as Associate Member on the Betsi Cadwaladr University Health Board to the Minister, through the Health Board Chair. They are also accountable to the Betsi Cadwaladr

University Health Board for the conduct of business in accordance with the governance and operating framework set by the Health Board.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

The Forum's main link with the Board is through the Forum Chair's membership of the Board as an Associate Member.

The Board should determine the arrangements for any joint meetings between the Betsi Cadwaladr University Health Board and the Forum.

The Health Board's Chair should put in place arrangements to meet with the Forum Chair on a regular basis to discuss the Forum's activities and operation.

The forum shall embed the corporate goals and priorities through the conduct of its business and in so doing and transacting its business shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-being of Future Generations Act.

The Health Board Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

- where the Forum recommends that a matter should be presented to the Board by a particular professional grouping, e.g., due to the specialist nature of the issues concerned; or

- where a professional group has demonstrated that the Forum has not afforded it due consideration in the determination of its advice to the Board on a particular issue, or

The Board may itself determine that it wishes to seek the views of a particular professional grouping on a specific matter.

Members of the Forum may be invited to attend other Board Committees / Groups at the discretion of the Health Board Chair.

RELATIONSHIP WITH THE NATIONAL PROFESSIONAL ADVISORY GROUP

The Forum Chair will be a member of the National Professional Advisory Group. The Forum may be asked to provide NJPAC with comments on national documents and the NJPAC meeting minutes will be shared with Forum Members.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Health Boards Standing Orders are equally applicable to the operation of the Forum, except in the following

areas:

- Quorum

REVIEW

These terms of reference and operating arrangements shall be reviewed annually by the Forum with reference to the Board.

DATE OF ACCEPTING THE TERMS OF REFERENCE AND APPROVAL

Audit Committee 14.9.17
Health Board 21.9.17
Reported to HPF 10.11.17

V5.0 approved

(Version 5 – updated solely to reflect the move to quarterly meetings from bi monthly-agreed by the Board Meeting in September 2018)

Appendix 2

Health Professionals Forum - Cycle of Business 2019/20

Item		Jun	Sept	Dec	Mar		
Standing items							
Welcome, apologies	Secretariat, HPF	✓	✓	✓	✓		
Declarations of Interest	Members declaration - *if applicable*	✓	✓	✓	✓		
Items for discussion							
Corporate Planning – including updates on AOP/IMTP/3 year outlook LHSW Strategy	Assistant Director Planning Assistant Director Health Strategy	✓	✓	✓	✓		
Strategies - TBA (per Lead Director) TBC							
Mental Health Strategy - Implementation	Appropriate Executive Director and/or representative						
Primary Care							
Innovation Strategy							
QI Hub		✓					
Others as evolve in year – TBC							
Updates							
Chief Executive	Annual discussion with CEO				✓		
Executive Director	Workforce & Organisational Development				✓		
Executive Director of Planning & Performance	Planning & Performance		✓				
Executive Director of Primary & Community Care	Primary Care		✓				
Executive Director Public Health	HMP Berwyn (NW Prison) – Update						
Executive Director Public Health	Public Health	✓					
Executive Director Nursing, Midwifery & Patient Services	Seasonal Plan						
Director Estates and Facilities	Estates developments						

Director Quality Assurance	Draft Annual Quality Statement	✓			✓		
Performance Director	Performance focus		✓		✓		
Assistant Nurse Director Infection Control	Infection Prevention and Control						
Assistant Director Communications	Engagement						
Head of Quality for CHC & Complex Care	A Place to Call Home – Impact & Analysis						
Head of Equality	Strategic Equality – the year ahead Including annual report and recommendations						
Governance							
Chairs written update	Chair, HPF	✓	✓	✓	✓		
Members written updates	All members HPF	✓	✓	✓	✓		
Summary of information to be included in Chair's report to Board		✓	✓	✓	✓		
Draft Advisory Group Annual report inc • COB approval • Terms of Reference review					✓		
Items received for information							
Adhoc items	Executive Director Therapies & Health Sciences	✓	✓	✓	✓		
Workforce Transformation Group	Office of the Director of Workforce and Organisational Development						
Minutes Quality, Safety & Experience Committee meetings	Office of the Board Secretary	✓	✓	✓	✓		
Minutes of Professional Advisory Group meetings	Office of the Director of Nursing & Midwifery	✓	✓	✓	✓		
NJPAC approved minutes (meet 3x per year dates to be sought)	Nigel Champ Directorate for Health Policy Business Unit, Health and Social Services Group, WG	✓	✓	✓	✓		
Team Briefing Updates	Communications	✓	✓	✓	✓		
Closing business							

Any Other Business	Members to raise with the Chair before meeting	✓	✓	✓	✓		
Forward Plan – *next meeting items*	Cycle of Business	✓	✓	✓	✓		
Dates of next meetings	Corporate calendar	✓	✓	✓	✓		

Stakeholder Reference Group Annual Report 2018/19

1. Title of Group: Stakeholder Reference Group (SRG)

2. Name and role of person submitting this report:

Ffrancon Williams, Chair
Mark Wilkinson, Lead Director and BCU Executive Director of Planning & Performance

3. Dates covered by this report:

14/05/2018 – 05/03/2019

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

The Advisory Group was routinely scheduled to meet 5 times, and otherwise as the Chair of the Group deemed necessary. During the reporting period, it met on 5 occasions. Attendance at meetings is detailed within the table below:

Members of the Group	Organisation	14.05.2018	16.07.2018	24.09.2018	11.12.2018	05.03.2019
Ffrancon Williams (Chair)	Housing Association	✓	✓	✓	✓	✓
Gwilym Elllis Evans (Vice Chair)	Mantell Gwynedd	✓	✓	✓	✓	✓
Cllr Christine Marston	Denbighshire County Council	✓	✓	✓	✓	✓
Mr Mike Harriman	One Voice Wales / Unllais	✓	✓	✓	✓	✓
Mr Mark Thornton	NW CHC Chair	✓	A	A	A	A
Dr Garth Higginbotham	Vice Chair, NW CHC (	✓	✓	✓	✓	✓
Fran Hughes	Flintshire VSC	✓	A	A	A	A
Hayley Hill	Flintshire FLVC & Ty Avow	♦	✓	✓	✓	✓
Mrs Ann Woods	Flintshire VSC (Part)	✓	✓	A	✓	A
Mrs Mary Wimbury	Care Forum Wales	✓	A	A	✓	✓

Members of the Group	Organisation	14.05.2018	16.07.2018	24.09.2018	11.12.2018	05.03.2019
Mrs Jacqueline Storer	Ty Avow, Wrexham	✓	A	A	♦	♦
■DVS Nominee	Denbighshire Voluntary Services	✓	✓	A	✓	A
Sian Purcell	Medrwn Mon VSC	✓	A	✓	✓	A
Mrs Fiona Evans	Conwy VSC	✓	A	✓	A	✓
Geraint Davies	Conwy VSC	♦	♦	♦	✓	♦
Prof Robert Moore	North Wales Regional Equality Network	✓	✓	✓	✓	✓
Cllr Gladys Healey	Flintshire LA	✓	A	✓	A	A
Cllr Llinos Medi Huws	Ynys Mon LA	✓	A	A	A	A
Cllr Joan Lowe	Wrexham LA	✓	✓	A	A	✓
Llinos M Roberts	Carer's Outreach Service	✓	✓	A	A	✓
Cllr Penny Andow	Conwy LA	A	A	A	A	✓
Mrs Claire Sullivan	NEWCIS	A	A	✓	A	A
Cllr Christine Jones	Flintshire LA	A	A	A	A	✓
Cllr W Gareth Roberts	Gwynedd LA	A	A	A	A	A
■WAST Nominee (Alternating Attendance)	WAST	A	✓	✓	A	A
Mrs G Winter	Carer's Trust	A	A	A	A	A
Directors & Officers In Attendance						
Sally Baxter	BCU Acting Director of Strategy (Lead Director)	✓	✓	✓	✓	✓
Mark Wilkinson	BCU Exec Director of Plnning & Performance (Lead Director)	♦	♦	✓	✓	A
Katie Sargent	BCU Asst Director Comms & Engagement (Lead Officer)	✓	✓	✓	✓	✓
Denise Hughes	BCU PA – Admin Support (Minutes)	✓	✓	✓	✓	✓

Key:

✓ Present A Apologies/Absent ♦ Not a member of the Group at this time
■ Where there are multiple nominees for one organisation, I have included the attendance based on the organisation rather than the individual.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of this Group. For a full list of attendance, please see the detailed Minutes which can be accessed on the Health Board's website via the following link **here** for 2018 and **here** for 2019.

From the above table it is suggested that:

- **There has been strong support from relevant directors and officers to the work of the SRG**
- **Those members who have attended have found it relevant enough to justify their continued participation.**
- **Attendance from some members continues to be a challenge where some representatives have not attended / hardly at all.**
- **The CHC have two places and perhaps not unreasonably have agreed to cover it between them.**

5. Assurances the Group is designed to provide:

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

- Continuous engagement and involvement in the determination of the LHB overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the UHB operations on the communities it serves

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

An integral part of the process is the requirement for the Group to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management Group who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year.

At a workshop of the Audit Committee held on 15 May 2018, members reviewed each of the Committee and Advisory Group's annual reports for 2017-2018 with the aim of providing evidence on the scope and effectiveness of Committees and of their evaluation of the sources of assurance available to them. As the system of Board Assurances continued to be refined, Audit Committee members made the following comments specific to the Stakeholder Reference Group:

- Concerns were expressed about membership and quoracy. Audit Committee recommends a review of the membership and frequency of meetings.

6. Overall *RAG status against Group's annual objectives / plan: GREEN

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

Objective as set out in Terms of Reference	Was sufficient advice provided? RAG	**Supporting narrative**
Continuous engagement and involvement in the determination of the LHB overall strategic direction		A variety of Reports & presentations on the specific service areas and the overall strategic direction to each meeting, as can be seen from the additional information presented below.
Provision of advice on specific service proposals prior to formal consultation		The SRG has Strategic Planning as a regular agenda item. Feedback has been given on several occasions as the strategy work has progressed, including via the Chair's regular report to the health Board.
Feedback on the impact of the LHB operations on the communities it serves		A significant focus has been on SRG influencing the organisation's strategic direction and ensuring impacts on communities are recognised and reflected as the strategy develops. Individual members have had opportunity to describe impacts on their constituents across a range of strategies and activities of the Board through the agenda items considered by the Group.

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

The Group has re-focussed its agenda and meetings to enable concentration on a limited number of key issues at each meeting. The topics covered are as follows:

May 2018:

- Learning Disability Services – Joint Strategy Development with Local Authorities
- Stroke Services
- BCUHB Partnership Working (PSBs, Regional Partnership Boards etc)

July 2018:

- NHS Wales Strategic Direction – A Healthier Wales Plan
- Unscheduled Care
- Cluster Development – Primary Care
- Third Sector Strategy

September 2018:

- Finance & Performance
- Corporate Planning – Seasonal Plan, Operational Planning Update & Update on "A Healthier Wales"
- Welsh Language Policy & Standards

December 2018:

- Special Measures Update
- Development of 3 Year Plan
- Updates on Corporate Planning, Seasonal Plan and "A Healthier Wales"
- Third Sector Strategy
- Wylfa Newydd – update on strategic development
- HMP Berwyn – update on strategic development

March 2019:

- Finance – Annual update
- Updates – Third Sector Strategy & Three Year Plan
- A Healthier Wales – Transformation Approach

Full details of the issues considered and discussed by the Group are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following link **here**.

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

Meeting Date	Key risks including mitigating actions and milestones
May 2018	**Learning Disability Services – Joint Strategy**: • This strategy should link in with wider strategies such as Mental Health and Living Healthier, Staying Well strategy • The importance of consultation should be stressed as 'one size does not fit all' – Carers, families and Client groups are important and should be included • There were reservations regarding the availability of the required resources in Local Authorities and at a local level to implement the Partnership approach of the Plan • There needs to be a strengthening of links with Education • When developing the Plan serious consideration should be given to the changes in Supporting People funding which may lead to reduced finances being available • There are striking inequalities around this client group and the SRG felt strongly that these should be addressed **Review of Stroke Services and the proposed changes to be considered by the Health Board**: • Ambulance Response – the dialogue with WAST should continue in order to upgrade the response from Amber to Red for suspected stroke attacks; SRG felt that despite implementation of the proposals, the patient outcomes sought may not be achieved if WAST continue to give a lesser priority (i.e. Amber status) to the call • Linked to the Ambulance Response rating is the reliance on paramedics during the journey, especially given the 90+ travel time (mins) areas involved. SRG felt that to achieve the required patient outcomes, paramedics should be trained to the highest level in responding to potential stroke attacks. • The Group expressed concern regarding bed availability on discharge (to the community and Social Services, domiciliary care and the third sector). • SRG recognised the data and research carried out in support of the compelling case for change in provision of stroke services. However, in view of the Health Board's previous negative experience involving the introduction of changes to Maternity services (which led to Surnicc etc.) where the public felt that key messages surrounding the change were not effectively communicated, SRG stressed the importance of key messaging being right from the outset. Effective communication will improve outcomes and it is important to ensure all groups are on board with the changes from the start. **Special Measures Framework** - whilst recognising the Health Board's efforts, SRG expressed concern regarding the time it is taking to come out of special measures.

Meeting Date	Key risks including mitigating actions and milestones
July 2018	**NHS Wales Strategic Direction – "A Healthier Wales Plan: Our Plan for Health & Social Care"** • The plan was generally welcomed by the Group • A number of challenges were noted, including - the climate of austerity and the impact of this on well-being and consequently all public services - the need to develop strategies for an integrated workforce, considering the impact on partner organisations - the need to include the housing sector, given the important role of housing in the agenda set out in the plan **Review of Unscheduled Care (Including Out of Hours):** • The need to develop better education and communication with the population, building on existing information campaigns • The need to target particular groups, including the younger more mobile population, and the need to commence education early in life **Cluster Development Plans - Primary Care**: • The need to develop better communication with the population regarding changing roles in healthcare and new models of support • The Group would like to see consistent terminology for initiatives, such as within social prescribing models, to simplify communication • Cluster Development Plans to reflect the outcomes that are being achieved by the initiatives within the plans **Developing the Third Sector Strategy**: • There is a strong view that the third sector strategy should be embedded in all Health Board strategies • The role of County Voluntary Councils should be reinforced • The importance of monitoring and evaluating third sector services funded by the Health Board, Welsh Government or other partners, to demonstrate outcomes achieved. **Any Other Business** • SRG discussed the importance of the attendance of representatives from the Local Authorities or their deputies
September 2018	**Finance** • the Board must work to deliver the £35m deficit and address key issues in terms of reducing agency spend and improving management capacity. **Corporate Planning / IMTP** • the SRG were supportive of the need for a greater emphasis on partnership working and integration of plans through the Public Service Boards and Regional Partnership Board. **Welsh Language Standards** • the SRG would support the enabling and encouragement for individuals to communicate through the language of their choice, particularly pertaining to the delivery of healthcare to patients. The SRG would wish to see more support and encouragement given to

September 2018 Cont'd	the Third Sector and independent primary care contractors to work within the principles of the Standards.
December 2018	**BCUHB Draft Three Year Plan** • There is a need to be creative in partnership working and creative in the use of community assets in the delivery of the services. • Also, the approach to workforce should look across organisations, and not compartmentalise into individual organisations – enablement across the different workforces should be the aim • Communication – everyone recognises the scale of the task, but "less is more" i.e. the simpler the communication the better. **Third Sector Strategy** • The SRG welcomed the focus given to the importance of this strategy and felt strongly that a set of agreed principles for the 3rd Sector should be developed and embedded alongside the Three Year Plan when it is published by March 2019. **Wylfa Development** • There is general concern within the Group regarding the impact on healthcare services and wellbeing of residents; the impact on Ysbyty Gwynedd and how this would then ripple out to the rest of Gwynedd and in particular South Gwynedd was of particular concern
March 2019	The Group were concerned about the high agency costs - nursing agency costs in particular - and were keen for BCU to consider, as part of their workforce strategy, the encouragement of agency nurses to return to work in BCU by providing support/training etc and also, to make it as attractive as possible to encourage previously registered nurses, in particular, to come back into the system. The Group are keen to see the SRG's cycle of business align with that of the Health Board's.

