Bundle Audit Committee 12 December 2019

1.0 09:30 - OPENING BUSINESS - OPEN SESSION

1.1 09:30 - AC19/74: Apologies for Absence

Apologies were received from the Deputy Chief Executive / Executive Director of Nursing and Midwifery

1.2 09:31 - AC19/75: Declarations of Interest

1.3 09:32 - AC19/76: Procedural Matters

1). To confirm the Minutes of the last meeting of the Committee held on 12/09/19 as a correct record and to discuss any matter arising; and
2). To review the Summary Action Log; and
3). To note that Chairs Action has been taken on the following matters since the last meeting;
• 16/10/19 – Draft Internal Audit, Continuing Health Care Review, deferment from 2019/20 plan
• 16/10/19 – Draft Internal Audit, Cluster Governance Arrangements, deferment from 2019/20 plan
• 16/10/19 – Draft Internal Audit, Compliance with Standing Financial Instructions – Procuring Goods and Services: Pharmacy EDS Review, removal from 2019/20 plan.
• 16/10/19 – Approval of revised Master SoRD together with the Model Standing Orders to be presented to the October Audit Workshop prior to Board sign off in November.

AC19/76a: Minutes Audit Committee_Open Session_12.09.19_Draft.doc

AC19/76b: Summary Action Log Audit Committee live version.doc

1.4 09:37 - AC19/77 Revised Terms of Reference

The Committee is asked review and approve the revised Terms of References (ToRs) and recommend approval of the revised ToRs to the Board:

• Audit Committee and;
• Digital Information Governance Committee and;
• Charitable Funds Advisory Group (pending approval at the Charitable Funds Committee on the 10th December)

AC19.77a Revised ToRs for Review Report.docx

AC19.77b Audit Committee ToR V11.1 showing track changes to be taken to AC on 12.12.19.doc

AC19.77c DIG Committee ToR V2.01.docx

AC19.77d CF Advisory Group_ToR December 2019.doc

1.5 09:42 - AC19/78: Issues Discussed in Previous In Committee Session

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

AC19.78 Private session items reported in public.docx

1.6 09:44 - AC19/79: Amendment to Standing Orders: Scheme of Reservation and Delegation (SoRD)

• The Committee is asked to approve the changes to the Standing Orders and SoRD on behalf of the Board.
• The Committee is asked to note that, following approval and ratification, operational level SoRDs for each Executive, Area and main hospital site will be updated in line with the changes made to the Health Board's overarching master SoRD.

AC19.79a Changes for December 2019 Audit Committee.docx

AC19.79b: Appendix 2 EASC Model SOs Reservation and Delegation of Powers approved by EASC 12 Nov 2019.docx

2.0 09:49 - AC19/80: Internal Audit Progress Report - Dave Harries

The Audit Committee is asked to:
• Receive the progress report;
• Note the approval via Chairs Action of the removal of the three reviews from the 2019/20 plan and;
• Discuss the two Limited Assurance Reports noting that the relevant Officers have been invited to attend.

AC19.80a BCUHB Internal Audit Committee cover sheet December 2019.docx

AC19.80b BCUHB Audit Committee Progress Report November 2019 v2.docx

AC19.80c Final Internal Audit Report - Welsh Language (Wales) Measure 2011.pdf

AC19.80d Adroddiad Archwilio Mewnol Terfynol - Mesur y Gymraeg (Cymru) 2011.pdf

AC19.80e Final internal Audit Report Patients Monies.pdf

2.1 10:34 - AC19/81: Wales Audit Office Update Report - Andrew Doughton/Amanda Hughes/Mike Usher

The Audit Committee is asked to:
• Note the content of the audit progress update.
• Receive and discuss the Integrated Care Fund report to the North Wales Partnership Board.
• Receive and discuss the national review of public service boards.*
• Receive and discuss the Wellbeing of Future Generations report and BCUHB response.
• Receive and discuss the Primary Care Services in Wales report
• Receive and discuss the Structured Assessment report
• Note the ICT Asset management report. The report has already been presented to the Digital Information and Governance Committee for assurance purposes (Included within the private session of the meeting)

**Given the complexity of progress tracking cross-sector recommendations made to public service boards, we recommend that assurance on progress against recommendations is provided in the form of a narrative report to appropriate committee.*

AC19.81a WAO Audit Committee cover sheet.docx

AC19.81b WAO BCUHB_Audit_Committee_Update_Dec 2019.pdf

AC19/80c north_wales_Integrated Care Fund_regional_partnership_board_english.pdf

AC19/80d WAO - review-of-public-service-boards-oct 19.pdf

AC19/80e BCUHB_WFG_report_final.pdf

AC19.81f Audit Committee Report_Response to WFG Report.docx

AC19.81g WAO_ Primary-care-services-in-Wales-2019-eng.pdf

AC19.81h BCUHB_Structured_Assessment_2019_English.pdf

3.0 11:19 - AC19/83: Corporate Risk Register and Assurance Framework Report - Justine Parry

The Audit Committee is asked to:
1) Note, approve and recommend the Corporate Risk Register (CRR) to the Board and to gain assurance that the risks are managed in line with the Health Board`s risk management strategy.
2) To recommend two new risks which were approved by the QSE to the Board for inclusion onto the CRR.

AC19.83 CRAF Report to AC -Final.docx

4.0 11:49 - AC19/84: Clinical Audit Policy - Melanie Maxwell

The Audit Committee is asked to approve the amended policy and procedure document.

AC19.84 Audit Policy Coversheet.docx

AC19.84a BCUHB- Draft-Clinical Audit Policy-2019.docx

5.0 12:19 - AC19/85: For Information Charitable Funds Accounts

The Audit Committee is asked to note the Charitable Funds Annual Report and Accounts 2018/19, together with the letter from WAO and BCUHB response.

AC19.85 Charitable Funds Accounts - Audit Committee.docx

AC19.85a Signed Awyr Las Annual Report & Accounts 2018-19.pdf

AC19.85b Appendix - Extract from WAO letter re funds held on trust.docx

AC19.85c Appendix to CF Accounts item formal response to WAO re Funds Held on Trust.doc

6.0 12:24 - AC19/86: Issues of Significance for reporting to Board

6.1 12:26 - AC19/87: 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 12.09.19
In the Boardroom, Carlton Court, St Asaph

Present:

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

In Attendance:

Mags Barnaby	Interim Director of Acute Care (for Minute AC19/57)
Andrew Doughton	Performance Audit Lead, Wales Audit Office
Dave Harries	Head of Internal Audit, NWSSP
Debra Hickman	Secondary Care Nurse Director (for Minute AC19/60)
Sue Hill	Acting Executive Director of Finance
Amanda Hughes	Financial Audit Manager, Wales Audit Office
Melanie Maxwell	Senior Associate Medical Director (for Minute AC19/56)
Amanda Miskell	Assistant Director of Nursing, Infection Prevention (for Minute AC19/58)
Justine Parry	Assistant Director of Information Governance & Risk (for Minute AC19/60)
Dawn Sharp	Acting Board Secretary
Mike Usher	Engagement Director, Wales Audit Office
Maureen Wain	Hospital Director Wrexham Maelor Hospital (for Minute AC19/57)
Bethan Wassell	Statutory Compliance, Governance & Policy Manager

Agenda Item	Action
AC19/51 Opening Business and Apologies for Absence AC19/51.1 The Chair welcomed everyone to the meeting and sought the Committee's agreement to vary the order of business slightly to take account of officer diary commitments. AC19/51.2 Apologies had been received from John Cunliffe, Independent Member.	
AC19/53 Declarations of Interest Independent Member, Lucy Reid (LR) declared an interest in item 19.61(c), the Legislation Assurance Framework, through her spouse's role as a local medical referee	
AC19/54 Minutes, matters arising and review of summary action log **RESOLVED:** That 1) The Minutes of the last meeting held on 30th May 2019, were approved as a true and accurate record.	

2) The Summary Action Log was noted and updated accordingly. 3) The proposed content for the next Audit Committee workshop was discussed with the date to be confirmed shortly by the Acting Board Secretary 4) It was noted that the revised Model of Standing Orders from Welsh Government was due imminently with a timeline for adoption by Health Boards across Wales for the end of November. Arrangements for sign off, prior to Board approval were agreed. 5) It was noted that it had been agreed to defer the C-PiP (Caldicott Principles into Practice) review from the Internal Audit Plan as a result of planned changes in the reporting tool and migration to the new process (as agreed via Chair's Action) 6) The updated Terms of Reference (TOR) for the Committee were noted (incorporating the changes agreed in the last meeting that Trade Union Partners were welcome to attend the open session of the meeting). It was further noted that the Terms of Reference would need to be further reviewed with regards Risk management and the attendance of the lead officer for Risk. 7) It was agreed to recommend to the Board the minor change of the Charitable Funds Committee membership, replacing the Executive Director of Nursing and Midwifery with the Executive Medical Director. 8) It was noted that the Management Response for the Welsh Audit Office, Betsi Cadwaladr University Health Board – Clinical Coding Follow-up Review had been received and was to be considered at the Digital and Information Governance Committee (DIGC) 27/09/19. Recommendations would be input into the TeamCentral system for tracking	DS DS DS DS BW
AC19/55 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 30.05.19, which related to:- • End of Year Governance Reporting • Financial Conformance Report • Counter Fraud Services Annual Report • Local Counter Fraud Work Plan 2019/20 • Update on Internal and External Audit Actions **RESOLVED: That the reports be received.**	
AC19/56 Clinical Audit Plan The Committee welcomed the Senior Associate Medical Director (SAMD) to the meeting. The Chair expressed recognition of the significant work undertaken and thanked the SAMD for the considerable advancement in progress. The SAMD proceeded to present an update on the draft BCUHB Clinical Audit Plan 2019/20 (Appendix 1) which included the prioritised projects to be conducted in order to provide assurance against risks to the Quality Improvement Strategy. It was acknowledged that whilst the plan detailed an absence of leads for certain audits and capacity issues across BCUHB continued to remain a challenge, the opinion was that the right framework was in place and gaps would continue to be addressed (via job planning) . In addition, the plan addressed and cross referenced external recommendations arising from the HASCAS/Ockenden reviews.	

Members were asked to note that Tier one audits were Nationally driven by both Welsh Government and English authorities (the cataracts audit had been removed on a national level). Complications were experienced in Wales whereby electronic medical records and digital platforms for audit management were not available as they are in England. The SAMD advised that the Secondary Care Medical Director will be reaffirming the importance of Tier one audits and the message that they were mandatory. Further discussion addressed the requirement that the plan be informed from a BCUHB wide perspective with equal engagement and input from both Secondary and Primary Care. Members were advised that the development of the 2021 plan would include workshops and engagement events with the involvement and input from the Executive Director of Primary Care and Community Services. Committee members enquired as to the proposed reporting content, frequency and reviewing Committee/Group against the plan. Members stressed the distinct functions of Audit Committee and the Quality, Safety & Experience (QSE) Committee with reference to their respective TORs. It was agreed that there should be two separate reports with outcomes/quality issues being overseen by QSE and progress against the plan monitored by Audit Committee. The SAMD agreed to draft two template reports to be shared with Members for consideration outside of the meeting. It was agreed that the report templates would be discussed at the audit workshop and subsequently submitted to the Joint Audit and QSE (JAQS) meeting in November for review.	MM
Members then proceeded to discuss the draft BCUHB-wide Clinical Audit Policy (Appendix 2) that had been produced in collaboration with a recent workshop event. As per the discussion of the plan, Members again noted the importance of clearly articulating reporting requirements and routes for review in the Policy, which was currently insufficiently documented. In addition, members stated that the roles and responsibility of staff required further definition within the Policy. It was acknowledged that the templates contained in the appendices of the Policy were a positive addition that encouraged a standardised approach. Members agreed that the Policy be further discussed at the October workshop before being submitted to JAQS in November for final approval though approved dissemination of the plan for clinical activity. *administrative note from Independent Member, Jacqueline Hughes (JH) - remove reference to ‘Trust’ from the Policy (top of page 10) The Head of Internal Audit confirmed that Clinical Audit would form part of the Internal Audit Risk/Audit plan for 2021. The Chair again, thanked the SAMD for attending and the work completed to date. **RESOLVED:** That (1) The Clinical Audit plan be approved and; (2) The Policy be submitted to the workshop in October prior to review/approval at Joint Audit, Quality Safety & Experience Committee in November	MM DS

AC19/57 Wales Audit Office Update Report - Andrew Doughton/Amanda Hughes/Mike Usher

The regular audit update was presented alongside reports which had been finalised since the last Audit Committee and included; the National Integrated Care Fund report, the Operating Theatres report and the accompanying operating theatres presentation for committee information only.

The Financial Audit Manager for Wales Audit Office, advised Members that the Charitable Funds audit was largely complete though asked Members to note a deferred final report date from September to November 2019.

The Performance Audit Lead for Wales Audit Office provided Members with an update on ongoing work and highlighted the Refurbishment / Asbestos removal at Ysbyty Glan Clwyd. The Engagement Director, Wales Audit Office would be progressing this review that would focus on lessons learnt for major capital investments, this was a national review to be published in May 2020.

The Performance Audit Lead for Wales Audit Office continued to provide an update on the forward plan including Continued Health Care and Public Sector Counter Fraud. Members noted that the Welsh Assembly Public Accounts Committee had taken significant interest in the published national report and that the Auditor General was subsequently looking at local counter fraud on an all Wales basis as an area for inclusion within the plan of work.

The Performance Audit Lead for Wales Audit Office directed members to some of the key sessions from the Good Practice Exchange (GPX) detailed on page 10 of the WAO Audit Committee Update report.

The Interim Director of Acute Care and the Hospital Director of Wrexham Maelor Hospital joined the meeting to specifically discuss the Operating Theatres report. The Chair welcomed both to the meeting.

The Performance Audit Lead for Wales Audit Office proceeded to provide an overview of the Operating Theatres report findings to Members. Positive improvements were noted in a number of areas including staff views of the service. However, there were still areas for improvement, particularly with regards to patient experience. Members were further asked to note the difference between theatre utilisation (start/finish time and gaps between procedures), and theatre productivity (the number of patients seen), of which BCUHB needed to continue to improve. The three distinct management structures across BCUHB were also highlighted and whilst this could be perceived to create a variation in service, delivery was overseen by a pan North Wales group to ensure consistency across the three sites.

The Interim Director of Acute Care and the Hospital Director of Wrexham Maelor Hospital concurred with the findings of the report and commented that they had found the audit useful in building strong foundations. Feedback on progress against recommendations to date was provided to Members and included the recruitment of a dedicated position with hands on experience to deliver improvements.

A discussion ensued and matters were raised with regards the three different approaches across the site, whether this posed a risk and if so, how that risk was

managed. For example, rotating surgeons that might need to be familiar with three separate systems. The Hospital Director of Wrexham Maelor Hospital commented that she considered the clinical risk was moderated due to the Theatre Nurse in Charge and supporting theatre staff being static. To support this opinion she referenced the finding that 66 of the 75 staff surveyed agreed they had the necessary information required before the start of the list (see para 29 of the report). Members raised further concerns with regards performance against targets in January as well as the number of administrative cancellations (cancellation not due to patient reason). It was acknowledged that further work was required to establish booking rhythm, rigour and routine though winter pressures were the significant factor. It was confirmed that the intention was to ensure appropriate lock down of hospital lists at the 6 week period. It was also highlighted that the data did not reflect ring fenced critical care beds. Five new recommendations were made to support improvement. A management response had been received and would be input into the TeamCentral system for tracking. The Interim Director of Acute Care and the Hospital Director of Wrexham Maelor Hospital left the meeting and the Chair thanked both for attending. The Performance Audit Lead, Wales Audit Office concluded by asking Members to note the last paper, the recent publication on Integrated Care Funds, of which, the overall finding was positive. There were recommendations made, the majority of which were for Welsh Government though AD suggested BCUHB may want to consider adding R4 (*We recommend that the Welsh Government works with NHS bodies and local authorities to ensure that appropriate scrutiny arrangements are in place for decisions made by the RPBs on behalf of those bodies*) to TeamCentral for tracking as the Strategy Partnerships & Population Health Committee (SPPH) may wish to take a view. Members agreed to track R4. **RESOLVED:** That (1) The content of the audit progress update be noted; (2) Received and discussed the Integrated Care Fund and Operating Theatres reports as well as noting the accompanying operating theatres presentation for information. (3) Five Recommendations from the Operating Theatres Report to be added to the Tracker (4) R4 of the Integrated Care Fund report to be added to the tracker	BW BW BW
AC19/58 Internal Audit Progress Report The report presented was summarised for the Committee and detailed the eight assurance reviews which had been finalised since the Committee meeting back in May 2019, with recorded assurance, as follows: • Substantial assurance (green) – one; • Reasonable assurance (yellow) – six; and • Assurance not applicable (blue) – one.	

The report also detailed the draft reporting stages; as well as work in progress; Follow-up status of two recommendations had also been reviewed within the period; and the recommendation for removal from the 2019/20 plan four reviews relating to: Caldicott – Principles into Practice (CPiP) self-assessment; Health Board governance arrangements – Quality & Safety; Compliance with Standing Financial Instructions – Procuring goods and services: Community Dental Services; and Capital Systems: Primary Care benefits realisation. The Head of Internal Audit provided an overview of the report and commented that overall, he considered the report to be very positive and proceeded to provide further comments on individual reviews ; • **Carbon Reduction Commitment (CRC) Order**: The report was positive though it would be the last time the Committee would receive the report (the CRC Energy Efficiency Scheme (Revocation and Savings) Order 2018 makes provision for the early closure of the CRC scheme). Although BCUHB were subject to a penalty from Natural Resources Wales, the penalty was outside the Health Board's control. • **Annual Quality Statement (AQS):** Though there were some data quality issues, overall the report was positive. • **Reporting Arrangements for Delivery of Savings**: No further comments • **Integrated Care Fund:** The report was positive though there were some issues with compliance of Standing Orders • **Annual Plan:** No further comments • **Capital Systems:** The TOR should not have enabled YG to follow a separate procurement route when a much larger procurement exercise was being undertaken by BCUHB. • **Patient Monies:** The report had been issued and would be tabled for review at the next Committee • **Infection Prevention:** The Assistant Director of Nursing, Infection Prevention joined the meeting to discuss the findings. The findings of the report had been well received by management and areas of good practice had been identified. However, there were areas of non-compliance. The Chair voiced concerns with regards some areas of poor practice. The Assistant Director of Nursing, Infection Prevention responded that annual Ward Accreditation was now in place and informed the Committee that an additional external review from Janice Stevens (conducted May 2019) had been undertaken and areas improvement had been acknowledged. The Assistant Director of Nursing, Infection Prevention assured Members that immediate measures had been put into place to address the findings of both reviews. It was further highlighted that domestic vacancies were resulting in fewer domestic audits being undertaken. However, 50% of Domestic staff time was currently taken up with audit completion. The intention was to reduce this time allocation in order to provide further training. Whilst members recognised and accepted insufficient storage created issues of clutter, Members were not satisfied with this approach and affirmed that areas of non-compliance were not training issues, but accountability issues. The Chair explicitly noted that the findings were operational issues, for which a zero tolerance approach should be adopted – training and meetings were not the answer. Independent Member, Jackie Hughes (JH) commented that the Credits 4 Cleaning was an unwieldy tool that took significant time. The Assistant Director of Nursing, Infection	DS

Prevention advised that quality reviews with Modern Matrons were underway and reported through infection prevention groups. Furthermore, the intention was to increase visibility via spot checks as well as a de clutter project which would deliver a multi-faceted approach. Members noted that the report was reasonable assurance though stated that progress needed to be monitored. Whilst Safe Clean Care reports were received at QSE Committee, the Chair of QSE stated it would be beneficial in addition to the these reports, to receive a briefing note on progress against findings. The discussion concluded and the Chair thanked The Assistant Director of Nursing, Infection Prevention for attending. The Assistant Director of Nursing, Infection Prevention left the meeting. DH formally requested approval of the recommendation to remove/defer four reviews for 2019 based on the narrative of the report (at para 19) of which the Committee approved. DH concluded by stating Internal Audit follow up reviews were conducive in that actions were evidenced as completed and wished to formally thank colleagues. MU further formally acknowledged the positive performance with regards the Report Turnaround KPI (as detailed on page 18 of the Internal Audit Progress Report). **RESOLVED:** That 1. The progress report be received and 2. The removal of the four reviews from the 2019/20 plan be approved and; 3. The Assistant Director of Nursing, Infection Prevention provide a briefing update note for QSE as outlined	AM
AC19/59 Amendments to the Scheme of Reservation and Delegation The Acting Board Secretary presented the report outlining the amendments to the SoRD whilst highlighting further amendments were now necessary to reflect recent portfolio changes. For example, the realignment of Risk Management to the Deputy Chief Executive with the Senior Information Risk Owner (SIRO) role still being under discussion. In addition, the revised SoRD would need to detail the newly appointed Director of Acute Care. The intention was to bring the revised Master SoRD together with the Model Standing Orders to the Audit Workshop in October (and subsequent sign of via Chair's action) prior to Board sign off in November. Members then proceeded to discuss the accompanying SoRD documents. Members referred to page 17 of the Master SoRD (17.1 (d), Ex-Gratia Payments). Whilst it was noted that the Financial Conformance report provided some detail on clinical negligence payments/costs. Members felt that an opportunity for learning was being missed. The Acting Board Secretary agreed to follow up the matter with the Executive Director of Nursing and Midwifery. The Head of Internal Audit noted an observation whilst undertaking the Ysbyty Gwynedd Emergency Department Patient Monitors review (July 2019) in that the Secondary Care delegated limits were not as high as other interim hospital managing directors. The Acting Board Secretary advised that this would be reviewed as part of the refresh. **RESOLVED:** That	DS DS DS

• The amendments be approved and reported to the Board as part of the Chair's Assurance Report noting that further amendments were imminent.	
AC19/60 Interim Risk Management Arrangements – Debra Hickman/Justine Parry The Holding Position of the Risk Management Strategy was noted, following discussion at a Workshop involving Independent members on the 02/09/19. The Secondary Care Nurse Director and the Assistant Director of Information Governance & Risk joined the meeting. The Chair welcomed both. The Assistant Director of Information Governance & Risk asked Members to note an inaccuracy in the submitted report in that the current risk table did not reflect risks as appended to the report. The Secondary Care Nurse Director and the Assistant Director of Information Governance & Risk proceeded to provide Members with an update on the Risk Management strategy review and outcomes from the 2nd September workshop. The Chair highlighted his concerns that the reasons for the change in approach had not been documented. The Head of Internal Audit further noted that the paper presented did not outline the rationale or drivers for the change in tiers from five to three. Additionally, there was insufficient information on how the current risks levels would be reclassified. Further concerns were raised with regards the scoring and level allocation – an operational risk that scores 25 should not necessarily be classified as a 'corporate' risk. The Head of Internal Audit acknowledged the verbal justification from the five to three tier change (inefficient and delayed escalation) though recommended that the current strategy remains in operation until March and proof of concept is established. The Head of Internal Audit advised against a mid-year change. The Secondary Care Nurse Director responded and advised Members that the work being undertaken was in the background to establish training needs and inform the plan on how to transfer to the new tier system. The Secondary Care Nurse Director confirmed the request was to continue background work in preparation for the revised strategy go live date and ensure a seamless transfer. The Head of Internal Audit queried the 2020 launch date and whether it was realistic. The Secondary Care Nurse Director reiterated that this further evidenced the requirement for the proposed background work. Members expressed a view that the change in direction was not clear and were concerned that the background work had not been approved. The Assistant Director of Information Governance & Risk addressed the query and explained that the revision was in response to the clinical opinion that the five tier was too cumbersome and confirmed that the revised Strategy would indeed go back to the Board. The Chair proposed the existing Strategy be extended though further commented that the proposed background work was not clear. A scheduled workshop was required to approve the background piloting work proposed. The Committee proceed to review each Corporate Risk from the submitted report and	

commented as follows: • CRR02: Members noted a reduced score though highlighted this had not been approved at QSE. The Secondary Care Nurse Director and the Assistant Director of Information Governance & Risk to confirm with the relevant lead and report back to Members • CRR06: Engagement Director, Wales Audit Office commented that the likelihood scoring or articulation need to change • CRR12 – Members expressed surprise that the current score was 3 and that given Estates issues it should be referred back to the Finance & Performance Committee (F&P) The acting Executive Director of Finance confirmed that this would be further considered by F&P • CRR13: Members noted that the score had been decreased, yet the Quality, Safety and Experience Committee (QSE) had previously reviewed twice and not approved. The Assistant Director of Risk and Information Governance agreed to review with the relevant lead and respond to the chair of QSE • CRR17 – action did not justify how it was going to achieve target score / address the issue. More clarity requested. Members suggested that extra boxes (date reviewed by exec and date reviewed by committee) could be inserted. The Assistant Director of Information Governance & Risk responded that information should be detailed in coversheet. **RESOLVED:** That (1) The existing Risk Management Strategy arrangements be extended, acknowledging the ongoing work to simplify the management of risks across the organisation which was being piloted and; (2) The latest Corporate Risk Register information be noted and; (3) The Assistant Director of Information Governance & Risk follow up the queries as outlined.	DHI/JP DHI/JP SH DHI/JP DHI/JP JP
AC19/61 Interim Board Assurance Framework (incorporating the Legislation Assurance Framework) The overview of the BAF narrative document described to the committee the arrangements in place for managing the Health Board's assurances across the breadth of its activities. Members were reminded of the previous iterations and discussion in relation to the BAF. Discussions at a previous All Wales Audit Chairs meeting in January 2018 had decided that the agreed BAF would include a narrative document, an overarching Map and the Corporate Risk Register (note, last Audit Committee, agreed that the draft Map would reflect the BCUHB annual objectives with the Legislation Assurance Framework forming Part B). The Acting Board Secretary advised Members that the BAF Narrative document would need to be reviewed in the light of the Deputy Chief Executive / Executive Nurse Director's work on governance arrangements The Acting Board Secretary concluded by informing Members that the Map had previously included a RAG (Red, Amber, Green) rating for assurance. However,	

discussions at Board on 05/09/19 in relation to Improvement Groups and how often they met had necessitated that the RAG rating be removed in the interim until the cycle of business for said Improvement Groups was confirmed. Members raised concerns with regards an absence of key clinical objectives such as waiting lists. The Acting Board Secretary affirmed that the plan should be driven by the Integrated Medium Term Plan, which the Health Board did not currently have. Therefore, Members had agreed (at March Audit Committee and subsequent Workshop) that the Map would reflect the Annual Plan though acknowledged that further work was required. The Engagement Director, Wales Audit Office commented that desired outcomes needed to be defined clearly. The Acting Board Secretary responded that the outcomes were taken from the latest Board approved Annual Plan. Questions were raised regarding clarity around individual actions ownership and that these should be sub divided where appropriate. Members proceeded to review the LAF. The Statutory Compliance, Governance & Policy Manager (SCGPM) provided Members with an update of progress since the last submission (December 2018). Members noted that BCUHB were considerably advanced in their development and that the LAF was very much a new product not available commercially or by way of any other health organisation. However, the requirement to identify all applicable legislation, assess requirements for compliance, assign to the relevant Division/identified lead, collate assurance criteria and summarise for review was a considerable task for which, resources were limited. Members also noted that there was no existing precedent for the project thus suggestions and critique on the report submitted as well as the structure of the framework were welcomed. The SCGPM went on to advise that conversations were ongoing with NHS Wales, Legal & Risk with regards national hosting as well as the Datix migration team for system continuity - verbal assurance had been provided that the utilised module within Datix would continue to be available to BCUHB post migration to the new system. Table two of the report was indicative of the progress against Divisional assurance criteria completion and was not demonstrative of non-compliance. For example, certain Divisions/Departments were yet to complete the assurance criteria against their allocated legislative obligations. This did not suggest that there were issues of non-compliance merely that the information was not yet collated for inclusion in the report. Furthermore, the percentage progress was subject to change as final legislation allocation was finalised or re allocated and Director portfolios changed. Members suggested that Table two would be better articulated via a narrative update. It was agreed that whilst Table two was helpful for the initial project launch, it would be removed from subsequent reports. A discussion ensued between Members. A query was raised with regards the lack of controls in place for the Public Health Wales Act 2017. BCUHB were awaiting subsequent Regulations, specifically the Smoke-free Premises and Vehicles (Wales) Regulations 2018 and the Public Health team were aware of the pending developments. The Acting Executive Director of Finance requested that the narrative in table three with regards the National Health Service Finance (Wales) Act 2014 be	DS BW BW

expanded to include the requirement for an IMTP. Members also queried the definition/types of controls and the SCGPM agreed to revise. Members discussed the allocation of The National Health Service (Clinical Negligence Scheme) (Wales) Regulations 2019 to the Executive Nurse Director and directed that it was more appropriately aligned to the Executive Medical Director. Independent Member, Jacqueline Hughes, expressed that she would be interested to see the electronic system, and specifically, review the identified Health & Safety legislation and the SCGPM agreed to facilitate. **RESOLVED:** That (1) The Committee recommend to the Board the endorsement of the Interim Assurance Framework via the Chair's Assurance Report and; (2) the contents of the report and the current position in respect of the LAF development be noted and; (3) the further work required in relation to both the LAF and BAF to liaise with Divisional Leads; Legislation/Objective allocation agreement and assurance criteria completion be noted and; (4) the items of previous non-compliance within the LAF and now reporting substantial assurance be removed from the next report.	BW BW
AC19/62 Annual review of Declaration of Interests/Gifts and Hospitality and review of the Standards of Business Conduct Policy The Acting Board Secretary presented the annual review and policy to the Committee. It was noted that there had been no Board Member declarations of interests or gifts and hospitality of concern; or other issues of significance to bring to the Audit Committee's attention. The Acting Board Secretary advised Members that with regard to the policy refresh, a light touch approach had been adopted which mainly included administrative (updated hyperlinks etc.) amendments due to the proposed All Wales document. The Chair noted a specific entry on the Gifts & Hospitality Report (AC19.62c) with regards two Consultants attending a Proton Beam radiotherapy training. Independent Member, Jaqueline Hughes provided an overview of the benefits of the technology in that it is very precise and well suited to tackling certain cancers, particularly in paediatrics. The Acting Board Secretary concluded by highlighting to Members that BCUHB had delivered a significant way forward with new electronic system that had generated considerable interest from other Health Boards. **RESOLVED:** That 1. The report be received and; 2. The revised Standards of Business Conduct Policy be approved.	
AC19/63 Briefings and Updates for noting The Committee received and noted the following briefings:	