9. Focus for the year ahead:

The primary focus of the Group over the next twelve months will be to continue to remain relevant by focussing on the items under discussion at Board and improve the timing of SRG discussion so that it becomes more useful to the Board in its service change related and strategic decision making. The reduction in frequency of SRG meetings brought about by the review of the Health Board's committee structure has created challenges for the SRG to cover the required agenda items in the time available.

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

**Key:*

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

V4.0

APPENDIX 1

Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

The Stakeholder Reference Group (SRG)

INTRODUCTION

The Board has a statutory duty to take account of representations made by persons who represent the interests of the communities it serves. To help discharge this duty the Board has appointed Advisory Groups to provide advice to the Board in the exercise of its functions. The Board Advisory Groups includes the Stakeholder Reference Group.

PURPOSE

The purpose of the Stakeholder Reference Group, hereafter referred to as "SRG", is to provide:

- Continuous engagement and involvement in the determination of the LHB overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB operations on the communities it serves.

DELEGATED POWERS AND AUTHORITY

The SRG will, in respect of its provision of advice to the Board:

- Provide a forum to facilitate continuous engagement and activate debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.
- The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. The SRG's role is distinctive from that of Community Health Councils (CHCs), who have a statutory role in representing the interests of patients and the public in their areas.

Authority

The SRG may offer advice specifically requested by the LHB on any aspect of its

business, and the SRG may also offer advice and feedback even if not specifically requested by the LHB. The SRG may provide advice to the Board:

- at Board meetings, through the SRG Chair's participation as Associate Member;
- in written advice; and
- in any other form specified by the Board

Sub Committees

The Board may determine that the SRG should be supported by sub groups to assist it in the conduct of its work, or the SRG may itself determine such arrangements, provided that the Board approves such action.

MEMBERSHIP

Chair — nominated from within the membership of the SRG by its members and approved by the Board

Vice Chair — nominated from within the membership of the SRG by its members and approved by the Board.

Members — The membership is drawn from within the area served by the LHB, and ensures involvement from a range of bodies and groups operating within the communities serviced by the LHB.

SRG Members can agree 'nominated/named deputies' to attend in exceptional circumstances such as a prolonged period of absence. These nominations must be notified in writing to the Board Secretary and approved by the Health Board.

The membership will be made up of representatives from the following sectors:

Sector/organisation	Number of places available
Third sector	6
Independent sector	1
Town/Community Councils	1
Housing Associations	1
Carers	3
Local Authorities	6
Disability equality	1
North Wales Regional Equality Network	1
Total	**20**

This membership will be reviewed by the Chair and Lead HB Officer on an annual basis

Representatives can be 'co-opted' to advise on specific issues as appropriate by agreement with the Chair.

Lead HB Officer	Executive Director of Planning and Performance
Secretary	As determined by the Board Secretary
In attendance	The Board may determine that designated board members or LHB staff should be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.
By invitation	The SRG shall make arrangements to ensure designated CHC members receive the SRGs papers and are invited to attend SRG meetings.

Member Appointments

Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder group where it has determined that formal bodies or groups are not already established or operating within the area who may represent the interests of these stakeholders on the SRG.

The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Assembly Government. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment.

Members shall be appointed for a period of no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively. The Board may, where it considers it appropriate, make interim or short term appointments to the SRG to fulfil a particular purpose or need.

The ***Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the LHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

The ***Chair's*** term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

The ***Vice Chair*** shall be nominated from within the membership of the SRG, by its members by the same process as that adopted for the Chair, subject to the condition that they be appointed from a different sector/organisation from that of the Chair.

The Vice Chair's term of office will be as described for the Chair.
A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.

Support to SRG Members

The LHB's Board Secretary, on behalf of the Chair, will ensure that the SRG is properly equipped to carry out its role by:

- ensuring the provision of governance advice and support to the SRG Chair on the conduct of its business and its relationship with the LHB and others;
- ensuring that the SRG receives the information it needs on a timely basis;
- ensuring strong links to communities/groups; and
- facilitating effective reporting to the Board enabling the Board to gain assurance that the conduct of business within the SRG accords with the governance and operating framework it has set.

SRG MEETINGS

Quorum

At least one third of the members must be present to ensure the quorum of the SRG.

Frequency of Meetings

Meetings shall be held bi-monthly or otherwise as the Chair of the SRG deems necessary – consistent with the LHB's annual plan of Board Business.

Openness and transparency

The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board therefore requires, wherever possible, the Forum to hold meetings in public unless there are specific, valid reasons for not doing so.

REPORTING AND ASSURANCE ARRANGEMENTS

The SRG Chair is responsible for the effective operation of the SRG:

- chairing Group meetings;
- establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating arrangements; and
- developing positive and professional relationships amongst the Group's membership and between the Group and the LHB's Board and its Chair and Chief Executive.
- The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Group in a timely manner with all the

necessary information and advice being made available to members to inform the debate and ultimate resolutions.

- As Chair of the SRG, they will be appointed as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

The SRG shall embed the Corporate goals and priorities through the conduct of its business and in so doing and transacting its business shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

The Board may determine that designated board members or LHB staff should be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

The Board should determine the arrangements for any joint meetings between the LHB Board and the Stakeholder Reference Group.

The Board's Chair should put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

APPLICABILITY OF STANDING ORDERS TO SRG BUSINESS

The requirements for the conduct of business as set out in the LHB's Standing Orders are equally applicable to the operation of the SRG, except in the following areas:

- Quorum

REVIEW

These terms of reference and operating arrangements shall be reviewed annually by the SRG with reference to the Board.

DATE OF ACCEPTING THE TERMS OF REFERENCE AND APPROVAL

Date of approval by the Board 21.9.17

Reported to SRG 27.11.17

Cycle of Business Stakeholder Reference Group 2019/20 v0.1 draft April 2019					**APPENDIX 2**
Agenda Item	**Lead Officer**	**4 June**	**10 Sep**	**17 Dec**	**3 Mar**
Opening Business (Standing Items)					
Apologies for Absence		x	x	x	x
Previous Minutes and Action Plan		x	x	x	x
Declaration of Interests		x	x	x	x
Chair's Report		x	x	x	x
Members' Reports		x	x	x	x
Key papers submitted to Health Board for information		x	x	x	x
Governance Matters					
Committee annual report (inc annual review of ToR and Cycle of Business)	Mark Wilkinson	x			
Strategic Matters					
BCU Third Sector Strategy Update	Sally Baxter	x			
BCU 3 Year Plan / Corporate Planning update incl Estate Strategy	John Darlington		x	x	x
BCU Services Strategy	Sally Baxter	x	x		
BCU Business Cases / Capital Development	Ian Howard / Neil Bradshaw	x	x	x	x
BCU Finance Report	Russ Favager		x		x
BCU Primary Care updates	Chris Stockport			x	x
BCU Medicines Management	Berwyn Owen	x		x	
Well-being of Future Generations Act	Sally Baxter		x		

Annual Reports – for information					
BCU Annual Quality Statement	Gill Harris				
BCU Annual Report of the Health Board	Grace Lewis-Parry		x		
BCU Director of Public Health Annual Report	Teresa Owen			x	
BCU Equality & HR Annual Report & Strategic Equality Plan Progress	Sue Green		X Eq/HR	X SEP	
BCU Welsh Language Strategic / Annual Report(s)	Teresa Owen		x		
Closing Business (Standing Items)					
Issues of Significance to Inform Chair's Report to Board		x	x	x	x
Date of Next Meeting		x	x	x	x

Audit Committee Annual Report 2018/19

1. Title of Committee:

Audit Committee

2. Name and role of person submitting this report:

Grace Lewis-Parry, Board Secretary

3. Dates covered by this report:

01/04/2018-31/03/2019

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

The Committee was routinely scheduled to meet four times and otherwise as the Chair of the Committee deemed necessary. During the reporting period, it met on four occasions and in addition held two workshops during the year, one on May 2018 primarily to review the suite of Committee Annual reports, the other being held in November 2018 as a training session given the refresh in Membership. Attendance at formal meetings is detailed within the table below:

Members of the Committee	31st May 2018	11th Sept. 2018	11th Dec. 2018	14th March 2019
Independent Members				
Ceri Stradling (Chair until 31.8.18)	✓	◆	◆	◆
Medwyn Hughes (Chair from 1.9.18)	✓	✓	✓	✓
John Cunliffe	✓	✓	✓	✓
Jacqueline Hughes (appointed as Health Board Member from 1.6.18)	◆	A	✓	✓
Lucy Reid (appointed as Health Board Member from 1.9.18)	◆	A	✓	✓

Directors In attendance	31st May 2018	11th Sept. 2018	11th Dec. 2018	14th March 2019
Grace Lewis-Parry, Board Secretary	✓	A	✓	✓
Russ Favager Executive Director of Finance	✓	A	✓	✓

Key ◆ not a member of the Committee at this time.

A Apologies

In addition to the core membership, other Directors and Officers from the Health Board attend meetings of the Committee to present items and respond to members' questions. For a full list of attendance please see the detailed Minutes which can be accessed on the Health Board's website via the following link:
http://www.wales.nhs.uk/sitesplus/861/page/51690

5. Assurances the Committee is designed to provide:

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

3.1.1 comment specifically in its Annual Report upon the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical). It is also intended to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement and the Annual Quality statement, providing reasonable assurance on:

- the organisation's ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards, quality and delivery requirements and other directions and requirements set by the Welsh Government and others;
- the reliability, integrity, safety and security of the information collected and used by the organisation;
- the efficiency, effectiveness and economic use of resources; and
- the extent to which the organisation safeguards and protects all its assets, including its people.

3.1.2 to ensure the provision of effective governance –by reviewing

- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- the effectiveness of the Board's Committees

- the accounting policies, the accounts, and the annual report of the organisation (as specified in the Manual for Accounts as issued by Welsh

Government), including the process for review of the accounts prior to submission for audit, levels of errors identified, the ISA260 Report and with Management's letter of representation to the external auditors;
- the, Annual Audit Report and Structured Assessment
- financial conformance and the Schedule of Losses and Compensation;
- the planned activity and results of both internal and external audit, the Local Counter Fraud Specialist and post payment verification work (including strategies, annual work plans and annual reports);
- the adequacy of executive and managements responses to issues identified by audit, inspection, external reports and other assurance activity;
- proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);
- anti-fraud policies, whistle-blowing processes and arrangements for special investigations;and
- any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

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

An integral part of the process is the requirement for the Committee to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management Group who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year with the addition of a dedicated Board level Committee for Information Governance and Informatics and the adjustment of other Committee terms of reference.

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

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

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	Supporting narrative
Comment specifically in its Annual Report upon the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non- clinical). It is also intended to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement and			Interim Annual Plan in place and work ongoing which will be represented to the Board in July. Work ongoing to embed Risk Management of operational levels.

the Annual Quality Statement, providing reasonable assurance on: • the organisation's ability to achieve its objectives; • compliance with relevant regulatory requirements, standards, quality and delivery requirements and other directions and requirements set by the Welsh Government and others; • the reliability, integrity, safety and security of the information collected and used by the organisation; • the efficiency, effectiveness and economic use of resources; and • the extent to which the organisation safeguards and protects all its assets, including its people.			
To ensure the provision of effective governance –by reviewing • the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);			
• the effectiveness of the Board's Committees			
• the accounting policies, the accounts, and the annual report of the organisation (as specified in the Manual for Accounts as issued by Welsh Government), including the process for review of the accounts prior to submission for audit, levels of errors identified, the ISA260 Report and with Management's letter of representation to the external auditors;			
• the, Annual Audit Report and Structured Assessment			Recommendations monitored as part of audit tracker. Amber status given as not all recommendations have been implemented by the due date.
• financial conformance and the			

Schedule of Losses and Compensation;			
) the planned activity and results of both internal and external audit, the Local Counter Fraud Specialist and post payment verification work (including strategies, annual work plans and annual reports);			Recommendations from both internal and external audits are monitored as part of the audit tracker. Amber status given as not all recommendations have been implemented by the due date.
) the adequacy of executive and managements responses to issues identified by audit, inspection, external reports and other assurance activity;			Management responses to internal and external audit recommendations continue to be monitored as part of the audit tracker. Amber status given as not all recommendations are implemented by the due date.
) proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);			
) anti-fraud policies, whistle-blowing processes and arrangements for special investigations; and			
) any particular matter or issue upon which the Board or the Accountable Officer may seek advice.			

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

-) Financial Conformance Reports
-) Independent external validation of the Internal Audit Service
-) Internal Audit Progress Reports/Charter and Annual Plan/Report and Opinion
-) Wales Audit Office update and Performance reports including Structured
-) Assessment and Annual Audit Report and Annual Plan
-) Updates against internal and external audit recommendations (Team Central - tracker tool)
-) Clinical audit progress reports/plan.
-) Post Payment verification reports and Annual Plan
-) Counter fraud progress reports/annual plan/annual report.
-) Various National reports and publications for Information.
-) Review of Committee Terms of Reference and Cycle of Business
-) Board Assurance framework review/mapping
-) Corporate Risk Register review
-) Annual Review of Declarations of Interest.

- Annual Governance Statement/Annual Quality Statement/ Annual Accounts/ Accountability Reports.
- Standing Orders Review
- Updates re Audit Committee Workshops
- Minutes of Joint Audit and Quality, Safety and Experience Committee
- Draft charitable accounts
- Committee Annual Reports including that of the Audit Committee
- Welsh Ambulance Service Internal Audit Report on Handover of Care at Emergency Departments.
- Review of Special Measures expectations allocated to the Committee
- Update on financial expenditure on major contracts associated with Tawel Fan
- Legislation Assurance Framework
- Detailed scrutiny of all Limited and no assurance audit reports.