• NHS Wales Fighting Fraud Strategy • WAST follow up Internal Audit report on Handover of Care • Conwy County Borough Council (CCBC) - Mental Health Governance - Conwy Community Mental Health Team With regards the CCBC report, The Head of Internal Audit informed Members that he had met with the Director of Mental Health & Learning Disabilities to discuss a joint follow up review to be conducted by Internal Audit and CCBC. Completion was expected to be the end of Q3/Q4.	
AC19/64 Issues of Significance for reporting to Board. The Chair agreed to prepare his assurance report for the Board.	
AC19/65 Date of Next Meeting – 12th December 2019 The date of the next formal meeting was noted as 12th December 2019.	
AC19/66 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 12.09.19				
Dawn Sharp	AC19/54 Audit Committee workshop date to be confirmed	Oct	Confirmed – 16/10/19	Close
Dave Harries John Darlington	AC19/30 Revenue Business Case –review management response and set clear milestones to address recommendations	August	DH will amend the timelines in TeamCentral once advised by management. John Darlington has forwarded to Ian Howard as the lead for revenue business cases to take forward.	
Dawn Sharp	AC19/54 Board approval required for revised Model of Standing Orders on receipt from Welsh Government	November	Approved by November Board	Close
Dawn Sharp	AC19/54 Committee Terms of Reference to be reviewed with regards Risk Management and attendance of lead officer for Risk	December	Included within Agenda for December	Close
Bethan Wassell	AC19/54 Management Response for WAO Clinical Coding Follow-up review to be input into TeamMate system for tracking	Oct	Complete and live tracking in TeamCentral	Close
Melanie Maxwell	AC19/56 Two template reports (Audit and QSE) to be drafted for consideration at Audit workshop	Oct	Draft Templates presented to JAQS and submitted to AC 12/12/19	Close
Melanie Maxwell	AC19/56 Staff roles and responsibility to be further defined within Clinical Audit Policy. Any reference to ‘NHS Trust’ to be removed	Oct	Complete.	

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Dawn Sharp	AC19/56 Clinical Audit Policy and Procedure to be submitted to Audit Committee workshop in October prior to review/approval at JAQS	Oct	Workshop held, presentation made to JAQS and revised Policy on agenda	Close
Dawn Sharp	AC19/57 Good Practice Exchange from WAO Update Report to be circulated to IM, John Cunliffe	Oct	Complete	Close
Bethan Wassell	AC19/57 Management response for WAO, Operating Theatres Report input into TeamMate	Oct	Live tracking in Teammate	Close
Bethan Wassell	AC19/57 R4 from the WAO Integrated Care Fund input into TeamMate	Oct	Management response received and now tracking in TeamMate	Close
Dawn Sharp	AC19/58 IA Report, Patient Monies tabled for review at next Committee	Dec	Complete	Close
Amanda Miskell	AC19/58 IA Infection prevention Report briefing update note to be provided to QSE	Oct	Complete	Close
Dawn Sharp	AC19/59 Revised Master SORD and Model Standing Orders to be tabled for review at Audit Workshop	Oct	Complete	Close
Dawn Sharp	AC19/59 Master SORD, Ex-Gratia Payments / Clinical Negligence payments and opportunities for learning to be followed up with Exec Nurse Director	Oct	Newly appointed Assistance Director of Patient Safety and Experience has reviewed reporting arrangements. New format reporting will be presented to QSE Committee in January 2020.	Close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Dawn Sharp	AC19/59 Master SORD Secondary Care delegated limits reviewed	Oct	Revised SORD to be presented to December Audit Committee.	Close
Debra Hickman / Justine Parry	AC19/60 Corporate Risks: CRR02, CRR06, CRR13, CRR17 follow up queries	Oct	All Risk Handlers and Leads were contacted with concerns raised during meeting. Updated risks will be presented during November. CRR02 and CRR13 to the Board 7th and QSE on 19th. CRR06 to Board 7th and F&P on 28th. CRR17 to Board 7th and SPPH 3rd December. Suggest to close action	Close
Sue Hill	AC19/60 Corporate Risks: CRR12 referred back to F&P for further consideration	Oct	Actioned	Close
Dawn Sharp	AC19/61 BAF individual action ownership sub divided where appropriate	March	Board Assurance Framework currently under revision following discussion at Audit Workshop. This will be aligned to the Annual Plan and presented to the March meeting	
Bethan Wassell	AC19/61 LAF, Table 2 be removed from future reports	Oct	Completed	Close
Bethan Wassell	AC19/61 LAF, narrative in table 3 to be expanded for NHS Finance (Wales) Act expanded to include reference to IMTP	Dec	Description updated. Meeting to be arranged with Finance Governance lead to review all allocated legislation	Close
Bethan Wassell	AC19/61 LAF, NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 reallocated to Executive Medical Director	Oct	Completed	Close
Bethan Wassell	AC19/61 LAF, demo for JQ of electronic system	Oct	Email sent to JQ for availability	

Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee** **12/12/19**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Review of Revised Terms of Reference (ToRs) for: • Audit Committee • Digital Information & Governance Committee (DIG) • Charitable Funds Advisory Group (CFA)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Acting Board Secretary
Awdur yr Adroddiad **Report Author:**	Statutory Compliance, Governance & Policy Manager.
Craffu blaenorol: **Prior Scrutiny:**	DIG ToR reviewed at DIG on 21/11/19
Atodiadau **Appendices:**	• Appendix 1: Audit ToR • Appendix 2: DIG ToR • Appendix 3: CFA ToR

Argymhelliad / Recommendation:

The Committee is asked review and approve the revised ToRs and recommend approval of the revised ToRs to the Board.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

This paper details the amendments to the Audit Committee, DIG Committee and CFA Group ToRs.

Cefndir / Background:

The revised amendments to the ToRs are as follows:

- **Audit Committee:**
  - Membership change to include the Deputy Chief Executive who is now responsible for Risk Management

- **DIG Committee:**
  - Amendments to references to Informatics throughout the ToR to 'Digital'
  - Include reference to the SIRO only (not named director role.)
  - Include Lead Director of Information Governance department in attendance (following Director Portfolio changes.)
  - Include section relating to Chair and Vice Chair appointments in line with other Board committees' ToR
  - It was further agreed that the Director of Finance (SIRO) be invited to future DIG Committee meetings via the Office of the Board Secretary

- **CFA Group**
  - A review of the Advisory Group membership and the attendance of members at meetings has been undertaken.

Asesiad / Assessment & Analysis

Strategy Implications
This report is purely administrative, there are no associated strategic implications.

Financial Implications
This report is purely administrative, there are no associated resource implications.

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

Legal and Compliance
Ensuring that Committee ToRs are frequently reviewed for accuracy and appropriateness supports good governance. ToRs form part of the Board's Standing Orders.

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

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
- Deputy Chief Executive/Executive Director of Nursing and Midwifery
- 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.

Trade Union Partners are welcome to attend the public session of the Committee

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 25.7.19

V11.0

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

DIGITAL AND INFORMATION GOVERNANCE COMMITTEE

1. INTRODUCTION

The Board shall establish a committee to be known as the Digital and Information Governance Committee (DIG). 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~~Digital 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~~digital 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~~digital 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~~digital 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~~digital (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~~digital 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~~digital and information governance operational plans including performance against the annual ~~Informatics~~Digital 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~~digital 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~~Digital
~~Board Secretary/~~ Senior Information Risk Owner (SIRO)
Caldicott Guardian
Lead Director of Information Governance department
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.

6.2.2 Trade Union Partners are welcome to attend the public session of the Committee

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.

For approval by Audit Committee 12.12.19

V2.01

Betsi Cadwaladr University Health Board
Terms of Reference

CHARITABLE FUNDS ADVISORY GROUP

1. INTRODUCTION

1.1 The Charitable Funds Committee (the 'Committee') has established the Charitable Funds Advisory Group. The function of this group is to consider funding applications from £5,000 to £25,000 from general or specific charitable funds and approve or reject those applications. The decision to approve or reject an application is undertaken on behalf of the Charitable Funds Committee under the Charitable Funds Scheme of Delegation.

1.2 The Health Board's scheme of delegation sets out the rules for approval for all levels of funding applications. Funding for applications over £25,000 must be approved by the Charitable Funds Committee. Such applications may also be reviewed by the Advisory Group to provide comments and reflections to support the Charitable Funds Committee in discharging its responsibility.

2. DUTIES OF THE CHARITABLE FUNDS ADVISORY GROUP

2.1 The Charitable Funds Advisory Group reviews funding applications from £5,000 to £25,000 to ensure that they meet the objectives of the charity, and approves or rejects these applications. If an application is novel or contentious then it should be referred to the Charitable Funds Committee for decision.

2.2 The Charitable Funds Advisory Group reviews funding applications over £25,000 and provides comments and a recommendation to the Charitable Funds Committee.

3. AUTHORITY

3.1 The Advisory Group has authority to review, approve and recommend funding applications under the Charitable Funds Committee Scheme of Delegation as follows.

Application Value	Advisory Group Authority
£5,000 to £25,000	Review and approve or reject
£5,000 to £25,000 – novel or contentious	Review and refer to Charitable Funds Committee with a recommendation
Over £25,000	Review and provide a recommendation to Charitable Funds Committee

3.2 The Advisory Group is authorised by the Charitable Funds Committee to 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 Advisory Group).

3.3 The Advisory Group cannot approve an application in part or at a reduced level.

4. MEMBERSHIP

4.1 Members

A panel of 11 members including the following:

- Representatives from each of the three Hospital Sites
- Representatives from each of the three Areas
- Representative from Mental Health
- Representative from Cancer Services
- Representative from North Wales Clinical Services
- Representative from Womens
- Representative from Corporate Services

Chair/ Vice Chair

- The Chair and Vice Chair will be nominated members from the Group.

Secretary

- As determined by the Executive Director of Finance

4.2 In attendance

4.2.1 The Advisory Group will require the attendance for advice, support and information routinely at meetings from:

- Trustee representative (Board Member on a rotational basis)
- Charitable Funds Accountant
- Head of Fundraising

4.3 Membership

4.3.1 The membership of the Advisory Group shall be determined by the Charitable Funds Committee, based on the recommendation of the Committee Chair, taking account of the balance of skills and expertise necessary.

4.3.2 Group Members shall hold office on the Advisory Group for a minimum period of a year.

5 ADVISORY GROUP MEETINGS

5.1 Quorum

At least 6 members must be present to ensure the quorum of the Advisory Group, one of whom should be the Chair or Vice-Chair.

5.2 Frequency of Meetings

Meetings shall be held bi monthly and otherwise as the Advisory Group Chair deems necessary.

5.3 Meetings of the Advisory Group shall not be open to the press or public.

6 REVIEW

6.1 These Guidelines shall be reviewed annually by the Charitable Funds Committee and any changes recommended to the Health Board for approval.

7 DATE OF ACCEPTING THE GUIDELINES AND APPROVAL

Approved by Audit Committee:
Ratified by Board:
Reported to Charitable Funds Committee:

Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee** **12/12/19**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Acting Board Secretary
Awdur yr Adroddiad **Report Author:**	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: **Prior Scrutiny:**	Acting Board Secretary
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

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

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

The issues listed below were considered by the Audit Committee at its private in committee meeting of 12.09.19.

- Financial Conformance Report
- Post Payment Verification Progress report
- Counter Fraud Services Progress Report
- Update on Internal and External Audit Actions

Asesiad / Assessment:
Strategy Implications This report is purely administrative, there are no associated strategic implications. **Financial Implications** This report is purely administrative, there are no associated resource implications. **Risk Analysis** This report is purely administrative, there are no associated risks. **Legal and Compliance** Compliance with Standing Order 6.5.3 **Impact Assessment** This report is purely administrative, there are no associated impacts or specific assessments required

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 12.12.19**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Amendment to Standing Orders: Scheme of Reservation and Delegation (SoRD).
Cyfarwyddwr Cyfrifol: Responsible Director:	Dawn Sharp, Board Secretary
Awdur yr Adroddiad Report Author:	Liz Jones, Assistant Director, Corporate Governance
Craffu blaenorol: Prior Scrutiny:	Board Secretary
Atodiadau Appendices:	1. Welsh Health Specialised Services Committee (WHSSC) Standing Orders – final approved version 2. Emergency Ambulance Services Committee (EASC) – Standing Orders – final approved version

Argymhelliad / Recommendation:

- The Committee is asked to approve the changes to the Standing Orders and SoRD on behalf of the Board.
- The Committee is asked to note that, following approval and ratification, operational level SoRDs for each Executive, Area and main hospital site will be updated in line with the changes made to the Health Board's overarching master SoRD.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The Board has delegated responsibility for scrutinising and approving its Standing Orders, including the SoRD, to the Audit Committee. The Board retains responsibility for ratification of any approval decisions made by the Committee.