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following link:- http://www.wales.nhs.uk/sitesplus/861/page/51690

At a workshop of the Audit Committee held on the 15th May 2018 members reviewed each of the Committee and Advisory Group's annual reports for 2017-18 with the aim of providing evidence on the scope and effectiveness of Committees and of their evaluation of the sources of assurance available to them. Members made a number of comments specific to the various Committees which have been taken into account and responded to as appropriate within the 2018/19 Committee Annual Reports. The following generic comments were also made and insofar as the Audit Committee is concerned these are responded to below:-

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Views expressed at Audit Committee Workshop in 2018	**Update position**
Recurring themes around the need for training for members in respect of specific Committee responsibilities, and concerns around the volume of work some Committees were dealing with.	Specifically in relation to the Audit Committee a training workshop was held in November 2018. Modifications to the overall Committee structure have been undertaken in year with the addition of a dedicated Board level Committee for Information Governance and Informatics and the adjustment of other Committee terms of reference together with a review of the frequency and duration of meetings.
Externally commissioned/produced reports e.g. Deanery/Royal Colleges should be centrally logged.	Central logging now in place within Office of the Board Secretary.
Chairs assurance reports to in future confirm actions being taken to address key risks identified.	Template amended in July 2018

Template for future Committee Annual reports to be amended to detail "focus for the year ahead" at the end of the report.	Completed
Any difficulties in identifying sources of assurance to be included as a key focus for the year ahead.	Annual reporting template amended to remove sources of assurance review by Committee with the agreement of the Committee Business Management Group.
In respect of internal or external audit reports individual committees are asked to review and provide commentary within their annual report on whether the implementations of the recommendations arising from audits relevant to their remit have led to overall qualitative improvements.	Process continues to be refined with a reporting schedule now in place to ensure Follow up reports are presented to the relevant Committee approximately six months later. This report will not be the representation of the Internal Audit report but a report by the Executive setting out progress of the actions taken to address the weaknesses identified and whether implementation of the actions has had the intended outcome and if not what other actions are being taken.
Ensure new assurance map addresses quality of primary care and quality of commissioned services.	Completed as part of ongoing development of Board Assurance Map.
Sources of assurance document to be updated as follows:- • Outcome findings of local clinical audit work to be included (ACS 21A) • Systems of internal control to be included (ACS 11A) • Team Central Tracker aligned to Audit Committee to be included (ACS66). • Delete RAG colour coding from document.	Superseded. Many of the sources of assurance now form an integral part of the annual plan work programme or are the stated mechanisms of assurances within the three lines of defence (documented within the draft Board Assurance Map as presented to the Audit Workshop on 14th May 2019). In addition, since the Sources of Assurance document was developed, extensive work has been undertaken to develop the legislation assurance framework which is seen as best practice and has been shared across Wales.

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

Meeting Date	Key risks including mitigating actions and milestones
3.5.18	• The Head of Internal Audit could only provide the Board with a Limited Assurance opinion for the year. Some of the audits completed in the last period contributed to this assessment including Risk Management at an operational level, Health & Safety arrangements, Business Continuity arrangements and Learning the Lessons from incidents. It is important that the deficiencies highlighted are addressed promptly and accordingly the Committee will be monitoring progress of the

	implementation of the recommendations arising from these Audits via the tracker tool which is presented to each meeting. J The NHS Accountable Officer has written to remind the Board that by approving an interim deficit budget for 2018-19 it has breached its own Standing Orders and Standing Financial Instructions. The Board should formally acknowledge these breaches as well as the breach of its financial duties. J The Board performs badly compared to other Health Boards in a number of areas highlighted by an Internal Audit report for WAST on the Handover of Care at Emergency Departments. It is important that an appropriate response is given to the findings of the report to complement the work already underway on Unscheduled Care across the Board. The Committee has requested that an appropriate BCU response to the report is prepared and then considered at the next meeting.
11.9.18	J The WAST Handover of Care at Emergency Departments (EDs) Internal Audit Report highlighted the significant challenges facing both the Ambulance Service and Health Boards across Wales to improve patient pathways and patient experience. The Health Board had put in place arrangements to address all of the relevant recommendations and in particular Members welcomed the 90 day plan which had been formulated to reduce the handover risks and pressures at the front door of EDs. The plan was due to conclude in December and the Committee requested a further update at the December meeting to review the effectiveness of the mitigation arrangements given that this was of such significance to the Health Board and the North Wales population. J In giving consideration to the PPV report, with input from Counter Fraud, Members recognised the potential risks around non-compliance with Welsh Government guidance in respect of General Practitioner annual reviews of patients in care home settings. Members requested that the Head of Counter Fraud review the findings of the PPV team to identify the nature and extent of the emerging issues. J In reviewing the Clinical Audit Plan Members sought assurance that there was a risk based approach underpinning the formulation of the BCU elements of the Plan. It was considered that further assurances were needed in this regard and additionally assurance was required that a robust process existed for the monitoring and tracking of Clinical Audit recommendations. A detailed report is to be prepared for the Joint meeting of Audit and Quality, Safety and Governance Committee in November. J In respect of the Limited Assurance Internal Audit reports, the Committee expressed serious concerns about the impact of the significant delays by the National Wales Informatics Services (NWIS) in delivery of important ICT projects. Members acknowledged that this was being addressed at an all Wales level. With regard to the Safeguarding Audit, Members were concerned about the Interim Safeguarding arrangements that had been in place and where decisions made at that time had not been in line with All Wales policies. Whilst these matters had since been resolved the Committee acknowledged the potential governance and accountability risks facing the organisation in particular during a period of significant portfolio change. The generality of these concerns would be raised with the Chief Executive.

	) Finally, having reviewed the 'Team Central' Audit Tracker, Members were concerned about the lack of progress of recommendations emanating from the reviews on National Cleaning Standards and Estates. Of particular concern was the need to confirm when the re-establishment of cleaning audits would commence, these audits having been suspended temporarily during the implementation of the Safe Clean Care programme. Other concerns emerged as a result portfolio changes and accountability for functions during this period of change. Health and Safety was sighted as a particular concern. A report back on progress was sought for the December meeting.
11.12.18	) The additional resources required to fully meet the audit frequency in the National Cleaning Standards will be considered as part of the 2019/20 budget setting process. The Committee received the Public Health Wales Programme Closure report following the WAO Report on the Collaborative Arrangements for managing Public Health resources. The Committee noted with some concern the review of allocated funding across Wales which would have a £400,000 adverse impact on the North Wales population. The BCU Director of Public Health informed Members that despite discussions at chief executive level attempts to reverse this decision had been unsuccessful.) Having reviewed the 'Team Central' Audit Tracker, Members expressed serious concerns about the lack of progress of numerous overdue recommendations and requested that the Executive Team address these as a priority. .) The Committee reviewed the Corporate Risk Register and raised concerns that updates from that other Committee meetings had not been shown in the version presented to the audit committee. The Board Secretary agreed to review the register with the Executive Team prior to its presentation to the Board in January and for future reports to provide a narrative update on what had changed since the last iteration. Members acknowledged the forthcoming Board Workshop on Risk Management which would discuss risk appetite of the Board, risk ratings and how risks were defined.
12.3.19	) Managing the Outpatients' Backlog – Limited Assurance Internal Audit Report -Members expressed serious concerns relating to demand and capacity and failure to manage the clinical risks effectively, and the lack of evidence and traction in terms of resolving any of the issues identified in the report despite the Board having been sighted on the issues previously. Members were concerned that the matter had not been escalated on the risk register and that the audit report stated that "there have been no reports (for oversight/scrutiny) in respect of the Outpatients Follow up Backlog by the Secondary Care Senior Management Team over a number of recent months". The Committee also felt that the management response to the recommendations did not contain sufficient detail to provide assurance that the issues would be effectively resolved in a timely manner going forward. Members felt that an overarching transformational plan was needed. The Committee concluded that the matter required escalation to both Quality, Safety and Experience Committee and Board to ensure sufficient oversight and traction given the scale of the issues involved, and the need to develop both a strategic and operation plan.

	• Clinical Audit – Members were dissatisfied that the report did not address the specific actions identified as part of previous Structured Assessments but also recommendations arising from the Joint Audit and Quality, Safety and Experience Committee meetings in both 2017 and 2018 and the lack of traction and movement to date. Expectations were for the report to set out how clinical audit would address the strategic objectives of the organisation taking a risk based approach to support quality improvement going forward. Wales Audit Office urged that a plan setting out future arrangements, together with a clinical audit plan for the year ahead be presented to the next meeting in order to satisfy the requirements in both the Annual Governance Statement and the Annual Quality Statement.

9. Review of 2018/19 Committee Annual Reports

Audit Committee members held a workshop on 14th May 2019 to review and take account of the contents of each of the Board Committees' and Advisory Groups' Annual Reports.

The review was intended to provide evidence on the scope and effectiveness of the 'committees'. Members concluded that overall the Board can be reasonably assured that 'committees' and assurance systems in place for the year have worked efficiently and effectively. Members acknowledged and thanked all committees for engaging in the process of annual review effectively. Members made a number of observations on the detail of the reports which have since been addressed in the version to be presented to the Audit Committee on 30th May. In addition the following comments were made:-

Quality Safety and Experience (QSE) Committee

- Health and Care Standards – Internal Audit raised the lack of specific evidence to relating to compliance with the standards compliance. Whilst the organization was continuously self-assessing and using the learning from self-assessments Members felt that the Committee's Terms of Reference should be adjusted to note that assurances in this respect were provided via the Quality Improvement Strategy and the Legislation Assurance Framework.
- Noted that it was unusual for there to be no risks highlighted from the 24.7.18 meeting.

Finance and Performance Committee

- Supported the proposal in relation to the change in Terms of Reference – para 3.1.4 – delete from third bullet point (which is to transfer to the RATS Committee) "including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and Allied professionals" and remove the word 'quarterly' from same bullet point.

Information Governance and Informatics Committee

- Supported the proposal to change of title of the Committee to Digital and Information Governance Committee

Strategy, Partnerships and Population Health Committee

- Commented that the overall RAG status and some of the colour coding in the assessment of the Committee's objectives should be amber rather than green given the fact that the organisation does not have an IMTP- as a consequence the report has been further refined.
- Supported the proposed removal of the reference to Prison Health in the Terms of Reference given that this was now monitored via QSE Committee.
- Stressed the importance of keeping under review the progress of the Mental Health Strategy and the need for a clear plan of actions and how these actions were being monitored.

Remuneration and Terms of Service Committee (RATS)

- Supported the proposal to amend the Terms of Reference to refer to Trade Union Partners as opposed to Staff Side and to include revalidation as removed from Finance and Performance Committee (see note above)

Stakeholder Reference Group

- Supported a proposal to include a Hospice Representative in the Group's Membership

General Commentary

- Relating to all Terms of Reference – Committee's should reference the changes if there have been more than one set in operation during the year
- Overall RAG status to be more prominent in future reports
- Future commentary in Chair's assurance reports should ensure that there is clarity about the risks and actions being described
- Members commented on the unique position of having the Chair of the Board chairing the Finance and Performance Committee. They acknowledged that in light of the financial position of the organization, the financial focus of Special Measures, and taking account that they organisation currently did not have an Independent Member with financial expertise this was appropriate. Members welcomed the interim support being provided by the Financial Adviser and the current recruitment exercise underway seeking a new Independent Member with financial expertise.
- Agreed to remove TU Partners reference from all Committee memberships but to refer that they are welcome to attend the open session of all Committees.

10. Focus for the year ahead:

The primary focus of the Committee over the next twelve months will be on monitoring any revised arrangements associated with the Corporate Risk and Assurance Framework; developing the Assurance Map; the continued tracking of both internal and external audit recommendations on the Team Central database and the overall financial position given the budget deficit.

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

***Key:**

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

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

AUDIT COMMITTEE

1. INTRODUCTION

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

2. PURPOSE

2.1 The purpose of the Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Health Board's system of assurance – to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Boards objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its assurance framework may be strengthened and developed further.

3. DELEGATED POWERS

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

3.1.1 comment specifically in its Annual Report upon the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical). It is also intended to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement and the Annual Quality statement, providing reasonable assurance on:

- the organisation's ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards, quality and delivery requirements and other directions and requirements set by the Welsh Government and others;
- the reliability, integrity, safety and security of the information collected and used by the organisation;
- the efficiency, effectiveness and economic use of resources; and
- the extent to which the organisation safeguards and protects all its assets, including its people.

3.1.2 to ensure the provision of effective governance -by reviewing

- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- the effectiveness of the Board's Committees
- the accounting policies, the accounts, and the annual report of the organisation (as specified in the Manual for Accounts as issued by Welsh Government), including the process for review of the accounts prior to submission for audit, levels of errors identified, the ISA260 Report and with Management's letter of representation to the external auditors;
- the, Annual Audit Report and Structured Assessment
- financial conformance and he Schedule of Losses and Compensation;
- the planned activity and results of both internal and external audit, clinical audit, the Local Counter Fraud Specialist and post payment verification work (including strategies, annual work plans and annual reports);
- the adequacy of executive and managements responses to issues identified by audit, inspection, external reports and other assurance activity;
- proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);
- anti fraud policies, whistle-blowing processes and arrangements for special investigations; and
- any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

3.2 The Committee will support the Board with regard to its responsibilities for risk and internal control by reviewing:

- the adequacy of the Board Assurance Framework and Corporate Risk Register;
- all risk and control related disclosure statements, in particular the Annual Governance Statement and the Annual Quality Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements, including declarations of interest and gifts and hospitality; and
- the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service;
- regular tender waiver reports to ensure compliance with the Standing Financial Instructions.

3.3 in carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions. It will also seek reports and assurances from directors and managers as appropriate in response to the recommendations made, monitoring progress via the Audit Tracker tool.

3.4 this will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- the comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Health Board's activities, both clinical and non clinical; and
- the reliability and integrity of these assurances.

3.5 To achieve this, the Committees programme of work will be designed to provide assurance that:

- There is an effective Internal Audit function that meets the standards set for the provision of Internal Audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
- work with the Quality, Safety and Experience Committee to ensure that there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer;
- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees;
- the work carried out by key sources of external assurance, in particular, but not limited to the Health Board's External Auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- the systems for financial reporting to the Board, including those of budgetary control, are effective; and that the results of audit and assurance work specific to the Health Board, and the implications of the findings of wider audit and assurance activity relevant to the Health Board's operations are appropriately considered and acted upon to secure

the ongoing development and improvement of the organisation's governance arrangements.

4. AUTHORITY

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

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

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

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

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

5. ACCESS

5.1 The Head of Internal Audit, the Auditor General and his representatives and the lead Local Counter Fraud Specialist (LCFS) shall have unrestricted and confidential access to the Chair of the Audit Committee and vice versa.

5.2 The Committee will meet with Internal and External Auditors and the nominated LCFS without the presence of officials on at least one occasion each year.

6. SUB-COMMITTEES

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

7. MEMBERSHIP

7.1 Members

Four Independent Members of the Board to include a member of the Quality, Safety and Experience Committee.

The Chair of the Organisation shall not be a member of the Audit Committee.

7.2 In attendance

- Board Secretary (lead Director)
- Executive Director of Finance
- Head of Internal Audit
- Head/individual responsible for Clinical Audit
- Local Counter Fraud Specialist
- Representative of Auditor General (External Audit)

The Chief Executive as Accountable Officer should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

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

7.3 Member Appointments

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

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

7.4 Secretariat

7.4.1 Secretary: as determined by the Board Secretary.

7.5 Support to Committee Members

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

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

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

8 COMMITTEE MEETINGS

8.1 Quorum

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

8.2 Frequency of Meetings

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

8.3 Withdrawal of individuals in attendance

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

9 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

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

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

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

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

9.3.2 sharing of information

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

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

10 REPORTING AND ASSURANCE ARRANGEMENTS

10.1 The Committee Chair shall:

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

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

10.2 The Committee shall provide a written annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement and the Annual Quality Statement, specifically commenting on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self- assessment and evaluation.

10.3 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

11. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

12. REVIEW

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

Date of approval by the Board 21.9.17

V10.0

Audit Committee Annual Cycle of Business - 2019-20

	Agenda Item	May workshop	End May/June	Sept	Dec	March	Notes for corporate staff
	Opening Business						
	Members discussions with internal and external audit		x	x	x	x	IMs and Auditors to have 15 minute pre-meeting before each meeting (agreed 19.3.15)
	Apologies for absence		x	x	x	x	
	Minutes of previous meeting for accuracy & matters arising and review of summary action plan		x	x	x	x	
	Governance						
	Review Corporate Risk and Assurance Framework together with Risk Management Strategy					x	
	Review of Corporate Risk Regiser				x		
	Other sources of assurance (audit reports, regulatory body reports, external reviews, shared services reports)		X	X	X	X	
	Note business of other committees and review inter-relationships	review cttee annual reports				x self assessment	Self assessment now being undertaken via CBMG
	Review of amendments to SOs		x	X	X	X	
	Review draft AGS	draft	approval				
	Review draft AQS	draft	approval				
	Review organisation's annual report (incorporating sustainability report)		approval				
	Annual review of gifts & hospitality and DoI registers			x			
	Special Measures Progress Update on relevant areas			x	x	x	
	Legislation Assurance Framework			x		x	
	Annual review of submissions on Database to capture externally commissioned reports etc. Eg DU, CHC etc.		**x**				To be incorporated within tracker report
	Finance						
	Review of amendments to SFIs		x	X	X	X	
*	Post payment verification progress report			X		x	
*	Financial Conformance report (inc review of losses & special payments, review of risks and controls and reporting of any SO breaches)		x	X	X	X	
	Agree financial accounting timetable				X		

	Review annual accounting progress					X	
	Review of audited annual accounts and financial statements including Charitable Funds if ready		X		CF final		
	Internal Audit						
	Internal Audit progress report		x	X	X	X	
*	Report from IA tracker tool		x	X	X	X	
	Review and approval of internal audit plan					x	
*	Internal Audit Charter (incorporating ToR for internal audit)					x	
	Receive annual internal audit report (head of IA opinion)		x				
	Review effectiveness of internal audit						Continuous process and via regular meetings prior to Committee
*	Any no assurance or limited assurance reports as a substantive item		x	X	X	X	
	External Audit						
	Auditor General's (external audit) progress reports		x	X	X	X	
*	Report from EA tracker tool		x	X	X	X	
*	National audit reports for information		x	X	X	X	
	Review and approval of Auditor General's (external audit) plan					x	
*	Structured Assessment				x feedback	x final report	
	Receive Auditor General's report to those charged with governance (through letter of representation)		X				
	Receive the Auditor General's annual audit report					X	
	Review the effectiveness of external audit (through quarterly WAO progress reports)		x	X	X	X	Continuous process and via regular meetings prior to Committee
	Counter Fraud						
	Review counter fraud progress reports		x	X	X	X	
	Agree counter fraud annual workplan		x				
	Review effectiveness of LCFS Specialist (through NHS Protect Assessment)			X			
	Counter fraud annual report		X				
	Clinical Audit						
	Clinical audit plan		x			x	
	Audit Committee						
	Plan how to discharge audit committee duties					Agree Cycle of Business	
	Undertake self assessement of Committee effectiveness						Undertaken via CBMG - process of continual assessment

	Briefings and update sessions (as appropriate)	x	x	x	x	x	
	Produce Committee annual report including refresh of ToR	x draft	x final				
	Members discussion with Head of Counter Fraud				x		to be arranged outside of meetings between Chair and Karl
	Closing Business						
	Summary of In Committee business to be reported in public						
	Issues of Significance		x	x	x	x	
	Date of Next meeting(s)		x	x	x	x	

Committee Annual Report 2018/19

1. Title

Information Governance and Informatics Committee

2. Name and role of person submitting this report:

Dr Evan Moore, Executive Medical Director

3. Dates covered by this report:

01/04/2018-31/03/2019

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

The Committee was routinely scheduled to meet twice. Attendance at meetings is detailed within the table below:

INDEPENDENT MEMBERS	13.11.18 Inaugural meeting	14.2.19
John Cunliffe (Chair)	✓	✓
Jo Ryecroft Malone (Vice Chair)	✓	A
Cheryl Carlisle	✓*	✓
Lucy Reid	✓	✓
Directors and Officers in Attendance	13.11.18 Inaugural meeting	14.2.19
Dr Evan Moore Executive Medical Director (Lead Director)	✓	✓

Dr Mark Walker Deputy Medical Director / Caldicott Guardian	A	◆
Dr Melanie Maxwell Senior Associate Medical Director / Caldicott Guardian	◆	✓
Grace Lewis-Parry Board Secretary / Senior Information Risk Owner (SIRO)	✓	✓
Dylan Williams Chief Information Officer	✓	✓
Justine Parry Assistant Director Information Governance and Assurance / Data Protection Officer (DPO)	✓	✓

Key:

✓ Present

✓* Part meeting

A Apologies/Absent

◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. For a full list of attendance, please see the detailed Minutes which can be accessed on the Health Board's website via the following link:-
http://www.wales.nhs.uk/sitesplus/861/page/97583

5. Assurances the Committee is designed to provide:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott, Information Security, Records Management, Information Sharing, national Information Governance policies and Information Commissioner's Office Guidance;

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

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

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

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

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

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

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

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

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference V1.0 which were operative from October 2018 following its inaugural meeting. The Terms of Reference are appended at Appendix1. During discussion at the IGIC meeting held on 9.5.19 to consider thus

report agreement was reached to change the title of the Committee to "Digital and Information Governance Committee" and this will be recommended to the Audit Committee and Board in due course.

An integral part of the process is the requirement for the Committee to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management Group (CBMG) who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year.

18.10.18 CBMG meeting – it was reported that the Executive Lead and Committee Chair had reviewed the inaugural ToRs and Cycle of Business. Members noted that this was a new committee and that updated the COB would be an iterative process as the Committee became more established.

At a workshop of the Audit Committee held on the 15th May 2018 members reviewed each of the Committee and Advisory Group's annual reports for 2017-18 with the aim of providing evidence on the scope and effectiveness of Committees and of their evaluation of the sources of assurance available to them. As the Committee had not been established until October 2018, no comments were provided.

In addition, Audit Committee members made the following generic comments pertaining to the Committee and Advisory Group Annual Reporting process:-

Recurring themes around the need for training for members in respect of specific Committee responsibilities, and concerns around the volume of work some Committees were dealing with.	A full review and refresh of the cycle of business has been undertaken with the Committee Chair and Lead Executive. Meeting duration has been extended to allow for full discussion of items. Committee members have also increased their skillset through the wider Board Development and Workshop programme. Other specific training has also been provided eg risk management, equality, safeguarding and continuing health care.
Externally commissioned/produced reports e.g. Deanery/Royal Colleges should be centrally logged.	Central logging now in place within Office of the Board Secretary.
Chairs assurance reports to in future confirm actions being taken to address key risks identified.	Template amended in July 2018
Template for future Committee Annual reports to be amended to detail "focus for the year ahead" at the end of the report.	Completed (see section 9)
Any difficulties in identifying sources of	Completed (see section 9)

assurance to be included as a key focus for the year ahead.	
In respect of internal or external audit reports individual committees are asked to review and provide commentary within their annual report on whether the implementations of the recommendations arising from audits relevant to their remit have led to overall qualitative improvements.	At its inaugural meeting in November 2018 the Committee considered the PAC report on Informatics systems in Wales alongside the Auditor General's report. The findings have shaped the business of the Committee with regard to risks, relationships and priorities.
Ensure new assurance map addresses quality of primary care and quality of commissioned services.	Completed as part of ongoing development of Board Assurance Framework
Sources of assurance document to be updated as follows:- • Outcome findings of local clinical audit work to be included (ACS 21A) • Systems of internal control to be included (ACS 11A) • Team Central Tracker aligned to Audit Committee to be included (ACS66). • Delete RAG colour coding from document.	Completed as part of ongoing development of Board Assurance Framework

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

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

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	Supporting narrative (Please provide detail for all actions showing amber or red assurance levels in terms of actions being taken to address these issues).
Oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;			Draft 2019 2020 Informatics operational plan presented to committee detailing approval and scrutiny routes.
Oversee the direction and delivery of the Health Board's informatics and information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation through the use of information and technology;			Routes consistent with requirements. Final plans required following budgetary agreements.
Consider the information governance and informatics implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners;			Corporate risks covering National IT systems, local IT services and Health records identified
Consider the information governance and informatics implications for the Health Board of internal and external reviews and reports;			Reported in Quarterly Assurance reports.
Oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation			

(e.g. General Data Protection Regulation).			
The Committee will, in respect of its assurance role, seek assurances that information governance and the informatics (including patient records) arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of the Health Board's activities.			A number of issues such as backlog of coding, inadequate facilities to store records and increased demands from national blood enquiry. Quarterly assurance report designed. Iterative development anticipated over the following two quarters to meet committee requirements.
To achieve this, the Committee's programme of work will be designed to ensure that, in relation to information governance, informatics and patient records:			
▪ there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;			
▪ there is a citizen centred approach, striking an appropriate balance between openness and confidentiality in the management and use of information and technology;			
▪ the handling and use of information and information systems across the organisation is consistent, and based upon agreed standards;			Change control policy defined.
▪ there is effective communication, engagement and the workforce is appropriately trained, supported and responsive to requirements in relation to the effective handling and use of information (including IT			Some concerns regarding system owners

Systems) – consistent with the interests of patients and the public;			
▪ there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);			
▪ the integrity of information is protected, ensuring valid, accurate, complete and timely information is available to support decision making across the organisation;			Limited assurance to date as evidence based upon limited number of meetings/reports. KPI's require development.
▪ the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott, Information Security, Records Management, Information Sharing, national Information Governance policies and Information Commissioner's Office Guidance;			
▪ The Health Board is safeguarding its information, technology and networks through monitoring compliance with the Security of Network and Information Systems regulations and relevant standards;			Via Quarterly Assurance report.
▪ all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the safety, security and use of information, and in particular that:) Sources of internal assurance are reliable, and have the capacity			Via Quarterly Assurance report.

and capability to deliver; • Recommendations made by internal and external reviewers are considered and acted upon on a timely basis; • Lessons are learned from breaches in the safe, secure and effective use of information, as identified for example through reported incidents, complaints and claims; and • Training needs are assessed and met.			
• receive assurance on the delivery of the informatics and information governance operational plans including performance against the annual Informatics Capital Programme;			Via year end report, progress against operational plan reports.
• seek assurance on the effectiveness and impact of the Health Board's Digital Transformation Plans;			Consistent under investment in IT restricts ability to implement transformation plans. Assurance via year end report, operational plan updates and corporate risks.
• seek assurance on the performance and delivery of the rollout of the core national IT systems which could have significant impact on the Health Board's operational services and escalate to the Board as appropriate.			Delays and barriers related to NWIS and national system programmes having a significant detrimental impact on health board performance.
The Committee will receive assurance on compliance with key performance indicators in relation to the quality and effectiveness of information and information systems against which the Health Board's performance will be			

regularly assessed.			
Maintain oversight of the effectiveness of the relationships and governance arrangements with partner organisations in relation to informatics and information governance. This will include NHS Wales Informatics Service (NWIS).			Perception that NWIS not working to support our priorities

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

Standing Items

- Informatics Operational Plan quarterly performance and update
- Review and approval of Informatics Operational Plan 2019/20

Regular Items

- Digital Transformation Group Chair's Assurance report
- Digital Strategy Development update
- Information Governance Group Chair's Assurance report incorporating quarterly KPI and compliance report
- Information Governance Summary KPI Summary quarterly report

Ad-Hoc

- Update in national response to Wales Audit Office Informatics report
- All Wales Information Governance Policy approvals for use by BCUHB :
  - Information Governance Policy
  - Email Use Policy
  - Internet Use Policy
  - Information Security Policy

Governance Items

- Review of minutes and actions
- Approval of Committee terms of reference
- Approval of Cycle of Business
- Agreement and review of corporate risks assigned to the Committee
- Endorsed Information Governance annual report 2017/18

InCommittee items

- Outline Business Case for delivering an Acute Digital Health Record

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following link:-
http://www.wales.nhs.uk/sitesplus/861/page/97583

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

Meeting Date	Key risks including mitigating actions and milestones
13.11.18	In respect of risk and the potential actions and mitigation costs outlined in supporting the Telepath system and the Committee's concern regarding escalation, the Board Secretary clarified the governance system in place. BCU's position on the Electronic Patient Record was discussed and concern raised regarding progress and whether the risks were adequately monitored Concerns with the performance of national systems were highlighted in the WAO Informatics report and the PAC report
14.2.19	The Committee requested further work to clarify the assigned corporate risks and to strengthen the sources of assurance. Of particular concern are the delays, functionality and prioritisation of National systems and programmes. The Committee raised a general point regarding the accurate completion of coversheets and that where risks or concerns were included within the accompanying narrative paper, these should also be highlighted on the coversheet. This had been brought to the attention of the Board Secretary. The Committee were concerned that models for integrating services would be at risk if national developments were not delivered. The progress with the CHAI (a mobile nursing application within paediatrics) remained of concern.

9. Focus for the year ahead:

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

Key areas of review in the coming year will include:

- Monitoring of revised corporate risk actions and controls.
- Scrutiny of the outcomes from the Welsh Government Informatics and Governance and National Architecture Reviews to ensure they support and are reflected in local plans, strategies and business cases.