Cefndir / Background:

Following prior approval by the Audit Committee in October 2019, adoption of the Health Board's updated Standing Orders (incorporating the SoRD) was ratified at the November 2019 Health Board meeting. A number of changes have become necessary since that ratification, as follows:

- It was subsequently agreed at an Executive Team meeting that section 44 of the SoRD, regarding operational responsibility delegated by the Chief Executive for acting as the

organisation's Senior Information Risk Officer (SIRO), should be amended from the Executive Medical Director to read 'Executive Director of Finance'. The amendment was considered necessary in order to avoid a potential conflict of interest with the Executive Medical Director's Caldicott Guardian responsibilities.

- Table B requires role title changes in its first column, so that 'Hospital Assistant Medical Director' now reads 'Hospital Site Medical Director' and 'Hospital Assistant Nurse Director' now reads 'Hospital Site Nurse Director'.
- Table B requires the addition of '£100k' in columns 3 and 6 for the Hospital Site Medical Director and Hospital Site Nurse Director
- Table B requires the addition of the wording 'can approve new posts within own team' in the penultimate column and 'as escalated by Direct Reports' in the final column, for the Hospital Site Medical Director and Hospital Site Nurse Director
- Table B requires the addition of a line for Hospital Directors, with '£100k' in columns 3 and 6 and the wording 'can approve new posts within own team' in the penultimate column and 'as escalated by Direct Reports' in the final column
- The Welsh Health Specialised Services Committee (WHSSC) locally amended and approved Standing Orders are attached at appendix 1 and are to be incorporated into BCUHB's Standing Orders, which will be published on the Health Board's website.
- The Emergency Ambulance Services Committee (EASC) locally amended and approved Standing Orders are attached at appendix 2 and are to be incorporated into BCUHB's Standing Orders, which will be published on the Health Board's website.

Asesiad / Assessment & Analysis

Strategy Implications

Adoption of up to date Standing Orders and SoRD is fundamental to the entirety of the Board's strategic business.

Financial Implications

There are no financial costs associated with this paper.

Risk Analysis

The Health Board risks non-compliance with regulations, and poor governance, if it does not maintain up to date Standing Orders and SoRD.

Legal and Compliance

The Health Board is legally bound to have Standing Orders in place.

Impact Assessment

Failure to ensure that Standing Orders and the SoRD are up to date will lead to poor governance and non-compliance with statutory obligations, as above.

APPENDIX 1- Welsh Health Specialised Services Committee (WHSSC)
Standing Orders – final approved version

STANDING ORDERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Foreword

Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing Standing Orders Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Welsh Health Specialised Services Committee's (the WHSSC or the Joint Committee) proceedings and business[1]. These WHSSC Standing Orders (WHSSC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Welsh Health Specialised Services Committee (Wales) Regulations 2009[2] and LHB Standing Order 3 into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with the Memorandum of Agreement dated 12 November 2019 made between the Joint Committee and the seven LHBs in Wales that defines the respective roles of the seven LHB Accountable Officers and a hosting agreement dated 12 November 2019 between the Joint Committee and Cwm Taf Morgannwg University LHB (the host LHB), form the basis upon which the Joint Committee governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members, Joint Committee members, LHB and Welsh Health Specialised Services Team (WHSST) staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of

1 Reference Part 3, Regulation 12 of WHSSC Regulations 2009 and Regulation 14(b) and 15(5) of the LHB Regulations 2009.
2 (2009/3097 (W.270)

the Standing Orders or the wider governance arrangements for the Joint Committee. Further information on governance in the NHS in Wales may be accessed at www.wales.nhs.uk/governance-emanual/

Contents

Section: A – Introduction

Statutory framework

i) The Welsh Health Specialised Services Committee (the Joint Committee) is a joint committee of each LHB in Wales, established under the **Welsh Health Specialised Services Committee (Wales) Directions 2009** (the WHSSC Directions). The functions and services of the Joint Committee are listed in Annex 1 of the WHSSC Directions and are subject to variations to those functions agreed from time to time by the Joint Committee**.** Annex 1 was amended by the **Welsh Health Specialised Services Committee (Wales) (Amendment) Directions 2014** following the establishment of the Emergency Ambulance Services Committee. The Joint Committee is hosted by the host LHB on behalf of each of the seven LHBs.

ii) The principal place of business of the WHSSC is Unit G1, The Willowford, Treforest Industrial Estate, Pontypridd CF37 5YL.

iii) All business shall be conducted in the name of the Welsh Health Specialised Services Committee on behalf of LHBs.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006**[3] which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006**[4] applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

v) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

vi) However in some cases the relevant function may be contained in other legislation.

vii) Each LHB's functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and specialised services for the citizens in their respective areas. The WHSSC Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and will establish the joint committee for the purpose of jointly exercising those

3 c.42
4 c.41

functions.

viii) Under powers in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006 the Minister has made the **Welsh Health Specialised Services Committee (Wales) Regulations 2009**[5] (the WHSSC Regulations) which set out the constitution and membership arrangements of the Joint Committee. Certain provisions of the **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009**[6] (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

x) The Host LHB shall issue an indemnity to the Chair, on behalf of the LHBs

NHS framework

xi) In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xii) Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiii) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

xiv) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015**, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

5 (2009/3097 (W.270)
6 (2009/779 W.67)

xv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some NHS Trusts in Wales. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvi) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Ministers' Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of Committee/LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Joint Committee Framework

xvii) The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These WHSSC SOs and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation to others;
- The WHSSC SFIs;
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A hosting agreement between the Joint Committee and the host LHB in relation to the provision of administrative and any other services to be provided to the Joint Committee.

xviii) Annex 2 to these SOs provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework. These documents must be read in conjunction with the WHSSC SOs.

xix) The Joint Committee may from time to time, subject to the prior approval of each LHB's Board, agree operating procedures which apply to Joint Committee members and/or members of the WHSST and others. The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will also be considered to be an integral part of these WHSSC SOs and SFIs. Details of the Joint Committee's key operating procedures are also included in Annex 2 of these SOs.

Applying WHSSC Standing Orders

xx) The WHSSC SOs (together with the WHSSC SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any joint sub-Committees established by the Joint Committee, including any Advisory Groups. The WHSSC SOs may be amended or adapted for the joint sub-Committees or Advisory Groups as appropriate, with the approval of the Joint Committee. Further details on joint sub-Committees and

Advisory Groups may be found in Annexes 3 and 4 of these WHSSC SOs, respectively.

xxi) Full details of any non-compliance with these WHSSC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit Committee to formally consider the matter and make proposals to the Joint Committee on any action to be taken. All Joint Committee members and Joint Committee officers have a duty to report any non-compliance to the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with WHSSC SOs is a disciplinary matter.**

Variation and amendment of WHSSC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment; or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

Interpretation

xxiii) During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the WHSSC SOs, the Chair of the Joint Committee shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Committee Secretary.

xxiv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these WHSSC SOs when interpreting any term or provision covered by legislation.

Relationship with LHB Standing Orders

xxv) The WHSSC SOs form a schedule to each LHB's own SOs, and shall have effect as if incorporated within them.

The role of the Committee Secretary

xxvi) The role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is

a key source of advice and support to the Chair and Joint Committee members. Independent of the Joint Committee, the Committee Secretary acts as the guardian of good governance within the Joint Committee:

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its joint sub-Committees and Advisory Groups;
- Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the Joint Committee's compliance with the law, WHSSC SOs and the framework set by the LHBs and Welsh Ministers.

xxvii) As advisor to the Joint Committee, the Committee Secretary's role does not affect the specific responsibilities of Joint Committee members for governing the Committee's operations. The Committee Secretary is directly accountable for the conduct of their role to the Chair of the Joint Committee.

Section: B – WHSSC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions[7]

1.1.1 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the planning and securing of certain specialised and tertiary services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales.

1.1.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of specialised and tertiary services for residents within their area.

1.1.3 Each LHB will have appropriate arrangements to equip the Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

1.1.4 The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;
- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;
- Agree annually those services that should be planned on a national basis and those that should be planned locally;
- Produce an Integrated Commissioning Plan, for agreement by the Committee in conjunction with the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;

7 The WHSSC (Wales) Directions 2009 and The WHSSC (Wales) Regulations 2009

- Establish mechanisms for managing the in year risks associated with the agreed service portfolio and new pressures that may arise;

- Secure the provision of specialised and tertiary services planned at a national level, including those to be delivered by providers outside Wales; and

- Establish mechanisms to monitor, evaluate and publish the outcomes of specialised and tertiary healthcare services and take appropriate action.

1.1.5 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its roles. In the event that the Joint Committee is unable to reach agreement, then the matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making of the Management Team undertaken at the direction of the Joint Committee.

1.1.7 The Joint Committee shall work with all its partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the Joint Committee[8]

1.2.1 The membership of the Joint Committee shall be 15 voting members and three associate members, comprising the *Chair* (appointed by the Minister for Health and Social Services) and the *Vice-Chair* (appointed by the Joint Committee from existing non-officer members of the seven LHBs)[9], together with the following:

Non-Officer Members [known as Independent Members] [10]

1.2.2 A total of 2, appointed by the Joint Committee from existing non-officer members of the seven LHBs.

Chief Executives

1.2.3 A total of 7, drawn from each Local Health Board in Wales.

Officer Members [known as WHSST Directors]

1.2.4 A total of 4, appointed by the Joint Committee, consisting of a Director of

8 Ref. Welsh Health Specialised Services Committee (Wales) Directions 2009, 5(1) and Welsh Health Specialised Services Committee (Wales) Regulations 2009, Part 2
9 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009, Regulation 4(1) & 4(2)
10 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009, Regulation 4(3)

Specialised and Tertiary Services[11]; a Medical Director of Specialised and Tertiary Services; a Finance Director of Specialised and Tertiary Services, and a Nurse Director of Specialised and Tertiary Services. These officer members may have other responsibilities as determined by the Joint Committee and set out in the scheme of delegation to officers. These officer members comprise the Management Team.

1.2.5 Where a post of WHSST Director is shared between more than one person because of their being appointed jointly to a post:

i. Either or both persons may attend and take part in Joint Committee meetings;
ii. If both are present at a meeting they shall cast one vote if they agree;
iii. In the case of disagreement no vote shall be cast; and
iv. The presence of both or one person will count as one person in relation to the quorum.

Associate Members

1.2.6 The following Associate Members will attend Joint Committee meetings on an ex-officio basis, but will not have any voting rights:

- Chief Executive of Velindre NHS Trust
- Chief Executive of the Welsh Ambulance Services NHS Trust
- Chief Executive of Public Health Wales NHS Trust.

In attendance

1.2.7 The Joint Committee Chair may invite other members of the WHSST or others to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work.

Use of the term 'Independent Members'

1.2.8 For the purposes of these WHSSC SOs, use of the term 'Independent Members' refers to the following voting members of the Joint Committee:

- Chair
- Vice-Chair
- Non-Officer Members

unless otherwise stated.

11 The Director of Specialised and Tertiary Services is also known as the Managing Director of Specialised and Tertiary Services Commissioning

1.3 Member Responsibilities and Accountability

1.3.1 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the Joint Committee.

1.3.2 Independent Members who are appointed to the Joint Committee must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the health service across Wales.

1.3.3 All members must comply with the terms of their appointment to the Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

The Chair

1.3.4 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with WHSSC SOs; and
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHB's Board.

1.3.5 The Chair shall work in close harmony with the Chair of each LHB and, supported by the Committee Secretary, shall ensure that key and appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.6 The Chair is directly accountable to the Minister for Health and Social Services in respect of their performance as Chair, to each LHB Board in relation to the delivery of the functions exercised by the Joint Committee on its behalf and, through the host LHB's Board, for the conduct of business in accordance with the defined governance and operating framework.

The Vice-Chair

1.3.7 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed[12].

12 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 3, Regulation 13

1.3.8 The Vice-Chair is accountable to the Chair for their performance as Vice Chair.

Non-Officer Members

1.3.9 Non-Officer members are accountable to the Chair for their performance as Non-Officer members.

WHSST Director of Specialised and Tertiary Services

1.3.10 The WHSST Director of Specialised and Tertiary Services (Lead Director), as head of the Management Team reports to the Chair and is responsible for the overall performance of the WHSST. The Lead Director is accountable to the Joint Committee in relation to those functions delegated to them by the Joint Committee. The Lead Director is also accountable to the Chief Executive of the host LHB in respect of the administrative arrangements supporting the operation of the team.

WHSST Directors (excluding the WHSST Director of Specialised and Tertiary Services)

1.3.11 The Medical Director of Specialised and Tertiary Services, the Finance Director of Specialised and Tertiary Services, and the Nurse Director of Specialised and Tertiary Services are accountable to the Joint Committee and the Chief Executive of the host LHB through the Lead Director.

1.4 Appointment and tenure of Joint Committee members

1.4.1 The ***Chair,*** shall be appointed by the Minister for Health and Social Services for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term[13].

1.4.2 The ***Vice-Chair*** and two other ***Independent Members*** shall be appointed by the Joint Committee from existing Independent Members of the seven Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than 4 years, in line with that individual's term of office on any LHB Board. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term[14].

13 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 7
14 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 7

1.4.3 The appointment process for the Vice Chair and the two other Independent Members shall be determined by the Joint Committee, subject to the approval of each LHB Board and any directions made by the Welsh Ministers. In making these appointments, the Joint Committee must ensure:

- A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the Joint Committee;
- That wherever possible, the overall membership of the Joint Committee reflects the diversity of the population; and
- Potential conflicts of interest are kept to a minimum.

1.4.4 The ***WHSST Directors*** shall be appointed by the Joint Committee[15], and employed by the host LHB in accordance with the eligibility requirements set out in the Welsh Health Specialised Services Committee (Wales) Regulations 2009 and the employment policies of the host LHB, as appropriate. The appointments process shall be in accordance with the workforce policies and procedures of the host LHB and any directions made by the Welsh Ministers.

1.4.5 WHSST Directors tenure of office as Joint Committee members will be determined by their contract of employment.

1.4.6 All Joint Committee members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they are applicable, and as specified in the relevant regulations. Any member must inform the Joint Committee Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office[16].