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

***Key:*

Red	*= not on target to achieve all actions, and may not achieve these actions by the next quarter*

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

V1.0

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

INFORMATION GOVERNANCE AND INFORMATICS COMMITTEE

1. INTRODUCTION

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

2. PURPOSE

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

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

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

3. DELEGATED POWERS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott, Information Security, Records Management, Information Sharing, national Information Governance policies and Information Commissioner's Office Guidance;

- The Health Board is safeguarding its information, technology and networks

through monitoring compliance with the Security of Network and Information Systems regulations and relevant standards;

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

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

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

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

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

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

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

4. AUTHORITY

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

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

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

4.2 May obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it

considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

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

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

5. SUB-COMMITTEES

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

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board

6.2 In Attendance

Executive Medical Director (lead director)
Chief Information Officer, Informatics
Board Secretary/ Senior Information Risk Owner (SIRO)
Caldicott Guardian
Assistant Director Information Governance & Assurance/ Data Protection Officer (DPO)

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

6.3 Member Appointments

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

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

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

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

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

7. COMMITTEE MEETINGS

7.1 Quorum

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

7.2 Frequency of Meetings

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

7.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

8.3.2 sharing of information

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

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

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

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

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

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

11. REVIEW

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

Date of approval by the Board 6.9.18
Reported to Committee
V1.0

INFORMATION GOVERNANCE & INFORMATICS COMMITTEE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER 2019/20 v1.0 draft last updated 18/07/2019 14:19

Part 1 – Annual Recurring Business

Agenda Items	Notes	May	Aug	Nov	Feb
Apologies	Standard Committee item	x	x	x	x
Declarations of Interest	Standard Committee item	x	x	x	x
Draft minutes of previous meeting, matters arising and review of Summary Action Plan	Standard Committee item	x	x	x	x
Governance matters					
Committee Annual Report (including annual review of ToR and cycle of business)	Submission to May Audit Committee prior to Board	x			
Terms of Reference review	Annual review			x	
Review of Corporate Risks allocated to the Committee	ToR 4.4	x		x	
Policies (compliance with national policy and development of organisational policy) – *as arise*	ToR	x	x	x	x
Periodic updates on Limited Assurance Audit reports	Per Audit Committee				
Informatics					
Digital Strategy – annual review	ToR 3.1.1			x	
Approval of Informatics – Operational Plan	ToR 3.1.2/10				x
Quarterly Update on Informatics Operational Plan					
Informatics Operational plan – quarterly update To include • updates against agreed plans • Capital expenditure and Revenue expenditure		x	x	x	x

INFORMATION GOVERNANCE & INFORMATICS COMMITTEE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER 2019/20 v1.0 draft last updated 18/07/2019 14:19

Agenda Items	Notes	May	Aug	Nov	Feb
Quarterly Assurance report - National Audit responses / progress updates on recommendations - Compliance against relevant regulations - Digital Transformation Group update (not minutes) - monitoring of existing national and local IT systems - updates on downtime and stability of systems and impact - Information security		x	x	x	x
System Demonstrations (ad hoc as relevant)					
(as appropriate for escalation)					
Partner organisation arrangements – other partners to be identified	ToR 3.5				
NWIS update report NWIS Director in attendance		x	x	x	x
Information Governance					
Information Governance Strategy – annual review	ToR 3.1.1			x	
Information Governance Assurance quarterly report (KPI and compliance report) To include: - Emerging Risks • FOI requests and compliance • DPA SAR requests and compliance • Access to Health Records requests and	ToR	x	x	x	x

INFORMATION GOVERNANCE & INFORMATICS COMMITTEE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER 2019/20 v1.0 draft last updated 18/07/2019 14:19

Agenda Items	Notes	May	Aug	Nov	Feb
compliance • IG Incidents reported and lessons learnt • IG Training compliance • IG Helpdesk support calls and actions • NIIAS reporting and compliance • Communication / compliance audits and findings • Sharing of information/WASPI • Data Protection Impact Assessments - Patient records - Issues of Significance from IGG					
Information Governance Annual Report	ToR 3.1.2 /10		x		
Toolkit Progress Report	Transfer from F&P				
Caldicott	ToR 3.3.5				
Health Records					
Corporate Records Management Project Update Report	Transfer from F&P				
Health Care Records (including Annual Report)					

INFORMATION GOVERNANCE & INFORMATICS COMMITTEE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER 2019/20 v1.0 draft last updated 18/07/2019 14:19

Agenda Items	Notes	May	Aug	Nov	Feb
To be determined:					
Data Protection (including General Data Protection Regulations)	ToR				
Integrated Quality Performance Review – relevant dimensions	ToR 3.4				
Implications of internal and external reviews and reports	ToR				
Strategy / plan development (eg; handling of PPI)	ToR				
Lessons learned from information breaches	ToR 3.4				
National Infected Blood Inquiry update	per Nov 2018 Board paper recommendation				
Closing Business (standing items)					
Summary of InCommittee business to be reported in public (if applicable)	Standard Committee item	x	x	x	x
Issues of significance to inform Chair assurance report	Standard Committee item	x	x	x	x
Date of next meeting	Standard Committee item	x	x	x	x
Exclusion of press and public (if applicable)	Standard Committee item	x	x	x	x
InCommittee Business (if applicable)					
Draft minutes of previous InCommittee meeting, matters arising and summary action plan	Standard Committee item	x	x	x	x

INFORMATION GOVERNANCE & INFORMATICS COMMITTEE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER 2019/20 v1.0 draft last updated 18/07/2019 14:19

Part 2 Rolling Plan of Ad-Hoc Business

	ITEM	FROM	NOTES
May 2019			
	Change management Policy	Sharon Smith *Informatics*	Email notification 25.2.19
August 2019			
November 2019			
February 2020			

Meeting date	Submission deadline for paper review/quality assurance	Publication date
9.5.19	26.4.19	2.5.19
15.8.19	5.8.19	8.8.19
21.11.19	11.11.19	14.11.19
13.2.20	3.2.20	6.2.20

Audit Committee
30.5.19

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

To improve health and provide excellent care

Title:	**Wales Audit Office Reports**
Author:	Andrew Doughton, Wales Audit Office
Responsible Director:	Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Purpose of the report:	The documents for audit committee include the regular audit update alongside reports finalised since the last audit committee which includes the Clinical Coding follow up report, together with a paper for committee information only (questions for board members to ask on discharge planning).
Approval / Scrutiny Route	Local reports are cleared through formal audit clearance processes with representatives of the Executive Team. National report clearance processes are agreed with the appointed national key contact for the work.
Governance issues and risks	*Specific risks, issues and recommendations are identified in the report.*
Financial Implications	Not applicable.
Recommendation:	The Audit Committee is requested to: • Note the content of the audit progress update. • Receive and discuss the Clinical Coding Follow up report • Note the paper which is provided for information purposes on discharge planning.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√

5.To improve the safety and quality of all services		5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper • Governance			
Equality Impact Assessment Not applicable			

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit Committee Update – **Betsi Cadwaladr University Health Board**

Date issued: May 2019

Contents

About this document

1 This document provides the Audit Committee of Betsi Cadwaladr University Local Health Board (the Health Board) with an update on current and planned Wales Audit Office work.

2 Financial and performance audit work is covered and information is also provided on the Auditor General's programme of national value-for-money examinations.

Financial audit update

3 The 2018-19 financial audit work on the Board's financial statements is largely complete, the results of which will be presented to the Audit Committee in a separate report. We have largely completed the planning work for the audit of the Charitable Funds accounts and we anticipate completing the remaining work in August, in time for the Charitable Funds Committee in September.

4 The planned key outputs and milestones from financial audit outputs and milestones are summarised in Exhibit 1 below.

Exhibit 1: Delivering the 2018-19 financial audit work

Planned Output	Planned Start Date	Planned Reporting Date	Report Finalised
Audit Plan	January 2019	March 2019	March 2019
Audit of Financial Statements report	May 2019	May 2019	May 2019
Opinion on the Financial Statements	May 2019	June 2019	
Whole of Government Accounts submission	May 2019	June 2019	
Audit of Charitable Funds Financial Statements report	July 2019	September 2019	
Opinion on the Charitable Funds Financial Statements	September 2019	September 2019	

Source: Wales Audit Office

Performance audit update

5 Exhibit 2 below provides members of the Audit Committee with a brief overview of the performance audit work reported to the Health Board in the last six months.

Exhibit 2: Performance audit update

Work completed in last six months (links to the report, where available, are in red)				
Topic	**Key findings**	**Date finalised**	**Executive Lead**	**Received at Audit Committee/ other**
Cross-cutting review	Our work found that whilst the Integrated Care Fund is having some positive impacts, there are also a number of challenges that the Regional Partnership Board needs to manage. Findings include: • the fund has had a positive impact although it is unclear whether partnership working would continue if the fund ceased to exist; • the fund has not always been used strategically to develop services based on need; and • there is general agreement that the fund is supporting the right projects but very few projects are being mainstreamed into core services.	Fieldwork complete and locally reported. National report June 2019		Regional partnership leadership group (October 2018) and Regional Partnership Board (November 2018)
Clinical coding follow-up	We reviewed the progress made in responding to the recommendations set out in the 2014 review of clinical coding arrangements. Our work found that the Health Board has improved its coding performance significantly, but has not yet realised the full potential of clinical coding and more work is needed to engage with clinicians and improve medical record.	Final report	Evan Moore	May 2019

Ongoing work and work due to start in 2019				
Topic	**Focus of the work**	**Status**	**Executive Lead**	**Expected date of final report**
Orthopaedic Services follow-up	This work will examine the progress made in orthopaedic services since our 2015 all-Wales review. This will assess whether recommendations and areas we identified for improvement have been effectively responded to and to determine whether health boards are developing arrangements to help manage the demand on, and supply of, orthopaedic services.	Terms of reference issued	Evan Moore	September 2019
Operating theatres – follow-up (Local work)	We will undertake a follow-up review of our previous reports on operating theatres, with an increased focus on economy and efficiency of services. We will consider the developments made by the Health Board since our previous reviews, opportunities for further improvement and identify barriers that may affect progress.	Drafting report	Gill Harris	July 2019
Review of legacy systems and infrastructure (Local work)	This work will focus on risks and opportunities for improvement in relation to old, out-of-date, unsupported, or difficult to support: • hardware infrastructure; and • operational and clinical systems (software licensing and support).	Fieldwork ongoing	Evan Moore	July 2019
Structured Assessment	We will assess progress that is being made in embedding sound arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management.	Not yet started	Gary Doherty	October 2019

Ongoing work and work due to start in 2019				
Topic	**Focus of the work**	**Status**	**Executive Lead**	**Expected date of final report**
Quality Governance arrangements	As an extension of the structured assessment work, we will undertake a specific review of quality governance arrangements and how these underpin the work of quality and safety committees. This will include examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting.	Not yet started	Gill Harris	November 2019
Well Being of Future Generations (Wales) Act 2015	The work will consider the Health Board's overall corporate approach to applying the 'Sustainable Development Principle' and 'Five Ways of Working'. We will seek to examine one of the Health Board's well-being objectives in more detail, reviewing the steps that have been taken to achieve that objective. This work will inform will inform the report that the Auditor General must prepare for the National Assembly by May 2020.	Fieldwork ongoing	Mark Wilkinson	August 2019
Local audit reviews	We will undertake thematic performance audit work that reflects issues specific to the Health Board. This will be agreed following completion of local audit planning.	TBC	TBC	TBC

Source: Wales Audit Office

Other Auditor General studies

The Audit Committee may also be interested in the following studies/planned outputs. Where the work is completed and reported, these are highlighted in red, and include a link to the report.

Exhibit 3: Other Auditor General Studies and reports

Recent publications / planned publications	
Topic	**Update**
Preparations in Wales for a 'no deal' Brexit – February 2019	The Auditor General found that public bodies are developing new structures for managing the consequences of Brexit alongside long-standing arrangements. Overall, most public bodies across Wales are clearly taking their 'no-deal' Brexit planning seriously. Many have significantly ramped up their activity since summer 2018, when a 'no-deal' outcome started looking more possible. Public services reported a lack of capacity to manage Brexit, which is also having a significant knock-on impact on other service areas. Most are absorbing Brexit preparations within, or on top of, their day jobs. In the NHS, our wider audit work has identified ongoing concerns about management capacity in relation to transforming services. This same cadre of management staff is being called on to prepare for and manage the implications of a 'no-deal' Brexit. Most bodies reported to us that their work on Brexit was having an adverse impact on other areas. Across NHS Wales, individual organisations have been helped in understanding their exposure to risks and possible opportunities by work by Public Health Wales and through work on supply chains related to medical devices and clinical consumables carried out by Deloitte. The NHS is putting place detailed plans, working with UK partners, to manage those risks it has identified.
What's the hold up? Discharging patients in Wales – Questions for Board members	The Auditor General and others have focused on this challenge in a range of work with local NHS bodies and community organisations. The Auditor General's audit work was done during 2017, with further work on the Integrated Care Fund (ICF) carried out during 2018. This document complements our formal audit reports and highlights important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways.

Good Practice Exchange

6 The Good Practice Exchange (GPX) helps public services improve by sharing knowledge and practices that work. We run events where people can exchange knowledge face to face and share resources online.

7 Details of past and forthcoming events, shared learning seminars and webinars can be found on the GPX page on the Wales Audit Office's website. The table below lists recent and forthcoming events.

Exhibit 4: Good Practice Exchange

Recent and forthcoming events
Recent events
Working in partnership to combat fraud – An opportunity for Welsh public services to learn about recent development in relation to combatting fraud. 16th May 2019 - Glasdir Rural Development Centre, Llanrwst.
Forthcoming events
Key issues for regional partnership boards - These webinars will highlight solutions to issues relating to fund implementation and ways of working: • Fund implementation - 13 Jun 2019 - 6:00pm - 8:00pm • Ways of working - 20 Jun 2019 - 6:00pm - 8:00pm
Innovative approaches to public services in rural communities - This seminar will share innovative approaches to help understand how public services can meet the needs of rural communities in Wales. The seminar is framed around the 7 Well-being goals of the WFG Act and is aimed at all public services in Wales. The ideas and approaches shared at this seminar can be adapted to suit a wide range of services. 18 July 2019 - Glasdir, Plas Yn Dre, Llanrwst, Conwy, LL26 0DF

8 Diary markers and details of new events are circulated in advance to the Health Board, together with information on booking delegate places. Further information on any of our past or planned GPX events can be obtained by contacting the local audit team or emailing good.practice@audit.wales.

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WALES AUDIT OFFICE
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Auditor General for Wales

Clinical coding follow-up review – **Betsi Cadwaladr University Health Board**

Audit year: 2018

Date issued: May 2019

Document reference: 1181A2019-20

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. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at info.officer@audit.wales.

The person who delivered the work was Sara Utley.

Contents

The Health Board has improved its coding performance significantly, but has not yet realised the full potential of clinical coding and more work is needed to engage with clinicians and improve medical records

Summary report

Introduction

1 Clinical coding involves the translation of written clinical information (such as a patient's diagnosis and treatment) into a code format. A clinical coder will analyse information about an episode of patient care and assign internationally recognised standardised codes[1].

2 Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used in many different systems and presented in different formats. It can be used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

3 Coding departments within Welsh NHS bodies are required to satisfy standards set by the Welsh Government on completeness and accuracy of coded data. Performance against these standards form part of NHS bodies' annual data quality and information governance reporting.

4 During 2014-15 the Auditor General reviewed the clinical coding arrangements in all relevant NHS bodies in Wales. That work pointed to several areas for improvement such as the accuracy of coding, the quality of medical records and engagement between coders, clinicians and medical records staff.

5 We also found that NHS bodies routinely saw clinical coding as a back-office role, often with little recognition of the specialist staff knowledge and understanding needed. In addition, not all NHS bodies understood the importance of clinical coding to their day to day business.

6 In October 2014 we reported our findings for Betsi Cadwaladr University Health Board (the Health Board). The report concluded that 'whilst there had been a positive investment and focus on clinical coding within the Health Board, a lack of consistent coding processes, low clinical engagement and slow access to medical records could potentially affect the accuracy of clinical coded data'. More specifically we found that:

- although the Health Board recognised the importance of clinical coding, resources were insufficient and stronger links were needed to medical records and the board needed to focus more on the accuracy of clinical coded data in its reviews;
- the effectiveness of the coding process was being affected by low levels of clinical engagement, slow access to medical records and a lack of consistent coding processes; and

[1] For diagnoses, the International Classification of Diseases 10th edition (ICD-10), and for treatment, the OPCS Classification of Interventions and Procedures version 4 (OPCS)

- clinical coded data was used appropriately with good overall performance against Welsh Government standards, but there were areas for improvements related to consistency, standards and accuracy.

7 We made a number of recommendations, which focused on:

- raising the profile and awareness of clinical coding across the Health Board;
- developing a single coding policy and procedure to ensure consistent practices and processes;
- strengthening clinical engagement with medical staff; and
- improving the quality of medical records across the Health Board.

8 As part of the of the Auditor General's 2018 audit plan at Betsi Cadwaladr University Health Board, we have examined the progress made in addressing the recommendations set out in the 2014 Review of Clinical Coding and any resulting improvement in clinical coding performance.

9 In undertaking this work, we have:

- reviewed documentation, including reports to the board and committees;
- asked the Health Board to self-assess its progress so far;
- analysed clinical coding data sent to the Welsh Government;
- sought board member views[2] on their understanding of clinical coding; and
- interviewed staff to discuss progress, current issues and future challenges.

10 We summarise our findings in the following section. Appendix 1 provides specific commentary on progress against each of our previous recommendations.

Our findings

11 We conclude that the **Health Board has improved its coding performance significantly, but has not yet realised the full potential of clinical coding and more work is needed to engage with clinicians and improve medical records.**

The Health Board's clinical coding performance has improved significantly but is not yet above the Welsh Government target

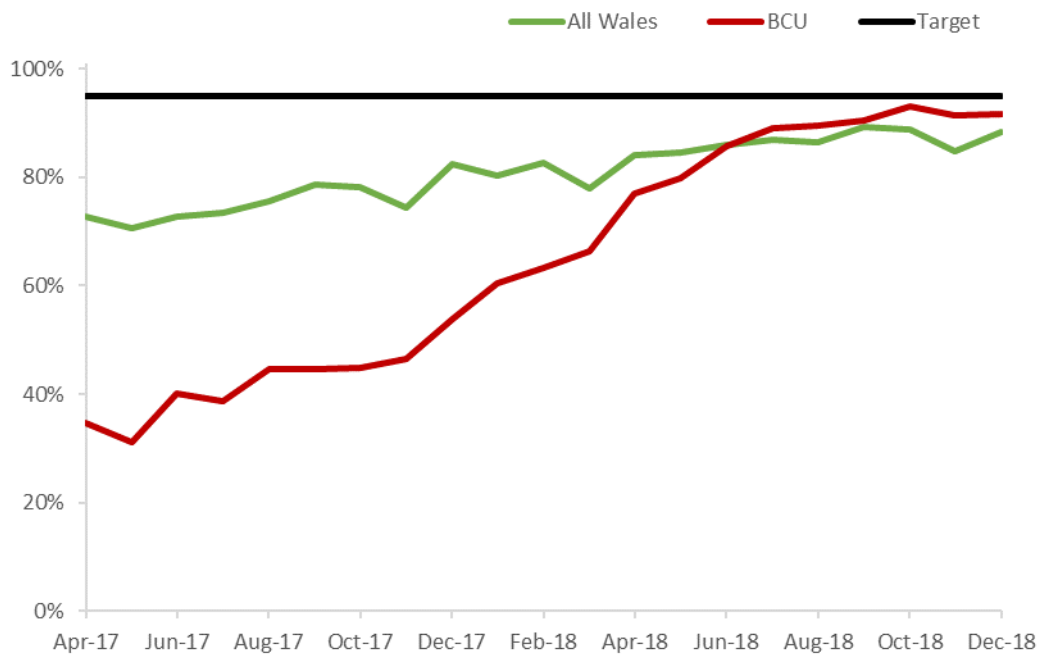
12 The Welsh Government has two coding related Tier 1 targets which NHS bodies are required to meet. These relate to completeness and accuracy.

13 Each year, NHS bodies send data to the Welsh Government showing their performance against the Tier 1 target for **completeness**. The target is that 95% of hospital episodes should have been coded within one month of the episode end date. NHS bodies need to meet this target monthly rather than at the end of each

[2] A number of questions relating to clinical coding were included in the board member survey which formed part of our 2018 Structured Assessment work. A total of eight responses out of a possible 22 responses were received.

financial year which was previously the case. Based on this data, Exhibit 1 shows that the Health Board's completeness has improved considerably over the past year and a half. However, they are yet to meet the Welsh Government target.

Exhibit 1: percentage coded within one month of the episode end date



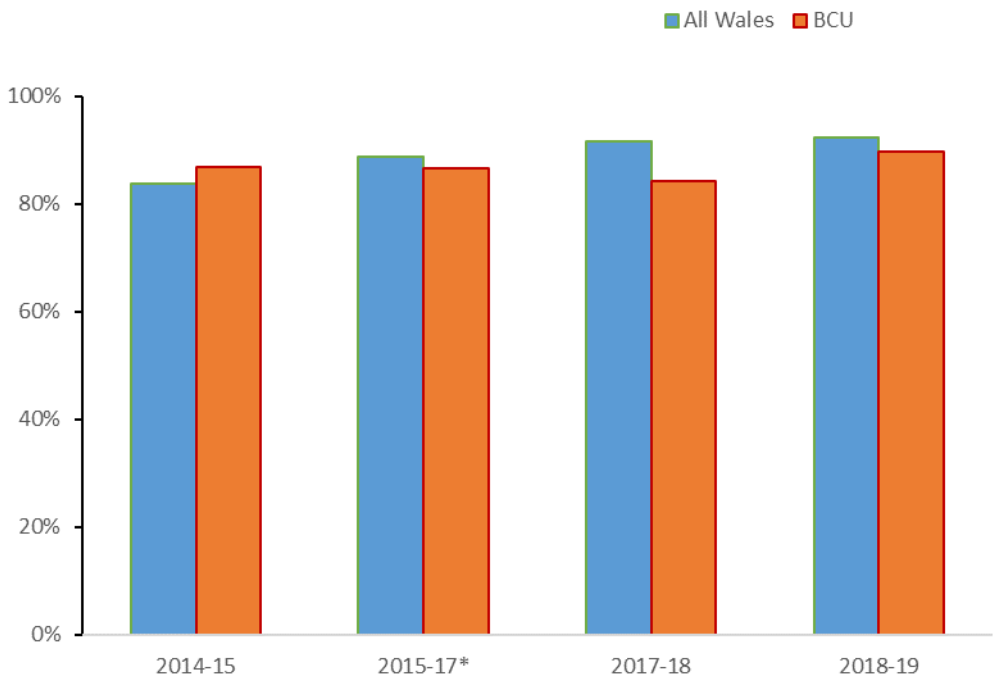
Source: Wales Audit Office analysis of clinical coding data reported by health bodies to the Welsh Government

14 As part of our fieldwork, we requested the year-end backlog position as at March 2018. The position at the end of 2017-18 was a backlog of 23,119 finished consultant episodes (FCE's) which was a considerable improvement on the previous year end position in 2016-17 of 70,000 FCEs. Work to address this backlog has been considerable and the team must be congratulated on their work to date in bringing the backlog down. However, this has meant that progress has not been made in other areas such as developing standard coding operating procedures and undertaking routine accuracy reviews due to pressures on staff capacity.

15 Each year, the NHS Wales Informatics Service (NWIS) Standards Team check the **accuracy** of clinical coding. They do this by reviewing a sample of coded episodes and checking the information against evidence within the patients' medical record to assess accuracy. NHS bodies are expected to show an annual improvement in their accuracy. Based on this review, Exhibit 2 shows that the Health Board's

accuracy has improved by 5.45% in their latest assessment. This is a positive result for the coding teams, especially against a background of significant backlog which has taken up considerable resources and time for the team to address. Accuracy levels however still fall short of the all-Wales comparison.

Exhibit 2: percentage of episodes coded accurately



Source: results of NWIS clinical coding accuracy reviews 2014-2019

* Note that due to capacity within the NWIS clinical coding team, a single accuracy review was undertaken during the period 2015-16 and 2016-17.

The Health Board has not yet started to use clinical coded data to its full potential to support improvement

16 Previously we found that not all NHS bodies understood the wider importance of clinical coding to their business and they were missing opportunities to use this information more extensively. For example, to plan and monitor services, where coding can be used to:

- assess volumes of patients following particular clinical pathways; and

- provide comparative activity data to evaluate productivity, quality and performance.

17 The coding portfolio remains with the office of the Medical Director reporting through the Informatics Department. Day-to-day management is by the Head of Clinical Coding who reports to the Head of Information who in turn reports to the Assistant Director of Informatics. Previously performance against the two key coding indictors; completeness and accuracy, was through the quarterly Integrated Quality Performance and Workforce Report. This report highlighted the backlog issues, as well as detailing the trajectory and actions being taken to remove the backlog. However, the information stopped short of explaining the implications of this backlog on the quality of the data and impact to the Health Board. The last of these reports was in September 2018 where the completeness performance was at 80%. However, following work by the executive to rationalise the performance report to a more manageable size, the focus on coding has been lost. A new sub group of the Board has been established called the Information Governance and Informatics Committee and it would seem sensible for coding performance to be reported at this group to maintain oversight of performance in terms of completeness and accuracy.

18 The Health Board is using coded data to inform some elements of service planning. However, this usage is ad hoc and not maximising the full potential of coded data. Since our previous work, the Health Board has expanded the activity which is coded. Following a request from clinicians within the clinical decision unit, this activity is now coded to accurately reflect the nature of their work and inform job planning. Some work has also been undertaken in speciality areas such as Urology to understand prevalence of particular illnesses. However, the benefits of coded data to clinicians have not yet been realised. These include supporting medical revalidation and being able to identify trends in diseases or prevalence within the population.

Some progress on implementing a number of recommendations has been made, but addressing the coding backlog has meant that a lot of actions still need to be completed fully

19 Exhibit 3 summarises the status of our 2014 recommendations.

Exhibit 3: Status of our 2014 recommendations

Total number of recommendations	Implemented	In progress	Overdue	Superseded
15	3	12	0	

Source: Wales Audit Office

20 Our follow-up work has found that the Health Board has made some progress against our 2014 recommendations, although the scale of progress has been limited due to capacity issues within the team.

21 Following our previous review, the Health Board delivered training for Board members on Clinical Coding. Since this training there has been a turnaround of Board Members. Also, five out of eight respondents to our Board member survey stated that they would find it helpful to have more information on clinical coding and the extent to which it affects the quality of performance information. The full board survey results are available in Appendix 2. The Health Board may need to revisit this training.

22 The Health Board has a coding policy and work is being undertaken to develop standard operational procedures to support consistent coding practice across the Health Board. Although there has not been any progress on internal coding audits, there are a range of validation checks in place. These are not as comprehensive as a full review but will highlight common mistakes. There remain however some variations in coding practices.

23 Positively there has been significant increase in staff levels amongst the teams since our last review. In our previous review we highlighted that filling vacancies and developing successions plans were vital for maintaining stability within the team. Our follow up has found that there has been a 32% increase in overall staffing numbers. Arrangements for succession planning have improved and currently the clinical coding department have 18 trainee coders, who are being supported to study towards their Accredited Clinical Coder qualification. This has been supported by additional monies allocated through the Health Boards informatics plan where it had been recognised that there were cost pressures within coding, and the need to reduce risks posed by over reliance on temporary staff.

24 Clinical engagement remains an area of focus for the teams. Engagement with clinicians on coding has remained the same with only a handful of individual conversations being held with consultants being identified. The coding team feel issues with capacity because they have been focussed on clearing the backlog has affected their ability to undertake awareness raising and clinician engagement activities and hope to focus on this in future. There is scope to improve the Health Board's arrangements for medical staff induction on clinical coding. The materials being used could be updated to provide a more holistic overview of the coding arrangements within the Health Board. It is clear to see that materials have not been updated for some time and would benefit from being refreshed. A positive development within the Health Board is the Medical Information Officer. This is a new role which reports to the Chief Medical Information Officer. Each hospital has a Medical Information Officer in post. Their role is to support the Chief Medical Information Officer with the development of a clinically-oriented Digital Strategy for the Health Board. They also have a positive influence from a coding perspective as they will lead on improving clinical engagement with clinical coding, as well as

supporting in promoting the work of the clinical coding service and the need for good record keeping amongst peers.

25 Since our last review there is better engagement between health records and coding. Previously there were informal working relationships in place between the two departments, and there was no formal engagement on the Health Records Group. The Health Records Group has subsequently been renamed the Patient Record Group, and coding staff are now attending this group. The group is chaired by a consultant, and there are representatives from various areas of the Health Board. This includes the Head of Digital Records which is an important link for coding as they will be a key user of the digital systems implemented by the Health Board. However, although attendance at this group is positive, the group appear to meet infrequently, which raises concerns about its effectiveness.

26 Improvements have been made to casenote tracking with the Health Board investing in a Radio Frequency Identification (RFID) file tracking system to track casenotes through the main hospital sites. This helps support coders trying to locate notes quickly to code them as they are automatically tracked through a series of scanners. However, there are still issues with the quality of casenotes. The latest NWIS accuracy report advised that an immediate effort should be made to ensure that all staff within the Health Board who have any responsibility for clinical case notes are reminded of the need for good practice regarding their use. Through our focus groups the issue of poor condition of records was highlighted with an emphasis on the lack of focus on ensuring the notes for deceased patients are filed correctly to ensure a complete record. This is of concern as this could potentially affect the mortality review process.

Recommendations still outstanding

27 In undertaking this work, we have made some additional recommendations. These are set out in Exhibit 4. The Health Board also needs to continue to make progress in addressing our previous recommendations. The outstanding recommendations are set out in Exhibit 5.

Exhibit 4: new recommendations

2019 Recommendations	
Board Awareness	
R1	Ensure that performance on coding is reporting into the newly formed information governance informatics committee to ensure that monitoring performance against the Welsh Government target is maintained.
Clinical engagement	
R2	Revisit training materials and standardise across the Health Board, ensuring that the materials reflect the totality of the Health Boards coding not just site based.