2. RESPONSIBILITIES AND RELATIONSHIPS WITH EACH LHB BOARD, THE HOST LHB AND OTHERS[17]

2.0.1 The Joint Committee is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf. The Joint Committee shall also be held to account by the Welsh Government through the NHS performance management system.

2.0.2 The Board of the host LHB will not be responsible or accountable for the

15 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 4(3)
16 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 6,7,8 and 11
17 Ref. Welsh Health Specialised Services Committee (Wales) Directions 2009 3(4)

planning, funding and securing of specialised services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the WHSST acts in accordance with its administrative policies and procedures.

2.0.3 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chair.

2.0.4 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

2.0.5 The LHB Chairs *[through the lead Chair]* shall put in place arrangements to meet with the Joint Committee Chair on a regular basis to discuss the Joint Committee's activities and operation.

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

3.0.1 Within the framework approved by each LHB Board and set out within these WHSSC SOs - and subject to any directions that may be given by the Welsh Ministers - the Joint Committee may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

3.0.2 The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i. Schedule of matters reserved to the Joint Committee;
ii. Scheme of delegation to joint sub-Committees and others; and
iii. Scheme of delegation to Officers.

all of which must be formally adopted by the Joint Committee.

3.0.3 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

3.1 Chair's action on urgent matters

3.1.1 There may, occasionally, be circumstances where decisions which would

normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and the Lead Director, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Independent Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

3.1.2 Chair's action may not be taken where either the Joint Committee Chair or the Lead Director has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or another WHSST Director acting on behalf of the Lead Director will take a decision on the urgent matter, as appropriate.

3.2 Delegation to joint sub-Committees and others

3.2.1 The Joint Committee shall agree the delegation of any of its functions to joint sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions agreed by the LHBs or the Welsh Ministers.

3.2.2 The Joint Committee shall agree and formally approve the delegation of specific powers to be exercised by joint sub-Committees which it has formally constituted or to others.

3.3 Delegation to Officers

3.3.1 The Joint Committee will delegate certain functions to the Lead Director. For these aspects, the Lead Director, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Lead Director will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

3.3.2 This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Lead Director may periodically propose amendment to the Scheme of Delegation and any such amendments must also be considered and approved by the Joint Committee.

3.3.3 Individual Directors are in turn responsible for delegation within their own teams in accordance with the framework established by the Lead Director and agreed by the Joint Committee.

4. JOINT SUB-COMMITTEES

4.0.1 In accordance with WHSSC Standing Order 4.0.3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

4.0.2 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies.

4.0.3 The Joint Committee shall establish a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs. As a minimum, it shall establish joint sub-Committees which cover the following aspects of Joint Committee business:

- Quality and Safety
- Audit

4.0.4 The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own joint sub-Committees or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the hosting agreement between the Joint Committee and the host LHB or the agreement between the seven LHB Accountable Officers (as appropriate).

4.0.5 Full details of the joint sub-Committee structure established by the Joint Committee, including detailed terms of reference for each of these joint sub-Committees are set out in Annex 3 of these WHSSC SOs.

4.0.6 Each joint sub-Committee established by or on behalf of the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.0.7 In doing so, the Joint Committee shall specify which aspects of the WHSSC SOs are not applicable to the operation of the joint sub-Committee, keeping any such aspects to the minimum necessary.

4.0.8 The membership of any such joint sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers. Depending on the joint sub-Committee's defined role and remit; membership may be drawn from the Joint Committee, LHB Board or committee members, staff (subject to the conditions set in WHSSC Standing Order 4.0.9) or others.

4.0.9 WHSST Directors or officers should not normally be appointed as joint sub-Committee Chairs, nor should they be appointed to serve as members on any committee set up to review the exercise of functions delegated to officers. Designated WHSST Directors or officers shall, however, be in attendance at such joint sub-Committees, as appropriate.

4.1 Other Groups

4.1.1 The Joint Committee may also establish other groups to help it in the conduct of its business.

4.2 Reporting activity to the Joint Committee

4.2.1 The Joint Committee must ensure that the Chairs of all joint sub-Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the Joint Committee on their activities. Joint sub-Committee Chairs' shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.2.2 Each joint sub-Committee shall also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

5.0.1 The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed terms of reference are set out in Annex 4 of the WHSSC SOs.

5.0.2 Any Expert Panel or Advisory Group established by the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.0.3 In doing so, the Joint Committee shall specify which aspects of the WHSSC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

5.0.4 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers.

5.1 Reporting activity

5.1.1 The Joint Committee shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the Joint Committee on their activities. Expert Panel or Advisory Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.1.2 Any Expert Panel or Advisory Group shall also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

6.1.2 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

6.2 Working with Community Health Councils

6.2.1 The Joint Committee shall make arrangements to ensure arrangements are in place to liaise with CHC members as appropriate.

6.3 Annual Plan of Committee Business

6.3.1 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall appear on every Joint Committee agenda.

6.3.2 The plan shall set out the arrangements in place to enable the Joint Committee to meet its obligations to its citizens as outlined in paragraph

6.1.1 whilst also allowing Joint Committee members to contribute in either English or Welsh languages, where appropriate.

6.3.3 The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of joint sub-Committees, Expert Panel and Advisory Groups.

6.3.4 The Joint Committee shall agree the plan for the forthcoming year by the end of March, and this plan shall be published on the organisation's website.

6.4 Calling Meetings

6.4.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

6.4.2 If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

6.5 Preparing for Meetings

Setting the agenda

6.5.1 The Joint Committee Chair, in consultation with the Committee Secretary and the Lead Director, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from joint sub-Committees and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

6.5.2 Any Joint Committee member may request that a matter is placed on the Agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of Joint Committee business.

Notifying and equipping Joint Committee members

6.5.3 Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 10[18] calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

6.5.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

6.5.5 In the event that at least half of the Joint Committee members do not receive the Agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.5.6 In the case of a meeting called by Joint Committee members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.5.7 Except for meetings called in accordance with WHSSC Standing Order 6.4, at least 10 calendar days before each meeting of the Joint Committee a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On each LHB's website, together with the papers supporting the public part of the Agenda; as well as

18 See Schedule 3, 2(3) of the LHB (Constitution, Membership and Procedures) Regulations 2009

- Through other methods of communication as set out in the Joint Committee's communication strategy.

6.5.8 When providing notification of the forthcoming meeting, each LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

6.6 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

6.6.1 The Joint Committee shall encourage attendance at its formal Joint Committee meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the Joint Committee. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility.

6.6.2 The Joint Committee shall conduct as much of its formal business in public as possible[19]. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter affecting a WHSST officer or a patient. In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee shall resolve:

> *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 [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].*

6.6.3 In these circumstances, when the Joint Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Joint Committee in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Joint Committee meeting held in public session.

6.6.4 The Committee Secretary, on behalf of the Joint Committee Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

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19 Schedule 3, 8 of the LHB(Constitution, Membership and Procedures) Regulations 2009

6.6.5 In encouraging entry to formal Joint Committee Meetings from members of the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.6.6 Unless the Joint Committee has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups

6.6.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

6.6.8 The Chair of the Joint Committee will preside at any meeting of the Joint Committee unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice-Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

6.6.9 The Chair must ensure that the meeting is handled in a manner that enables the Joint Committee to reach effective decisions on the matters before it. This includes ensuring that Joint Committee members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Joint Committee must have access to appropriate advice on the conduct of the meeting through the attendance of the Committee Secretary. The Chair has the final say on any matter relating to the conduct of Joint Committee business.

Quorum

6.6.10 At least 8 voting members, at least 4 of whom are LHB Chief Executives and 2 are Independent Members, must be present to allow any formal business to take place at a Joint Committee meeting.

6.6.11 If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

6.6.12 If the Lead Director or another WHSST Director is unable to attend a Joint Committee meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, their voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Joint Committee member in their own right, e.g., a person deputising for the Lead Director will usually be another WHSST Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

6.6.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee member or their deputy disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.6.14 In the normal course of Joint Committee business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken. The Committee Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Joint Committee unless moved by a Joint Committee member and seconded by another Joint Committee member (including the Joint Committee Chair).

6.6.15 **Proposing a formal notice of Motion –** Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in writing of the proposed motion at least 12 days before a planned meeting.

Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.6.16 The Joint Committee Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Joint Committee business.

6.6.17 **Amendments –** Any Joint Committee member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

6.6.18 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

6.6.19 **Motions under discussion –** When a motion is under discussion, any Joint Committee member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Joint Committee member may not be heard further;
- The Joint Committee decides upon the motion before them;
- An ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.6.20 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.6.21 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Joint Committee Chair.

6.6.22 **Motion to rescind a resolution –** The Joint Committee may not consider a motion to amend or rescind any resolution (or the general substance of any

resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Joint Committee members.

6.6.23 A Motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a joint sub-Committee/WHSSC Director to which a matter has been referred.

Voting

6.6.24 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Joint Committee.

6.6.25 In determining every question at a meeting the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales. Such views may be presented to the Joint Committee through the Chairs of the LHB's Advisory Groups.

6.6.26 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

6.6.27 A nominated deputy of a LHB Chief Executive may vote. In no circumstances may a nominated deputy of a WHSST member vote. Absent Joint Committee members may not vote by proxy. Absence is defined as being absent at the time of the vote.

6.7 Record of Proceedings

6.7.1 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence, and shall be

submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.7.2 Agreed minutes shall be circulated in accordance with Joint Committee members' wishes, and, where providing a record of a formal Joint Committee meeting shall be made available to the public on each LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act, the Joint Committee's Communication Strategy and the host LHB's Welsh language requirements.

6.8 Confidentiality

6.8.1 All Joint Committee members (including Associate Members), together with members of any joint sub-Committee, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Joint Committee Chair or relevant joint sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the WHSSC Values and Standards of Behaviour (including Gifts and Hospitality) Policy or legislation such as the Freedom of Information Act 2000, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Joint Committee must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, WHSST officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the WHSSC SOs.

7.1 Declaring and recording Joint Committee members' interests

7.1.1 **Declaration of interests –** It is a requirement that all Joint Committee members should declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Joint Committee member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Joint Committee's business. Joint Committee members must be familiar

with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. Joint Committee members must notify the Joint Committee of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Joint Committee members.

7.1.2 Joint Committee members must also declare any interests held by family members or persons or bodies with which they are connected. The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Joint Committee members are in any doubt about what may be considered as an interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

7.1.3 **Register of interests –** The Lead Director, through the Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members. The register will include details of all Directorships and other relevant and material interests which have been declared by Joint Committee members.

7.1.4 The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, through which Joint Committee members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This may include publication on the Joint Committee's website.

7.1.6 **Publication of declared interests in Annual Report –** Joint Committee members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each LHB Board's Annual Report.

7.2 Dealing with Members' interests during Joint Committee meetings

7.2.1 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn,

individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides specialised and tertiary services.

7.2.2 Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary, before the start of the Joint Committee meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Joint Committees minutes.

7.2.3 It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting.

ii. The declaration is formally noted and recorded, and the Joint Committee member participates fully in the Joint Committee's discussion, but takes no part in the Joint Committee's decision;

iii. The declaration is formally noted and recorded, and the Joint Committee member takes no part in the Joint Committee discussion or decision;

iv. The declaration is formally noted and recorded, and the Joint Committee member is excluded for that part of the meeting when the matter is being discussed. A Joint Committee member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Joint Committee.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

7.2.5 Where the Joint Committee Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice-Chair, on behalf

of the Joint Committee.

7.2.6 In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take advice from the Committee Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a Joint Committee member, or any person they are connected with[20] has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

7.2.8 **The Local Health Boards (Constitution, Membership and Procedures) Wales Regulations 2009** define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The WHSSC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a Joint Committee meeting, an individual Joint Committee member may establish a clear conflict of interest between their role as a Joint Committee member and that of their professional role outside of the Joint Committee. In any such circumstance, the Joint Committee shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Committee Secretary.

7.3 Dealing with officers' interests

7.3.1 The Joint Committee must ensure that the Committee Secretary, on behalf of the Lead Director, establishes and maintains a system for the declaration, recording and handling of WHSST officers' interests in accordance with the Values and Standards of Behaviour Framework.

7.4 Reviewing how Interests are handled

7.4.1 The Joint Committee's Audit Committee will review and report to the LHBs upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

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[20] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

7.5 Dealing with offers of gifts,[21] hospitality and sponsorship

7.5.1 The Standards of Behaviour (including Gifts and Hospitality) Policy adopted by the Joint Committee prohibits Joint Committee members and WHSST officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Joint Committee member or WHSST officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Joint Committee member or WHSST officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Committee Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Joint Committee;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Joint Committee; and

[21] The term gift refers also to any reward or benefit.

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Sponsorship

7.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the WHSSC Values and Standards of Behaviour (including Gifts and Hospitality) Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

7.7.1 The Committee Secretary, on behalf of the Joint Committee Chair, will maintain a Register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Joint Committee members. WHSST Directors will adopt a similar mechanism in relation to WHSST officers working within their areas.

7.7.2 Every Joint Committee member and WHSST officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship made in their capacity as Joint Committee members, including those offers that have been refused. The Committee Secretary, on behalf of the Joint Committee Chair and Lead Director, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship is kept under active review, taking appropriate action where necessary.

7.7.3 When determining what should be included in the register with regard to gifts and hospitality, individuals must apply the following principles, subject to the considerations in WHSSC Standing Order 7.5:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value would not usually need to be recorded, e.g., seasonal items such as diaries/calendars with normally fall within this category.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[22]' hospitality need not be included in the Register.

7.7.4 Joint Committee members and WHSST Officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the Joint Committee;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.7.5 The Committee Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Joint Committee to be submitted to the designated Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the LHBs jointly upon the adequacy of the Joint Committees arrangements for dealing with offers of gifts, hospitality and sponsorship.

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

8.0.1 The Joint Committee shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

8.0.2 The Joint Committee shall ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit Committee.

[22] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

8.1 The role of Internal Audit in providing independent internal assurance

8.1.1 The Joint Committee shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Ministers.

8.2 Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups

8.2.1 The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its joint sub-Committees, Expert Panel and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

8.2.2 Each joint sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

8.2.3 The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Committee Development Programme, as part of an overall Organisation Development framework; and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

8.3.1 The Joint Committee shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

8.3.2 The Joint Committee may be assured, from the work carried out by external

audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Joint Committee itself may commission specifically for that purpose.

8.3.3 The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

8.3.4 The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

9. DEMONSTRATING ACCOUNTABILITY

9.0.1 Taking account of the arrangements set out within these WHSSC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the citizens it serves, its officers and healthcare professionals.

9.0.2 The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

9.0.3 The Joint Committee shall ensure that within the WHSST, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

9.1.1 The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee;

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others;
- Ensuring the provision of secretariat support for Joint Committee meetings;
- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;
- Ensuring an effective relationship between the Joint Committee and its host LHB; and
- Facilitating effective reporting to each LHB

enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

10. REVIEW OF STANDING ORDERS

10.0.1 The WHSSC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in WHSSC SOs, including the appropriate impact assessment.

Annex 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Introduction

As set out in WHSSC Standing Order 3, the Welsh Health Specialised Services Committee (the Joint Committee) - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively, and in a manner that secures the achievement of the Joint Committee's aims and objectives. The Joint Committee may delegate functions to:

i. A sub-Committee of the Joint Committee, e.g., Audit Committee;

ii. A Group, Expert Panel or Advisory Group , e.g., with other LHBs established to take forward certain matters relating to specialist services; and

iii. Officers of the Joint Committee (who may, subject to the Joint Committee's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Joint Committee is notified of any matters that may affect the operation and/or reputation of the Joint Committee.

The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Joint Committee;
- Scheme of delegation to sub-Committees or sub-Groups and others; and
- Scheme of delegation to officers.

all of which form part of the WHSSC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Joint Committee will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- *Everything is retained by the Joint Committee unless it is specifically delegated in accordance with the requirements set out in WHSSC SOs or WHSSC SFIs*

- *The Joint Committee must retain that which it is required to retain (whether by statute or as determined by the Welsh Government) as well as that which it considers is essential to enable it to fulfil its role in setting the Joint Committee's direction, equipping the Joint Committee to deliver and ensuring achievement of its aims and objectives through effective performance management*

- *Any decision made by the Joint Committee to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility*

- *The Joint Committee must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development*

- *The Joint Committee must take appropriate action to assure itself that all matters delegated are effectively carried out*

- *The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes*

- *The Joint Committee may delegate authority to act, but retains overall responsibility and accountability*

- *When delegating powers, the Joint Committee will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.*

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Joint Committee

The Joint Committee will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Lead Director

The Lead Director will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Joint Committee must formally agree this scheme.

In preparing the scheme of delegation to officers, the Lead Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in WHSSC SFIs);
- The Memorandum of Agreement agreed with the seven LHBs and approved by the Joint Committee; and
- The Hosting Agreement agreed with the host LHB and approved by the Joint Committee.

The Lead Director may re-assume any of the powers they have delegated to others at any time.

The Committee Secretary

The Committee Secretary will support the Joint Committee in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Joint Committee is presented to the Joint Committee for its formal agreement;
- Effective arrangements are in place for the delegation of Joint Committee functions within the organisation and to others, as appropriate; and

- Arrangements for reservation and delegation are kept under review and presented to the Joint Committee for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Joint Committee of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Lead Director of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Lead Director is absent their nominated Deputy may exercise those powers delegated to the Lead Director on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Lead Director or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Joint Committee. The Scheme is to be used in conjunction with the system of control and other established procedures within the Joint Committee.

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[23]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with WHSSC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are listed below:
3	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Joint Committee, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges

[23] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards: ▪ WHSSC SOs ; ▪ WHSSC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework
6	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework for performance management, risk and assurance
7	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Joint Committee determines it so based

			upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Lead Director in accordance with WHSSC Standing Order requirements

9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with WHSSC SOs
10	FULL	OPERATING ARRANGEMENTS	Approve policies for dealing with complaints and incidents
11	FULL	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with WHSSC SFIs
12	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Lead Director and Officers
13			N/A
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of the WHSST Directors and any other Joint Committee level appointments, e.g., the Committee Secretary
15	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. from Audit Committee
16	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Joint Committee's top level organisation structure and Joint Committee policies
17	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-Committees, including any joint sub-Committees directly accountable to the Joint Committee

18	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the Joint Committee
19	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups
20	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the Joint Committee
21	FULL	STRATEGY & PLANNING	Determine the Joint Committee's strategic aims, objectives and priorities
22	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Commissioning Plan
23	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Risk Management Strategy and plans
24	FULL	STRATEGY & PLANNING	Approve the Joint Committee's citizen engagement and involvement strategy, including communication
25	FULL	STRATEGY & PLANNING	Approve the Joint Committee's partnership and stakeholder engagement and involvement strategies

26	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient centred specialised and tertiary services for the population of Wales ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
27	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
28	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Lead Director set out in the WHSSC SFIs
29			N/A
30	FULL	PERFORMANCE & ASSURANCE	Receive reports from the WHSST Directors on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
31	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee's sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans

32	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate)
33			N/A
34			N/A
35			N/A
36	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government
37			N/A

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE-CHAIR AND INDEPENDENT MEMBERS			
	Chair		Chair of the Integrated Governance Committee
	Independent Member or Vice-Chair		Audit Lead

	Independent Member or Vice-Chair		Chair of the Quality and Patient Safety Committee

DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS[24]

WHSSC Standing Order 3 provides that the Joint Committee may delegate powers to sub-Committees and others. In doing so, the Joint Committee has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such sub-Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Joint Committee has delegated a range of its powers to the following sub-Committees and others:

- Audit Committee (of the host organisation)
- Quality and Patient Safety Committee
- Individual Patient Funding Request (IPFR) Panel (WHSSC)
- Integrated Governance Committee
- Welsh Renal Clinical Network
- Management Group

[24] As defined in Standing Orders.

The scope of the powers delegated, together with the requirements set by the Joint Committee in relation to the exercise of those powers are as set out in i) sub-Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Joint Committee's Scheme of Delegation to sub-Committees.

SCHEME OF DELEGATION TO WHSST DIRECTORS AND OFFICERS

The WHSSC SOs and WHSSC SFIs specify certain key responsibilities of the Lead Director, the Director of Finance and other officers. The Lead Director's Job Description sets out their specific responsibilities, and the individual job descriptions determined for other WHSST Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the WHSSC SFIs form the basis of the Joint Committee's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
Agreeing and signing Health Care Agreements and Contracts with service providers for health care services	Lead Director Director of Finance (Deputy)
Approval to commission Specialist healthcare services	Lead Director

Information Governance arrangements	Committee Secretary (in conjunction with the host LHB)
Management of Concerns	Director of Nursing & Quality Assurance
Health and Safety arrangements	Lead Director/ Committee Secretary (in conjunction with the host LHB)
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with government directions.	Chair/ Lead Director Director of Finance (Deputy)
Issuing tenders and post tender negotiations.	Lead Director Director of Finance (Deputy)
Legal advice	Committee Secretary
Action on litigation	Lead Director/ Committee Secretary
Operation of detailed financial matters, including bank accounts and banking procedures	Director of Finance (in conjunction with the host LHB Director of Finance)
Workforce	Committee Secretary
Public consultation	Lead Director
Manage central reserves and contingencies	Director of Finance
Management and control of stocks other than pharmacy stocks	Lead Director

Management and control of computer systems and facilities	Committee Secretary
Monitor and achievement of management cost targets	Lead Director
Recording of payments under the losses and compensation regulations	Director of Finance
Individual Patient Funding Requests	Director of Nursing & Quality Assurance
Approve and ensure the publication of non-statutory Annual Report	Lead Director

This scheme only relates to matters delegated by the Joint Committee to the Lead Director and other WHSST Directors, together with certain other specific matters referred to in WHSSC SFIs.

Each WHSST Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Joint Committee framework

The Joint Committee's governance and accountability framework comprises these WHSSC SOs, incorporating schedules of Powers reserved for the Joint Committee and Delegation to others, together with the following documents:

- ***WHSSC SFIs***
- ***Values and Standards of Behaviour Framework***
- ***Risk and Assurance Framework***
- ***Key policy documents***

agreed by the Joint Committee. These documents must be read in conjunction with the WHSSC SOs and will have the same effect as if the details within them were incorporated within the WHSSC SOs themselves.

These documents may be accessed from the Committee Secretary by written request.

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of Joint Committee business are also issued electronically, usually under cover of a Welsh Health Circular.

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

[Joint Committee to insert details, including detailed Terms of Reference and Operating Arrangements for each sub-Committee]

Annex 4

ADVISORY GROUPS AND EXPERT PANELS TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

[Joint Committee to insert details, including detailed Terms of Reference and Operating Arrangements for each Advisory Group and Expert Panel]

Appendix 2
Schedule 4.2

MODEL STANDING ORDERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing SOs Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Emergency Ambulance Services Committee's (the EASC or the Joint Committee) proceedings and business. These EASC Standing Orders (EASC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014 No.566 (w.67)) and LHB Standing Order 3 into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with the Memorandum of Agreement dated [26 September 2017] made between the Joint Committee and the seven LHBs in Wales that defines the respective roles of the seven LHB Accountable Officers and a hosting agreement dated [26 September 2017] between the Joint Committee and Cwm Taf Morgannwg University Health Board (the host LHB), form the basis upon which the Joint Committee governance and accountability

framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members, Joint Committee members, LHB and the National Collaborative Commissioning Unit (NCCU) staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee.

Further information on governance in the NHS in Wales may be accessed at www.wales.nhs.uk/governance-emanual/.

Contents

Section: A – Introduction

Statutory framework

i) The Emergency Ambulance Services Committee (the Joint Committee) is a joint committee of each LHB in Wales, established under the **Emergency Ambulance Services Committee (Wales) Regulations 2014** (the EASC Regulations). The functions and services of the Joint Committee are listed in the **Emergency Ambulance Services Committee (Wales) Directions 2014,** (EASC Directions) and are subject to variations to those functions agreed from time to time by the Joint Committee**.** The Directions were amended by the **Emergency Ambulance Services Committee (Wales) Amendment Directions 2016.** The Joint Committee is hosted by the Cwm Taf Morgannwg University Health Board on behalf of each of the seven LHBs.

ii) The principal place of business of the EASC is National Collaborative Commissioning Unit, 1 Charnwood Court, Heol Billingsley, Treforest Industrial Estate, CF15 7QZ.

iii) All business shall be conducted in the name of the Emergency Ambulance Services Committee on behalf of LHBs.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

v) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

vi) However in some cases the relevant function may be contained in other legislation.

vii) Each LHB's functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and specialised services for the citizens in their respective areas. The EASC Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance

and non-emergency patient transport services and for the purpose of jointly exercising those functions will establish the joint committee.

viii) Under powers in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006 the Minister has made the EASC Regulations, which set out the constitution and membership arrangements of the Joint Committee. Certain provisions of the **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009** (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

x) The Cwm Taf Morgannwg University Health Board as the host LHB shall issue an indemnity to the Chair, on behalf of the LHBs.

NHS framework

xi) In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xii) Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiii) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

xiv) The Welsh Ministers, reflecting their constitutional and legal obligations under the **Well-being of Future Generations (Wales) Act 2015 (2015 No.02)**, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in

all it does.

xv) The **Well-being and Future Generations (Wales) Act** also places duties on LHBs and some NHS Trusts in Wales. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvi) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Minister's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Joint Committee Framework

xvii) The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These EASC Standing Orders (SOs) and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation (The former Cwm Taf University LHB Scheme of Delegation has been adopted for use by the Committee in November 2016) to others;
- The EASC SFIs (The former Cwm Taf Standing Financial Instructions have been adopted for use by the Committee in November 2016);
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A hosting agreement between the Joint Committee and the host LHB in relation to the provision of administrative and any other services to be provided to the Joint Committee.

xviii) **Annex 2** to these SOs provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework. These documents must be read in conjunction with these EASC SOs.

xix) The Joint Committee may from time to time, subject to the prior approval of each LHB's Board, agree operating procedures which apply to Joint Committee members and/or members of the National Collaborative Commissioning Unit (NCCU) staff and others. The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will also be considered to be an integral part of these EASC SOs and SFIs. Details of the Joint Committee's key operating procedures are also included in **Annex 2** of these SOs.

Applying EASC Standing Orders

xx) The EASC SOs (together with the EASC SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any Joint Committee Sub Groups established by the Joint Committee, including any Advisory Groups. The EASC SOs may be amended or adapted for the Joint Committee Sub Groups or Advisory Groups as appropriate, with the approval of the Joint Committee. Further details on Joint Committee Sub Groups and Advisory Groups may be found in Annexes 3 and 4 of these EASC SOs, respectively.

xxi) Full details of any non-compliance with these EASC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit and Risk Committee at Cwm Taf Morgannwg UHB to formally consider the matter and make proposals to the Joint Committee on any action to be taken. All Joint Committee members and Joint Committee officers have a duty to report any non-compliance to the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with EASC SOs is a disciplinary matter.**

Variation and amendment of EASC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment; or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

Interpretation

xxiii) During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the EASC SOs, the Chair of the Joint Committee shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Committee Secretary.

xxiv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these EASC SOs when interpreting any term or provision covered by legislation.

Relationship with LHB Standing Orders

xxv) The EASC SOs form a schedule to each LHB's own SOs, and shall have effect as if incorporated within them.

The role of the Committee Secretary

xxvi) The role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is a key source of advice and support to the Chair and Joint Committee members.
Independent of the Joint Committee, the Committee Secretary acts as the guardian of good governance within the Joint Committee:

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, Joint Committee Sub Groups and Advisory Groups;
- Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the Joint Committee's compliance with the law, EASC SOs and the framework set by the LHBs and Welsh Ministers.

xxvii) As advisor to the Joint Committee, the Committee Secretary's role does not affect the specific responsibilities of Joint Committee members for governing the Committees operations. The Committee Secretary is directly accountable for the conduct of their role to the Chair of the Joint Committee.

Section: B – EASC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions

1.1.1 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the commissioning of emergency ambulance and non-emergency patient transport services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales. Since 2016, this has also included the commissioning of the Emergency Medical Retrieval and Transfer Services (EMRTS).

1.1.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of emergency ambulance and non-emergency patient transport services for residents within their area.

1.1.3 Each LHB will have appropriate arrangements to equip the Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

1.1.4 The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of emergency ambulance service, non-emergency patient transport services and emergency medical retrieval and transfer services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging ways of working and commission the best quality emergency ambulance, non-emergency patient transport services and emergency medical retrieval and transfer services;
- Produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of emergency ambulance, non-emergency patient transport services and emergency medical retrieval and transfer services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the National Collaborative Commissioning Unit (NCCU) staff) in

accordance with any specific directions set by the Welsh Ministers;

- Establish mechanisms for managing the commissioning risks;
- Establish mechanisms to monitor, evaluate and publish the outcomes of emergency ambulance, non-emergency patient transport services and emergency medical retrieval and transfer services and take appropriate action.