28 The outstanding recommendations are set out in Exhibit 5.

Exhibit 5: recommendations still outstanding

2014 recommendations not yet complete
Clinical Coding Policy and Procedures R2 Introduce a single coding policy and procedure across the heath board which brings together all practices and processes to ensure consistency. The policy and procedure should include: a) ensuring coding practices are well described; b) providing guidance and feedback to staff to enable consistent practices across the health board; d) address variations in practices across the three sites; and e) strengthen internal coding audits.
Clinical Engagement R3 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the coding process is recognised. This should include: a) embedding a consistent approach to clinical coding training for medical staff across the health board; b) ensuring a consistent approach to medical staff induction across the health board; c) encourage the use of coding information for uses other than mortality statistics; and d) improve clinical engagement in the validation of coded data to drive improvements in quality and awareness of potential use of information.
Medical Records R4 Improve the arrangements surrounding medical records, to ensure that accurate and timely coding can take place. This should include quality of medical records across the Health Board. This should include: a) improving engagement between the clinical coding department and medical records; c) addressing the size of casenotes by clarifying roles and responsibilities; and d) ensuring the availability of training on the importance of good quality medical records to all staff.

Source: Wales Audit Office

Appendix 1

Health Board progress against our 2014 recommendations

Exhibit 5: Assessment of progress

Recommendation	Status	Target date for implementation	Summary of progress
Board Awareness R1 Improve Board reports to include detailed information on accuracy as well as comparative data:			
a. provide more information on accuracy of coding as well as backlogs and the effect this has on RAMI figures	**In progress**	December 2014	Following our review, the Health Board received reports on accuracy of coding at Board level through the Integrated Quality and Performance Report. These reports highlighted issues with a significant coding backlog which meant the Health Board were not meeting the Welsh Government target of coding 95% of episodes within one month of the episode end date. However, the information stopped short of explaining the implications of this backlog on the quality of the data and impact to the Health Board. The last of these reports was in September 2018 where performance was at 70.90%. Performance against the target has not been reported through a committee since this date. We recognise the recent establishment of the Information Governance and Informatics Committee and recommend that coding performance is reported at this group. We also previously recommended that the Board received more detail on coding and the impact on the Risk Adjusted Mortality Index (RAMI). In 2014 RAMI was removed as an indicator following the Palmer Review therefore this element of the recommendation is no longer relevant.

Recommendation	Status	Target date for implementation	Summary of progress
b. undertake training with board members on clinical coding to raise awareness of implications of clinical coding accuracy	**Completed**	December 2014	Following our original review all Board members received training in January 2016. However, since that time, there has been Independent Member turnover. The Health Board may wish to consider revisiting this training due to the new Independent Members within the Health Board. The results from our Board member survey show that five of the eight respondents through it would be helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information.
Clinical Coding Policy and Procedures R2 Introduce a single coding policy and procedure across the health board which brings together all practices and processes to ensure consistency. The policy and procedure should:			
a. ensure coding practices are well described	**In progress**	January 2015	At our last review we found that the Health Board did not have a clinical coding policy which covered all sites and activities. There were historical policies in place for Wrexham Maelor and Glan Clwyd, with no policy in place in Ysbyty Gwynedd. The Health Board recognised the need for a single policy to address potential inconsistencies in practice and to provide more clarity for staff as to what is expected of them. A single coding policy is now in place, however there is further work to be done to fully complete implementation of this. Through our interviews, awareness of the policy was low amongst coding staff. Additionally, there are some elements that need to be changed to reflect the changes in the Welsh Government targets. The coding manager is currently developing standard operational procedures (SOP) to support the clinical coding procedure. This is positive and will provide additional information to support the coding policy and should address inconsistencies as well as clearly identify the routine validation checks which have been introduced.

Recommendation	Status	Target date for implementation	Summary of progress
b. provide guidance and feedback to staff to enable consistent practices across the Health Board	**In progress**	January 2015	The Health Board uses the PDP process and at the time of our review, the coding department were near 100% compliance with only one member of staff waiting for their review. Arrangements are in place for routine validation checks and if issues are identified these are fed back to the individuals. However, there could be more consistency in feeding back issues to the whole team across sites.
c. ensure plans are put in place to fill current vacancies and ensure effective succession planning	**Completed**	January 2015	Vacancies and succession planning are not detailed within the policy; however, the team have a workforce plan for the department. Positively there has been a significant change in staffing numbers since we last did the review. Overall staffing levels are up by 32% and the coding manager feels they are fully staffed. This has been supported by additional monies allocated through the Health Board's informatics plan where it had been recognised that there were cost pressures within coding, and the need to reduce the risks posed by over reliance on temporary staff. Arrangements for succession planning have also been improved since 2014. During our last review a third of the staff within the department were aged 56 and over and likely to retire in the next five years. Currently the clinical coding department have 18 trainee coders, who are being supported to study towards their Accredited Clinical Coder national clinical coding qualification. This increase in staff will have provided stability for the department.

Recommendation	Status	Target date for implementation	Summary of progress
d. address variations in practices across the three sites	**In progress**	January 2015	Work is ongoing to address any variations in practices across sites, and the coding management team meet to discuss any issues highlighted through routine validation checks. However due to pressures of work local team meetings do not always happen, and opportunities for the coding team to get together as a whole group are difficult to organise. Currently standard operational procedures are being developed by the coding manager, and these should help remove any variations in coding practices by providing more detailed instructions. In our last review we found variations in policies between the three DGH sites relating to mental health and community hospital coding. At Ysbyty Gwynedd coders within the team were coding activity relating to mental health and community hospital, whereas in Wrexham Maelor coding staff did not code mental health but did code community provision. At Ysbyty Glan Clwyd, they did not code either mental health or community. Positively all mental health activity across the Health Board is now coded by the coding departments, following changes in April 2015. However, there are still differences in approach in relation to coding community activity as previously found. There are also still different systems within the Health Board. Coding is carried out using the Welsh Patient Administration System (PAS) and 3ms Clinical Encoder in Wrexham Maelor and Ysbyty Glan Clwyd, but the Patient Information Management System (PIMS) is still used in Ysbyty Gwynedd.

Recommendation	Status	Target date for implementation	Summary of progress
e. strengthen internal coding audits	**In Progress**	January 2015	In our last review we highlighted that ensuring the consistent application of coding rules across the Health Board was a challenge, and one recognised by the Head of Coding. We recommended that the Health Board strengthen their own internal coding audits. The Health Board has two accredited clinical coding auditors; however, their qualification has now lapsed. There are no plans in place to renew their qualifications although they are aware of the audit methodology. The Health Board places reliance on the external audit conducted by NWIS at each of the three sites every other year as part of the National Audit Programme. They note that additional external audit may be commissioned additionally if required. The results from the NWIS accuracy audits are positive, and the Health Board are showing improvements. The Health Board has recently recruited a staff member who can undertake audit work, however they were not employed for this purpose, so it is unclear if they will undertake this role going forward. The Health Board recognises this position but reflects that the coding audits are very time consuming. A range of validation checks have been put in place which automatically look for common coding errors. These are positive but would not give the depth of information a formal review back to casenotes would.

Recommendation		Status	Target date for implementation	Summary of progress
Clinical Engagement				
R3	Strengthen engagement with medical staff to ensure that the positive role that doctors have within the coding process is recognised:			
	a. embedding a consistent approach to clinical coding training for medical staff across the health board	**In Progress**	August 2014	There is a recognition from coding staff that this work will never be completed, and that clinical engagement remains an ongoing challenge. During our last review we found that clinical coding positively featured as part of the induction for junior doctors. These arrangements have continued, and coders continue to attend the junior doctors' inductions with the last ones being in September 2018. Further work in this area has been affected by capacity within the team. Although there is recognition by the team they want to do more.
	b. ensuring a consistent approach to medical staff induction across the health board	**In Progress**	January 2015	We noted in our previous report that there were different approaches to medical staff induction at different sites. This has continued. There is evidence of clinical engagement events being undertaken, such as meeting junior doctors in Wrexham Maelor and providing information on the importance of coding and data quality. However, the approaches remain inconsistent across the Health Board, and the presentation shared with us for this review could helpfully be updated as it appears not to have been reviewed for some time. The training slides do not give an overview of the Health Board coding function, which would be helpful.

Recommendation	Status	Target date for implementation	Summary of progress
c. encourage the use of coding information for uses other than mortality statistics	**In Progress**	January 2015	In our last review we highlighted the potential for the data produced through coding to be used for other purposes such as service transformation and planning. There have been some examples of this however its usage remains adhoc. Since our previous work, the Health Board has expanded the activity which is coded. Following a request from clinicians within the clinical decision unit, this activity is now coded to accurately reflect the nature of their work and inform job planning. Some work has also been undertaken in speciality areas such as Urology to understand prevalence of particular illnesses. One positive aspect that could improve this is the new Medical Information Officer roles which have been appointed across the organisation. This role supports the work of the Chief Medical Information Officer, and engagement with coding is part of their role with a responsibility for improving clinical engagement for clinical coding.
d. improve clinical engagement in the validation of coded data to drive improvements in quality and awareness of potential use of information	**In progress**	January 2015	The Health Board recognises the need to improve clinical engagement and the Coding Manager is confident that this can improve now they have tackled the coding backlog. The clinical coding department at Wrexham Maelor has run ten clinical engagement events over the past 12 months. Since our last review the staff at Ysbyty Gwynedd have moved to a larger space to place all the staff and the additional staff in one location. This is positive. However, the relocation of staff at Ysbyty Glan Clwyd to outside of the main hospital building is felt by the team to have impacted on their ability for the coding staff to engage with clinical staff.

Recommendation	Status	Target date for implementation	Summary of progress
			The role of the Medical Information Officer is also seen as a key enabler of this recommendation. From their role description there is a clear commitment for them to focus on improving clinical engagement with clinical coding and promoting the clinical coding services.
Medical Records R4 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include:			
a. improving engagement between the clinical coding department and medical records	**In Progress**	September 2014	Our last review highlighted there was no formal coding engagement on the Health Records Group. This has now been addressed. The group has changed name to the Patient Record Group and there is regular attendance from the Head of Coding or his deputy. A review of minutes for this group show good attendance and issues with casenotes being discussed. However, these meetings appear infrequent. A review of minutes for this group show good attendance and issues with casenotes being discussed. However, these meetings appear infrequent.
b. ensuring quicker access to records for coding staff	**Completed**	September 2015	Work has been undertaken to help ensure quicker access to medical records. Staff we spoke to as part of the focus group did not report any issues with accessing records. The Coding Manager is confident that any issues with access would be raised at the Health Records Group, however we are mindful that the meeting of this group is infrequent. Improvements have been made to casenote tracking with the Health Board investing in a Radio Frequency Identification (RFID) file tracking system to track casenotes through the main hospital sites. This helps support coders trying to locate notes quickly to code them as they are automatically tracked through a series of scanners.

Recommendation	Status	Target date for implementation	Summary of progress
c. addressing the size of casenotes by clarifying roles and responsibilities	**In progress**	Long Term Project	Issues with medical records remain. The medical records team have responsibility to setting up the record and ensuring that it is stored appropriately. However, the responsibility for filing information and the quality of information recorded in the medical records rest with other staff. One area in our last review was regarding results slips and this is a topic on the Health Records Group which they are trying to address. The Health Records department remain responsible for the policy entitled 'Health Records Management procedure'. The procedure outlines the definition of a health record as well as responsibilities. There are also standards of record keeping and good record keeping principles, which although are not the Royal College of Physicians standards, they are similar in their nature. There is no evidence of any additional work on casenotes to tackle their size. Staff within the focus groups at Wrexham Maelor and Ysbyty Glan Clwyd raised concerns around the poor quality of casenotes. As well as that, deceased patient records are not being filed correctly and there was not enough effort to ensure the files were a complete record.
d. ensuring the availability of training on the importance of good quality medical records to all staff	**In progress**	Long Term Project	There is a policy in place in relation to health records, and staff receive induction on this. Processes are in place for the Health Board to regularly audit records management systems, and as a minimum there must be an annual record keeping audit. Through mortality reviews, issues with record keeping are identified as well and fed back to staff. Arrangements are in place through the new Medical Information Officer role to support improvements in medical records. Part of the role description is to work with health records and promote the need for good record keeping.

Source: Wales Audit Office

Appendix 2

Results of the board member survey

Responses were received from eight of the board members in the Health Board. The breakdown of responses is set out below.

Exhibit 6: rate of satisfaction with aspects of coding

	How satisfied are you with the information you receive on the robustness of clinical coding arrangements in your organisation?		How satisfied are you that your organisation is doing enough to make sure that clinical coding arrangements are robust?	
	This Health Board	**All Wales**	**This Health Board**	**All Wales**
Completely satisfied	-	6	2	5
Satisfied	4	34	3	40
Neither satisfied nor dissatisfied	2	46	2	46
Dissatisfied	2	10	1	4
Completely dissatisfied	-	-	-	1
Total	**8**	**96**	**8**	**96**

Exhibit 7: rate of awareness of factors affecting the robustness of clinical coding

	How aware are you of the factors which can affect the robustness of clinical coding arrangements in your organisation?	
	This Health Board	**All Wales**
Full awareness	4	26
Some awareness	3	50
Limited awareness	1	17
No awareness	-	3
Total	**8**	**96**

Exhibit 8: level of concern and helpfulness of training

	Are you concerned that your organisation too readily attributes under performance against key indicators to problems with clinical coding?		Would you find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information?	
	This Health Board	**All Wales**	**This Health Board**	**All Wales**
Yes	2	8	5	77
No	6	84	3	19
Total	**8**	**92**	**8**	**96**

Exhibit 9: additional comments provided by respondents from the Health Board

- Have an understanding of the importance of coding but no real knowledge of the process and I believe more knowledge would improve my ability to gain assurance.
- There have been historical problems in coding, but it seems as though they are being tackled, partly by increasing the energy devoted to targeting coding problems.

Appendix 3

Management response

Exhibit 10: management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Board Awareness** Ensure that performance on coding is reporting into the newly formed information governance informatics committee to ensure that monitoring performance against the Welsh Government target is maintained.	To ensure that coding performance has a profile within the Health Board and performance against the Welsh Government targets is monitored.	Yes	Yes	In May 2019 the IGIC agenda items will include an Informatics Quarterly Assurance Report this report includes a summary of this audit and its action along with coding performance against Welsh Government targets. Coding completeness will be recorded quarterly via the mechanism.	Quarter 1 of 2019/20	Head of Clinical Coding
R2	**Clinical engagement** Revisit training materials and standardise across the Health Board, ensuring that the materials reflect the totality of	Ensure consistency of training across the Health Board and also to raise awareness of the	Yes	Yes	Clinical Coding training materials are currently being updated to assist with engagement and	Quarter 1 of 2019/20	Head of Clinical Coding

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	the Health Boards coding not just site based.	benefits and opportunities of coded data to clinicians			knowledge, once completed these will be released as part of a wider engagement strategy.		