1.1.5 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its roles. In the event that the Joint Committee is unable to reach agreement, then the matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making of the National Collaborative Commissioning Unit (NCCU) staff undertaken at the direction of the Joint Committee.

1.1.7 The Joint Committee shall work with all its partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the Joint Committee

1.2.1 The membership of the Joint Committee shall be 9 voting members and three associate members, comprising the *Chair* (appointed by the Welsh Ministers) and the *Vice-Chair* (appointed by the Joint Committee from existing chief officer (executive) or nominated representatives of the seven LHBs), together with the following:

Chief Officers or nominated representative

1.2.2 A total of 7, drawn from each Local Health Board in Wales. (Where a Chief Officer intends to nominate a representative the nomination must be an Officer Member (Executive Director) of the LHB, must be in writing addressed to the Chair of the Joint Committee and must specify if the nomination is for a specific length of time.

Officer Member

1.2.3 An officer member employed by Cwm Taf Morgannwg University Health Board (the host LHB) to undertake the functions of the Chief Ambulance Services Commissioner. In addition,

1.2.4 Where a post of Chief Ambulance Services Commissioner is shared between more than one person because of their being appointed jointly to a

post:

i. Either or both persons may attend and take part in Joint Committee meetings;
ii. If both are present at a meeting they shall cast one vote if they agree;
iii. In the case of disagreement no vote shall be cast; and
iv. The presence of both or one person will count as one person in relation to the quorum.

Associate Members

1.2.5 The following three Associate Members who will attend Joint Committee meetings on an ex-officio basis, but will not have any voting rights:

- Chief Executive of Velindre NHS Trust;
- Chief Executive of the Welsh Ambulance Services NHS Trust;
- Chief Executive of Public Health Wales NHS Trust.

In attendance

1.2.6 The Joint Committee Chair may invite other members of the National Collaborative Commissioning Unit (NCCU) staff or others to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work.

1.3 Member Responsibilities and Accountability

1.3.1 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the Joint Committee.

1.3.2 All members must comply with the terms of their appointment to the Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

The Chair

1.3.3 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with EASC SOs; and
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHB's Board.

1.3.4 The Chair shall work in close harmony with the Chair of each LHB and, supported by the Committee Secretary, shall ensure that key and

appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.5 The Chair is directly accountable to the Minister for Health and Social Services in respect of their performance as Chair, to each LHB Board in relation to the delivery of the functions exercised by the Joint Committee on its behalf and, through the host LHB's Board, for the conduct of business in accordance with the defined governance and operating framework.

The Vice-Chair

1.3.6 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

1.3.7 The Vice-Chair is accountable to the Chair for their performance as Vice-Chair.

Officer Members

1.3.8 Officer members are accountable to the Chair for their performance.

1.4 Appointment and tenure of Joint Committee members

1.4.1 The ***Chair,*** appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.4.2 The ***Vice-Chair*** shall be appointed by the Joint Committee from amongst the Chief Executives or their nominated representatives of the seven Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than four years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.4.3 Reference to the tenure of office of the Vice-Chair are to this appointment and not to their tenure of office as a member of the Joint Committee.

1.4.4 The appointment process for the Vice-Chair shall be determined by the Joint Committee, subject to the approval of each LHB Board and any directions made by the Welsh Ministers. In making these appointments, the Joint Committee must ensure:

- A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the Joint Committee;

- That wherever possible, the overall membership of the Joint Committee reflects the diversity of the population; and
- Potential conflicts of interest are kept to a minimum.

1.4.5 All Joint Committee members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they applicable, and as specified in the relevant regulations. Any member must inform the Joint Committee Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office.

2. RESPONSIBILITIES AND RELATIONSHIPS WITH EACH LHB BOARD, THE HOST LHB AND OTHERS

2.0.1 The Joint Committee is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf. The Joint Committee shall also be held to account by the Welsh Government through the NHS performance management system.

2.0.2 The Board of the host LHB will not be responsible or accountable for the planning, funding and securing of emergency ambulance or non-emergency patient transport services and emergency medical retrieval and transfer services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the National Collaborative Commissioning Unit (NCCU) staff acts in accordance with its administrative policies and procedures.

2.0.3 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chief Officer.

2.0.4 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

3.0.1 Within the framework approved by each LHB Board and set out within these EASC SOs - and subject to any directions that may be given by the Welsh Ministers - the Joint Committee may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

3.0.2 The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i. Schedule of matters reserved to the Joint Committee;
ii. Scheme of delegation to Joint Committee Sub Groups and others; and

Scheme of delegation to Officers all of which must be formally adopted by the Joint Committee.

3.0.3 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

3.1 Chair's action on urgent matters

3.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and the Chief Ambulance Services Commissioner, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Joint Committee Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

3.1.2 Chair's action may not be taken where either the Joint Committee Chair or the Chief Ambulance Services Commissioner has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair and/or Deputy Chief Ambulance Services Commissioner will take a decision on the urgent matter, as appropriate.

3.2 Delegation to Joint Committee sub Committees and others

3.2.1 The Joint Committee shall agree the delegation of any of their functions to Joint Committee sub-Committees or sub-Groups or others, setting any conditions and restrictions it considers necessary and following any directions agreed by the LHBs or the Welsh Ministers.

3.2.2 The Joint Committee shall agree and formally approve the delegation of specific powers to be exercised by Joint Committee sub-Committees or sub-Groups which it has formally constituted or to others.

3.3 Delegation to Officers

3.3.1 The Joint Committee will delegate certain functions to the Chief Ambulance Services Commissioner (CASC). For these aspects, the CASC, when compiling the Scheme of Delegation, shall set out proposals for those

functions they will perform personally and shall nominate other officers to undertake the remaining functions. The CASC will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

3.3.2 This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Chief Ambulance Services Commissioner may periodically propose amendments to the Scheme of Delegation and any such amendments must also be considered and approved by the Joint Committee.

3.3.3 Individual Chief Officers are in turn responsible for delegation within their own teams in accordance with the framework established by the Chief Ambulance Services Commissioner and agreed by the Joint Committee.

4. JOINT COMMITTEE SUB-COMMITTEES AND SUB-GROUPS

4.0.1 In accordance with EASC Standing Order 4.0.3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint sub-Committees and sub-Groups of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

4.0.2 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies.

4.0.3 The Joint Committee shall establish a Joint Committee sub-Committee and sub-Groups structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs. As a minimum it shall establish joint –sub-Committee which cover the following aspects of Joint Committee business:

- Quality and Safety (of the Host body)
- Audit and Risk Committee (of the host body)

4.0.4 The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own Joint Committee sub-Committee or sub-Groups or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the hosting agreement between the Joint Committee and the host LHB or the agreement between the seven LHB Accountable Officers (as appropriate).

4.0.5 Full details of the Joint Committee sub-Committee or sub-Groups structure established by the Joint Committee, including detailed terms of reference for each of these Joint Committee sub-Committees or sub-Groups are set

out in **Annex 3** of these EASC SOs.

4.0.6 Each Joint Committee sub-Committee or sub-Group established by or on behalf of the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.0.7 In doing so, the Joint Committee shall specify which aspects of the EASC SOs are not applicable to the operation of the Joint Committee Sub-Groups, keeping any such aspects to the minimum necessary.

4.0.8 The membership of any such Joint Committee sub-Committee or sub-Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers. Depending on the Joint Committee sub-Committees' or sub-Groups' defined role and remit; membership may be drawn from the Joint Committee, LHB Board or committee members, staff (subject to the conditions set out in EASC SOs 4.0.9) or others.

4.0.9 Members of the National Collaborative Commissioning Unit (NCCU) staff should not normally be appointed as Joint sub-Committee Chair, nor should they be appointed to serve as members of any sub-Committee set up to review the exercise of functions delegated to officers. Designated National Collaborative Commissioning Unit (NCCU) staff officers shall, however, be in attendance at Joint sub-Committees/groups as appropriate.

4.1 Other Groups

4.1.1 The Joint Committee may also establish other groups to help it in the conduct of its business.

4.2 Reporting activity to the Joint Committee

4.2.1 The Joint Committee must ensure that the Chairs of all Joint Committee sub-Committees and sub-Groups and other bodies or groups operating on its

behalf report formally, regularly and on a timely basis to the Joint Committee on their activities. Joint Committee sub-Committee and sub-Group Chairs' shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.2.2 Each Joint Committee sub-Committee and sub-Group shall also submit an annual report to the Joint Committee through the Chair within - six weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

5.0.1 The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed terms of reference are set out in **Annex 4** of the EASC SOs.

5.0.2 Any Expert Panel or Advisory Group established by the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.0.3 In doing so, the Joint Committee shall specify which aspects of the EASC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

5.0.4 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers.

5.1 Reporting activity

5.1.1 The Joint Committee shall ensure that the Chairs of any Sub Group reports formally, regularly and on a timely basis to the Joint Committee on their

activities. Sub Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.1.2 Any Sub Group shall also submit an annual report to the Joint Committee through the Chair within six weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

6.1.2 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

6.2 Annual Plan of Committee Business

6.2.1 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall

appear on every Joint Committee agenda.

6.2.2 The plan shall set out the arrangements in place to enable the Joint Committee to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Joint Committee members to contribute in either English or Welsh languages, where appropriate.

6.2.3 The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of Joint Committee sub-Committees or sub-Groups, Expert Panel and Advisory Groups.

6.2.4 The Joint Committee shall agree the plan for the forthcoming year by the end of March, and this plan shall be published on the organisations website.

6.3 Calling Meetings

6.3.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

6.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

6.4 Preparing for Meetings

Setting the agenda

6.4.1 The Joint Committee Chair, in consultation with the Committee Secretary and the Chief Ambulance Services Commissioner, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from Joint Committee Sub Group and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

6.4.2 Any Joint Committee member may request that a matter is placed on the Agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of Joint Committee business.

Notifying and equipping Joint Committee members

6.4.3 Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

6.4.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

6.4.5 In the event that at least half of the Joint Committee members do not receive the Agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.4.6 In the case of a meeting called by Joint Committee members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.4.7 Except for meetings called in accordance with EASC Standing Order 6.4, at least 10 calendar days before each meeting of the Joint Committee a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- At each LHB and the Joint Committee's principal sites; On each LHB's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the Joint Committee's communication strategy.

6.4.8 When providing notification of the forthcoming meeting, each LHB shall set out when and how the Agenda and the papers supporting the public part of

the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

6.5 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

6.5.1 The Joint Committee shall encourage attendance at its formal Joint Committee meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the Joint Committee. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility.

6.5.2 The Joint Committee shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter affecting an National Collaborative Commissioning Unit (NCCU) staff member or a patient.

In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee shall resolve:

> *'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 [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].'*

6.5.3 In these circumstances, when the Joint Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Joint Committee in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Joint Committee meeting held in public session.

6.5.4 The Committee Secretary, on behalf of the Joint Committee Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.5.5 In encouraging entry to formal Joint Committee Meetings from members of the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.5.6 Unless the Joint Committee has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Joint Committee, its Joint Committee Sub-Groups, Expert Panel or Advisory Groups

6.5.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its Joint Committee sub-Committees or sub-Groups, expert panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

6.5.8 The Chair of the Joint Committee will preside at any meeting of the Joint Committee unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice-Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Chief Executives present will agree who will preside.

6.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Joint Committee to reach effective decisions on the matters before it. This includes ensuring that Joint Committee members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Joint Committee must have access to appropriate advice on the conduct of the meeting through the attendance of the Committee Secretary. The Chair has the final say on any matter relating to the conduct of Joint Committee business.

Quorum

6.5.10 At least four voting members, whom are LHB Chief Executives, must be present to allow any formal business to take place at a Joint Committee meeting.

6.5.11 If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a representative/deputy to attend on their behalf. The nominated representative/deputy should be an Officer Member (Executive Director) of the same organisation. Nominated representatives/deputies will

formally contribute to the quorum and will have delegated voting rights.

6.5.12 If the Chief Ambulance Services Commissioner or another Associate Member is unable to attend a Joint Committee meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, their voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Joint Committee member in their own right, e.g. a person deputising for the Chief Ambulance Services Commissioner will usually be the Deputy Chief Ambulance Services Commissioner, they will not have any voting rights.

6.5.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee member or their nominated deputy/representative disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.5.14 In the normal course of Joint Committee business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken. The Committee Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Joint Committee unless moved by a Joint Committee member or their deputy/representative and seconded by another Joint Committee member or their deputy/representative (including the Joint Committee Chair).

6.5.15 **Proposing a formal notice of Motion –** Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in writing of the proposed motion at least 12 calendar days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.5.16 The Joint Committee Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Joint Committee business.

6.5.17 **Amendments –** Any Joint Committee member or their deputy/representative may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

6.5.18 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

6.5.19 **Motions under discussion** – When a motion is under discussion, any Joint Committee member or their deputy/representative may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Joint Committee member may not be heard further;
- The Joint Committee decides upon the motion before them;
- An ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.5.20 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.5.21 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Joint Committee Chair.

6.5.22 **Motion to rescind a resolution –** The Joint Committee may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Joint Committee members.

6.5.23 A motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a Joint Committee sub-Committee or sub-Group /CASC to which a matter has been referred.

Voting

6.5.24 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Joint Committee.

6.5.25 In determining every question at a meeting the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales.

6.5.26 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

6.5.27 A nominated deputy/representative of a LHB Chief Executive may vote. In no circumstances may a nominated deputy of the Chief Ambulance Services Commissioner vote. Absent Joint Committee members may not vote by proxy. Absence is defined as being absent at the time of the vote.

6.6 Record of Proceedings

6.6.1 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.6.2 Agreed minutes shall be circulated in accordance with Joint Committee members' wishes, and, where providing a record of a formal Joint Committee meeting shall be made available to the public on each LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Freedom of Information Act, the Joint Committee's Communication Strategy and the Cwm Taf Morgannwg University Health Board Welsh language requirements.

6.7 Confidentiality

6.7.1 All Joint Committee members (including Associate members), together with members of any Joint Committee sub-Committee or sub-Group, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Joint Committee Chair or relevant Joint Committee sub-Committee or sub-Group or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework or legislation such as the Freedom of Information Act 2000, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Joint Committee must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, National Collaborative Commissioning Unit (NCCU) staff officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the EASC SOs. The Values and Standards of Behaviour document is the same as the host body Cwm Taf Morgannwg University Health Board.