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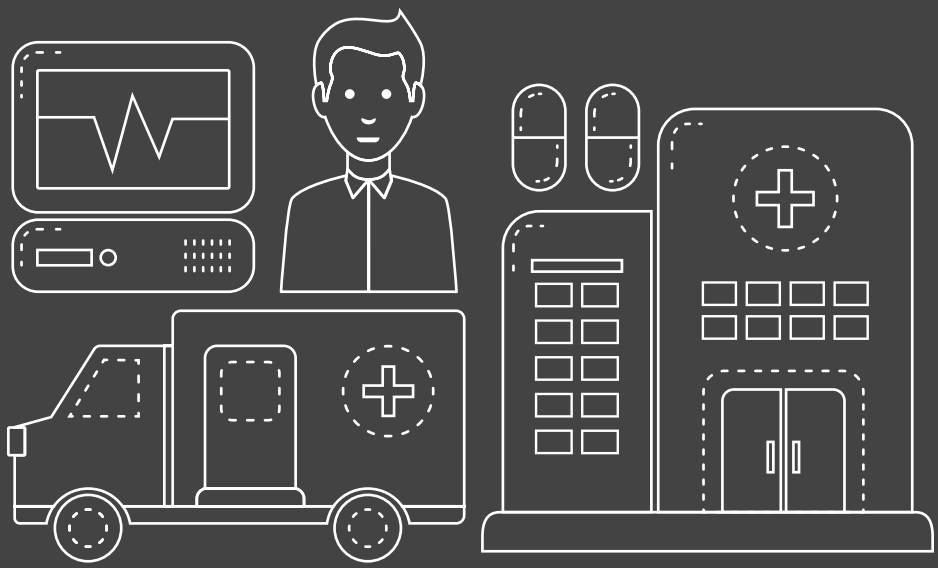
What's the hold up?

Discharging patients in Wales

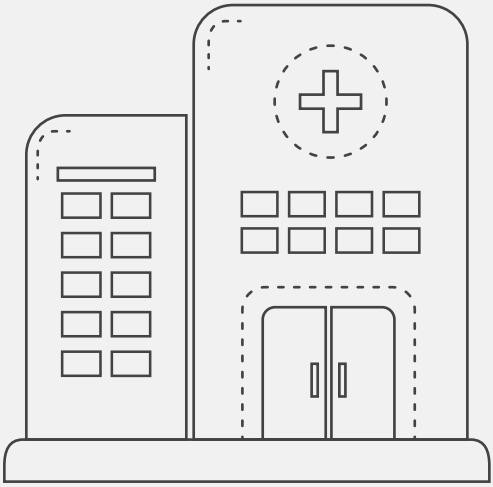


Background

One of the biggest challenges facing NHS bodies in Wales is the problem known as delayed transfer of care. This is when a patient does not need to be in that hospital any longer, but something is preventing them from moving on. When patients are not discharged from hospital promptly, the whole healthcare system 'backs up' as hospital capacity fills up and it gets harder to admit people who need hospital treatment. Clearly it is not good for the patient either – making it harder for them to regain their independence.

The Auditor General and others have focused on this challenge in a range of work with local NHS bodies and community organisations. The Auditor General's audit work was done during 2017, with further work on the Integrated Care Fund (ICF) carried out during 2018. This document complements our formal audit reports and highlights important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways.

The findings from our discharge planning audits at health boards and Velindre NHS Trust are available on the Wales Audit Office website.

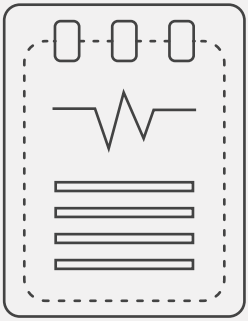


How NHS bodies and their partners are doing

Planning to discharge people from hospital is a theme in many delivery plans and strategies, not least winter plans. The sheer number of synergies and alignments needed for this planning creates problems of overcomplexity.

NHS bodies told us that across Wales, a shortage of home carers, a shortage of care home beds for people with dementia, and limited capacity across community reablement services are major factors in causing delays. Healthcare professionals need to work with others to find and plan solutions that meet peoples' needs on discharge and ensure the best recovery possible.

There have been many initiatives to improve discharge arrangements, such as the SAFER patient flow bundle, 'red2green',[1] 'end PJ paralysis'[2] and last 1000 days[3]. The Welsh Government has also created funding to foster greater collaboration between health, social care, housing and the third sector. For example, the ICF gives relatively short-term funding to initiatives to make sure only people who really need to be in hospital are there. During 2019, the Auditor General intends to publish a report on how this fund is being used by public bodies across Wales.



1 'red2green' is a visual system to identify wasted time in a patient's journey; patients on the red list no longer benefit from being in an acute hospital bed while those on the green list are still benefitting from their admission.

2 'End PJ Paralysis aims to get patients up and about and out of their pyjamas as soon as they are able to improve recovery and prevent complications.

3 The last 1000 days is a concept that reinforces the value of patients' time as the most important currency in healthcare and to create a sense of urgency to act.

Questions for board members on working with partners

- Does the Board receive information about the effectiveness of partnership working to support discharge planning arrangements and improve patient outcomes?
- Is the organisation evaluating what difference ICF funded initiatives have made in facilitating safe and timely discharge?
- Has the organisation mainstreamed successful ICF funded initiatives that support discharge planning?
- Is the organisation evaluating the impact of initiatives, such as the SAFER patient flow bundle, red2green, end PJ paralysis or last 1000 days, on patient flow and patient outcomes?

Encouragingly, we found relatively clear lines of accountability, and regular scrutiny of discharge planning performance. A range of information is generally available to support timely scrutiny and board members feel well informed. It is clear then, that leaders of Welsh NHS bodies generally understand the importance of effective discharge arrangements.

However, delayed transfers of care are the only national measure of discharge. They are regularly monitored, reported and scrutinised by health and local government bodies. Hospital IT systems can capture a range of data to support monitoring and reporting but, fewer than half of Welsh NHS bodies recorded whether a discharge was simple or complex while only a third recorded the date a patient was declared medically fit for discharge.

Questions for board members on information relating to discharge

- Is the organisation's patient information system supporting the accurate recording of data for monitoring and reporting on operational performance related to discharge planning?
- Is the organisation developing and implementing operational performance metrics and outcome measures to monitor the effectiveness of discharge planning arrangements, for example:
  - the number of patients discharged before midday;
  - the number of patients whose expected date of discharge is recorded;
  - the date patients are medically fit for discharge;
  - whether the discharge is simple or complex;
  - the number of readmissions avoided because of good discharge planning;
  - the number of patients who do not need longer term support;
  - the number of permanent placements in residential care settings avoided?
- Is the organisation regularly collating and reporting on patients' experience of being discharged from hospital?
- Is discharge planning performance, other than delayed transfers of care, regularly reported to the Board or its committees?

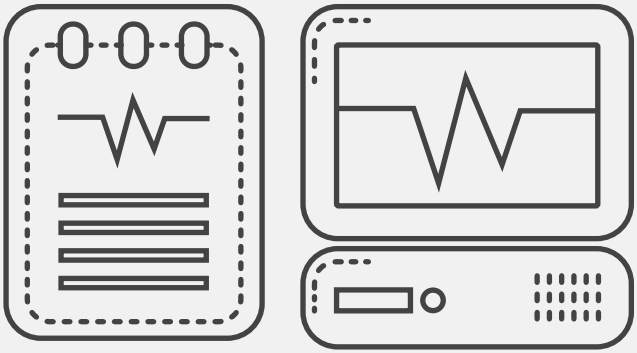
Steps towards improvement

Defined discharge pathways set out steps that healthcare professionals should take when discharging different types of patients. They can be very helpful. Most Welsh NHS bodies had set out some of these pathways, but they varied widely in approach and were not used consistently.

The Welsh Government is encouraging a new model where going home is the default pathway given most patients benefit from assessment in their normal place of residence with the ability to cope in familiar surroundings. The 'home first: discharge to recover and assess' pathway means patients are discharged home once they are medically fit and no longer need a hospital bed. Patients' immediate support needs will have been assessed prior to discharge and the necessary arrangements put in place. Ongoing assessment of patients' support needs can be safely continued at home by members of the appropriate community health and social care team. The approach means patients are not kept in a hospital bed longer than is necessary. We found that just four out of eight NHS bodies were using this model at all or some hospitals. The challenge is enabling community services to respond as soon as patients are discharged and making the discharge to recover and assess approach standard practice.

Questions for board members on pathways to support better discharge

- Is the organisation implementing the discharge to recover and assess pathway?
- Is the organisation identifying and addressing the barriers to implementing the discharge to recover and assess pathway?
- Is the organisation and its partners assessing the capacity of community-based services to underpin discharge to recover and assess pathways?
- Is the organisation evaluating the impact and outcomes of discharge pathways, including the discharge to recover and assess approach?



Across Wales, all NHS health boards operated one or more discharge liaison teams. These teams represent a significant investment of funding and have the potential to help things improve. But, we found that the teams tended to be available weekdays only, with a range of alternative arrangements for outside office hours. Most teams were nurse led rather than being truly multi-disciplinary. We also found that discharge lounges were often under-used. Discharge lounges can provide a suitable environment in which patients can wait to be collected, by either their family or hospital transport, or while medication is dispensed.

Questions for board members on discharge liaison teams and discharge lounges

- Is the organisation regularly reviewing the availability and capacity of the discharge liaison team(s) to provide support seven days a week?
- Is the composition of the discharge liaison team changing to ensure a multidisciplinary approach to discharge planning?
- Is the organisation actively promoting the use of the discharge lounge(s) to support patient flow and release beds promptly for patients waiting admission?
- Is the organisation monitoring and reporting on the efficiency and effectiveness of the discharge lounge(s)?

Important challenges

It is important that staff understand clearly how patients are discharged. We reviewed discharge policies and protocols and found that most NHS bodies set out their approach quite well.

Across Wales, ward staff are generally confident about what needs to be done to support safe and timely discharge, but staff cited several challenges that sometimes make it difficult. These challenges include: underestimating the time needed to effectively plan patient discharge; failing to start the discharge process on admission; discharge assessments undertaken only when the patient is declared fit for discharge; and reliance on temporary staff who may be unfamiliar with discharge processes and the availability of community services.

Questions for board members on improving discharge planning

- Is the organisation taking steps to encourage a culture where 'discharge planning is everyone's business' and a key part of the patient care continuum?
- Does the discharge planning process start on admission?
- Does the organisation know what the key barriers are to safe and timely discharge and is it addressing them?
- Is simple guidance available for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements?

Ward staff also speak of a culture of risk aversion, whereby staff are reluctant to discharge patients because they might be at risk for fear they would not cope at home. Whilst staff may be acting out of kindness, they may not be acting in a patient's best interest. Training and information are important tools in improving staff understanding of discharge arrangements and the range and capacity of community health and social care services available to support people in their own homes. There were a lot of materials and resources available, but they were usually locally-produced and not well promoted. We found that access to information on community services was often patchy and training was not done well or not sufficiently frequent. We also found that the discharge liaison teams played only a limited role in helping to train other staff.

Questions for board members on training and awareness raising

- Is information on the range and availability of community health and social care services readily available to ward staff when planning a discharge?
- Are staff involved in, or responsible for, discharge planning supported by regular training?
- Does the discharge liaison team play a role in training staff on discharge planning?

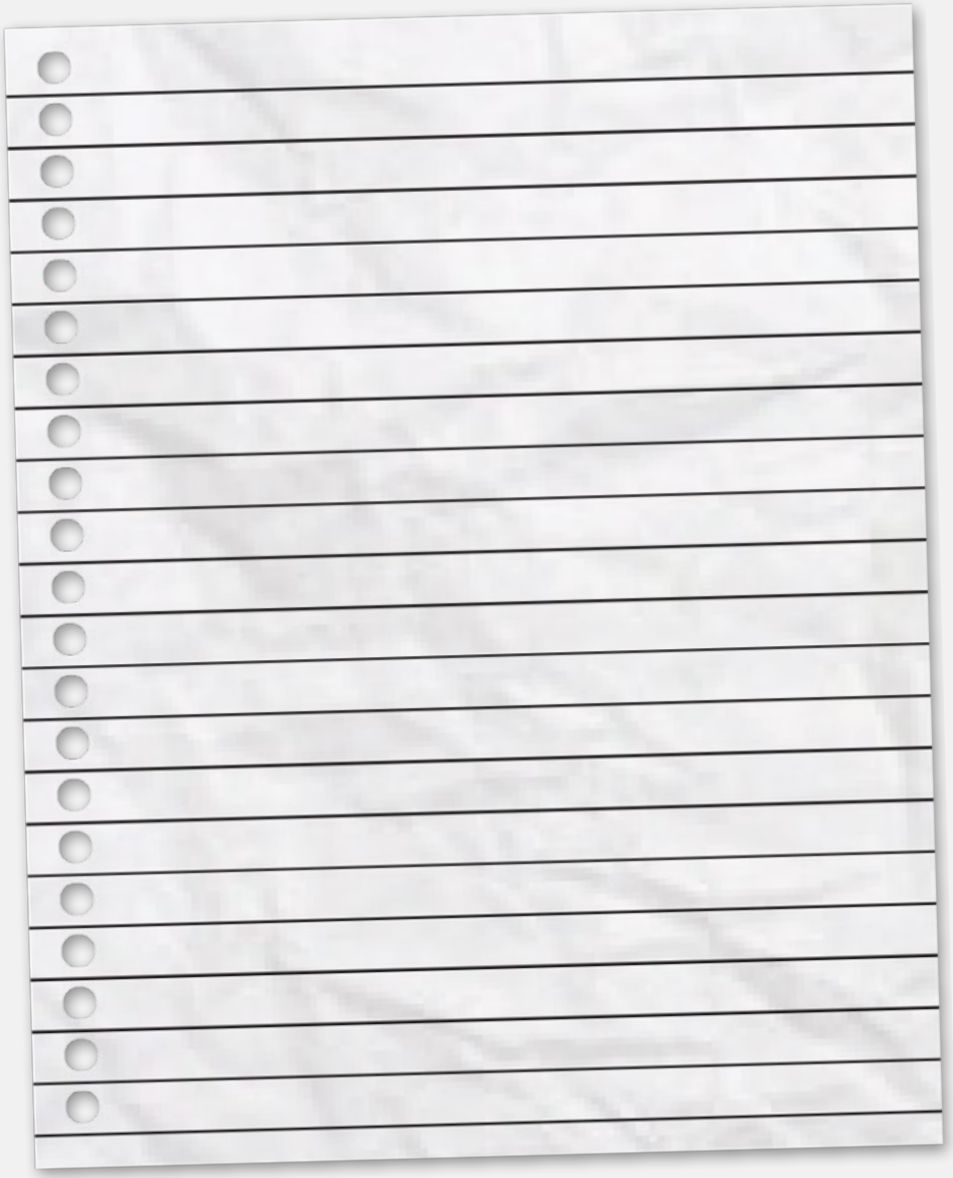
Patients and their families or carers need to understand the discharge process and the support that they can get when they leave hospital if recovery is to be maximised and readmission or long-term residential placement avoided. Across Wales as a whole, we found that the information given to patients and their families or carers was limited.

Questions for board members on patient engagement

- Is the organisation preparing general written information for patients and families on what they should expect from the discharge process and what is expected of them?
- Do staff talk with patients about 'what matters to them'[4] to ensure that discharge is safe, timely and effective?

4 'What matters to you' is a campaign to encourage and support more meaningful conversations between people who provide health and social care and the people, families and carers who receive health and social care.

Notes



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