7.1 Declaring and recording Joint Committee members' interests

7.1.1 **Declaration of interests –** It is a requirement that all Joint Committee members should declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Joint Committee member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Joint Committee's business. Joint Committee members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. Joint Committee members must notify the Joint Committee of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Joint Committee members.

7.1.2 Joint Committee members must also declare any interests held by family members or persons or bodies with which they are connected. The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Joint Committee members are in any doubt about what may be considered as an

interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

7.1.3 **Register of interests –** The Chief Ambulance Services Commissioner, through the Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members. The register will include details of all Directorships and other relevant and material interests which have been declared by Joint Committee members.

7.1.4 The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, through which Joint Committee members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This will include publication on the EASC website.

7.1.6 **Publication of declared interests in Annual Report –** Joint Committee members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each LHB Board's Annual Report.

7.2 Dealing with Members' interests during Joint Committee meetings

7.2.1 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales.

7.2.2 Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary before the start of the Joint Committee meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Joint Committees minutes.

7.2.3 It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting. This may be appropriate, for example where the Committee is considering particular aspect of healthcare and a Member's organisation may be affected by the commissioning intention determined by the Committee;

ii. The declaration is formally noted and recorded, and the Joint Committee member participates fully in the Joint Committee's discussion, but takes no part in the Joint Committee's decision;

iii. The declaration is formally noted and recorded, and the Joint Committee member takes no part in the Joint Committee discussion or decision;

iv. The declaration is formally noted and recorded, and the Joint Committee member is excluded for that part of the meeting when the matter is being discussed. A Joint Committee member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Joint Committee.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

7.2.5 Where the Joint Committee Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice-Chair, on behalf of the Joint Committee.

7.2.6 In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take advice from the Committee Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a Joint Committee

member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

7.2.8 The **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009** define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The EASC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a Joint Committee meeting, an individual Joint Committee member may establish a clear conflict of interest between their role as a Joint Committee member and that of their professional role outside of the Joint Committee. In any such circumstance, the Joint Committee shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Committee Secretary.

7.3 Dealing with officers' interests

7.3.1 The Joint Committee must ensure that the Committee Secretary, on behalf of the Chief Ambulance Services Commissioner, establishes and maintains a system for the declaration, recording and handling of National Collaborative Commissioning Unit (NCCU) staff officers' interests in accordance with the Values and Standards of Behaviour Framework. This will be done in conjunction with the declarations of interest recorded by the Welsh Health Specialised Services Committee which is also hosted by Cwm Taf Morgannwg University Health Board.

7.4 Reviewing how Interests are handled

7.4.1 The Joint Committee's Audit and Risk Committee (of the host body) will review and report to the LHBs upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with offers of gifts,[2] hospitality and sponsorship

7.5.1 The Values and Standards of Behaviour Framework the Cwm Taf Morgannwg Standards of Behaviour Policy to be adopted by the Joint Committee prohibits Joint Committee members and National Collaborative

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.
[2] The term gift refers also to any reward or benefit.

Commissioning Unit (NCCU) staff officers receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Joint Committee member or National Collaborative Commissioning Unit (NCCU) staff officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Joint Committee member or National Collaborative Commissioning Unit (NCCU) staff officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Committee Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Joint Committee;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Joint Committee; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the

investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Sponsorship

7.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** Cwm Taf Morgannwg Standards of Behaviour Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

7.7.1 The Committee Secretary, on behalf of the Joint Committee Chair, will maintain a Register of Gifts and Hospitality to record offers of gifts, hospitality and sponsorship made to Joint Committee members. The National Collaborative Commissioning Unit (NCCU) staff officers will adopt a similar mechanism in relation to Cwm Taf Morgannwg University Health Board staff working within their areas.

7.7.2 Every Joint Committee member and National Collaborative Commissioning Unit (NCCU) staff officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship made in their capacity as Joint Committee members, including those offers that have been refused. The Committee Secretary, on behalf of the Joint Committee Chair and Chief Ambulance Services Commissioner, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship is kept under active review, taking appropriate action where necessary.

7.7.3 When determining what should be included in the register with regards to gifts and hospitality, individuals must apply the following principles, subject to the considerations in EASC Standing Order 7.5:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value would not usually need to be recorded,

e.g., seasonal items such as diaries/calendars with normally fall within this category.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

7.7.4 Joint Committee members and National Collaborative Commissioning Unit (NCCU) staff Officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the Joint Committee;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.7.5 The Committee Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Joint Committee to be submitted to the designated Audit and Risk Committee (or equivalent) at least annually. The Audit and Risk Committee will then review and report to the LHBs jointly upon the adequacy of the Joint Committees arrangements for dealing with offers of gifts, hospitality and sponsorship.

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

8.0.1 The Joint Committee shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

8.0.2 The Joint Committee shall ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit and Risk Committee (of the Host Body).

8.1 The role of Internal Audit in providing independent internal assurance

8.1.1 The Joint Committee shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance

[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Ministers.

8.2 Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups

8.2.1 The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Joint Committee Sub Group, expert panel and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

8.2.2 Each Joint Committee Sub Group and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair within six weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

8.2.3 The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Committee Development Programme, as part of an overall Organisation Development framework; and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

8.3.1 The Joint Committee shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

8.3.2 The Joint Committee may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Joint Committee itself may commission specifically for that purpose.

8.3.3 The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee,

the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

8.3.4 The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

9. DEMONSTRATING ACCOUNTABILITY

9.0.1 Taking account of the arrangements set out within these EASC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the citizens it serves, its officers and healthcare professionals.

9.0.2 The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

9.0.3 The Joint Committee shall ensure that within the **National Collaborative Commissioning Unit (NCCU)** individuals supporting EASC at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

9.1.1 The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others;
- Ensuring the provision of secretariat support for Joint Committee meetings;
- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;

- Ensuring an effective relationship between the Joint Committee and its host LHB; and
- Facilitating effective reporting to each LHB

enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

10. REVIEW OF STANDING ORDERS

10.0.1 The EASC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in EASC SOs, including the appropriate impact assessment.

Annex 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

Introduction

As set out in EASC Standing Order 3, the Emergency Ambulance Services Committee (the Joint Committee) - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively, and in a manner that secures the achievement of the Joint Committee's aims and objectives. The Joint Committee may delegate functions to:

i) A sub-Committee of the Joint Committee e.g., Audit and Risk Committee (of the Host Body);

ii) A Group, Expert Panel or Advisory Group, e.g., with other LHBs established to take forward certain matters relating to specialist services; and

iii) Officers of the Joint Committee (who may, subject to the Joint Committee's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Joint Committee is notified of any matters that may affect the operation and/or reputation of the Joint Committee.

The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Joint Committee;
- Scheme of delegation to Joint Committee sub-Committee or sub Group and others; and
- Scheme of delegation to officers.

all of which form part of the EASC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Joint Committee will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- **Everything is retained by the Joint Committee unless it is specifically delegated in accordance with the requirements set out in EASC SOs or EASC SFIs**

- **The Joint Committee must retain that which it is required to retain (whether by statute or as determined by the Welsh Government) as well as that which it considers is essential to enable it to fulfil its role in setting the Joint Committee's direction, equipping the Joint Committee to deliver and ensuring achievement of its aims and objectives through effective performance management**

- **Any decision made by the Joint Committee to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility**

- **The Joint Committee must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development**

- **The Joint Committee must take appropriate action to assure itself that all matters delegated are effectively carried out**

- **The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes**

- **The Joint Committee may delegate authority to act, but retains overall responsibility and accountability**

- **When delegating powers, the Joint Committee will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.**

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Joint Committee

The Joint Committee will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Ambulance Services Commissioner

The Chief Ambulance Services Commissioner will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Joint Committee must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Ambulance Services Commissioner will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in EASC SFIs);
- The Memorandum of Agreement agreed with the seven LHBs and approved by the Joint Committee; and
- The Hosting Agreement agreed with the host LHB and approved by the Joint Committee.

The Chief Ambulance Services Commissioner may re-assume any of the powers they have delegated to others at any time.

The Committee Secretary

The Committee Secretary will support the Joint Committee in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Joint Committee is presented to the Joint Committee for its formal agreement;
- Effective arrangements are in place for the delegation of Joint Committee functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Joint Committee for revision, as appropriate.

The Audit and Risk Committee (of the Host Body)

The Audit and Risk Committee will provide assurance to the Joint Committee of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify **[The Chair of the Audit and Risk Committee]** of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Chief Ambulance Services Commissioner is absent their nominated Deputy or Assistant may exercise those powers delegated to the Chief Ambulance Services Commissioner on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Chief Ambulance Services Commissioner or reallocate powers, e.g., to a Committee or another officer.

The Quality and Safety Committee

The Quality and Safety Committee will provide assurance to the Joint Committee of the effectiveness of its arrangements for managing quality and safety.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify **[Joint Committee to insert details]** of their

concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Chief Ambulance Services Commissioner is absent their nominated Deputy or Assistant may exercise those powers delegated to the Chief Ambulance Services Commissioner on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Chief Ambulance Services Commissioner or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Joint Committee. The Scheme is to be used in conjunction with the system of control and other established procedures within the Joint Committee.

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[4]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with EASC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are: • Collaborative Commissioning Framework Agreement(s) • EAS Integrated Medium Term Plan
3	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Joint Committee, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges
4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards: EASC SOs ; ▪ EASC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

[4] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Assembly Government requirements.

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
5	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework
6	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework for performance management, risk and assurance
7	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Joint Committee determines it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Ambulance Services Commissioner in accordance with EASC Standing Order requirements
9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with EASC SOs
10	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Ambulance Services Commissioner and officers
11	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Joint Committee
12	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Joint Committee level appointments, e.g., the Committee Secretary
13	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. From Audit and Risk Committee

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
14	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-groups, including any joint sub-groups directly accountable to the Joint Committee
15	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Joint Committee sub-groups, or Group set up by the Joint Committee
16	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups
17	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all Joint Committee sub-groups, and groups established by the Joint Committee
18	FULL	STRATEGY & PLANNING	Determine the Joint Committee's strategic aims, objectives and priorities
19	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
20	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Risk Management Strategy and plans
21	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Commissioning Plan and Population Health Needs Assessment (from HBs and Trusts) ▪ The development and delivery of emergency ambulance, non-emergency patient Transport services and emergency medical retrieval and transfer services for the population of Wales ▪ Improving quality and patient safety outcomes

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
			▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
22	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
23	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Ambulance Services Commissioner set out in the EASC SFIs
24	FULL	PERFORMANCE & ASSURANCE	Approve the Joint Committee's audit and assurance arrangements
25	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Joint Committee's National Collaborative Commissioning Unit (NCCU) staff on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
26	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee sub-groups, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans
27	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-groups (as appropriate)
28	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Joint Committee's Chief Internal Auditor and approve action required, including improvement plans through the arrangements of the Host Body

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
29	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the Joint Committee's external auditor and approve action required, including improvement plans through the arrangements of the Host Body
30	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the Joint Committee's performance against Healthcare Standards for Wales and approve action required, including improvement plans
31	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Assembly Government
32	FULL	REPORTING	Receive, approve and ensure the publication of Joint Committee reports, including its Annual Report and annual financial accounts

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR AND VICE-CHAIR			
34	CHAIR		In accordance with statutory and Welsh Government requirements
35	VICE-CHAIR		In accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS[5]

EASC Standing Order 3 provides that the Joint Committee may delegate powers to sub-groups and others. In doing so, the Joint Committee has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such sub-Groups; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Joint Committee has delegated a range of its powers to the following sub-Committees and others:

Cwm Taf Morgannwg Audit and Risk Committee arrangements
Cwm Taf Morgannwg Quality and Safety Committee arrangements
Management Group
Emergency Medical Retrieval and Transfer Services (EMRTS) Delivery and Commissioning Group
Non-Emergency Patient Transport Service (NEPTS) Delivery Assurance Group

The scope of the powers delegated, together with the requirements set by the Joint Committee in relation to the exercise of those powers are as set out in i) sub-Group terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Joint Committee's Scheme of Delegation to Joint Committee Sub Groups.

[5] As defined in Standing Orders

SCHEME OF DELEGATION TO NATIONAL COLLABORATIVE COMMISSIONING UNIT (NCCU) STAFF AND OFFICERS

The EASC SOs and EASC SFIs specify certain key responsibilities of the Chief Ambulance Services Commissioner, the Director of Finance (WHSSC/EASC) and other officers. The Chief Ambulance Services Commissioner's Job Description sets out their specific responsibilities, and the individual job descriptions determined for other National Collaborative Commissioning Unit (NCCU) staff level posts also define in detail the specific responsibilities assigned to those post holders.

These documents, set out in detail, together with the schedule of additional delegations below and the associated financial delegations set out in the EASC SFIs form the basis of the Joint Committee's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[Joint Committee to determine]	**[Joint Committee to determine]**

This scheme only relates to matters delegated by the Joint Committee to the Chief Ambulance Services Commissioner and other members of the National Collaborative Commissioning Unit (NCCU) staff together with certain other specific matters referred to in EASC SFIs. In November 2016, the Joint Committee agreed to use the host body's Standing Financial Instructions (former Cwm Taf) and Scheme of Delegation.

Each member of the National Collaborative Commissioning Unit (NCCU) staff is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated (aligned to the arrangements of the host body).

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annex forms part of, and shall have effect as if incorporated in the EMERGENCY AMBULANCE Services Committee Standing Orders

Joint Committee framework

The Joint Committee's governance and accountability framework comprises these EASC SOs, incorporating schedules of Powers reserved for the Joint Committee and Delegation to others, together with the following documents:

- ***EASC SFIs***
- ***Scheme of Delegation***
- ***Values and Standards of Behaviour Framework (Cwm Taf Morgannwg University Health Board Standards of Behaviour Policy)***
- ***Risk Register***
- ***Key policy documents***

agreed by the Joint Committee. These documents must be read in conjunction with the EASC SOs and will have the same effect as if the details within them were incorporated within the EASC SOs themselves.

These documents may be accessed by:

EASC Website http://www.wales.nhs.uk/easc/the-committee

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at www.wales.nhs.uk/governance-emanual/.Directions or guidance on specific aspects of Joint Committee business are also issued electronically, usually under cover of a Welsh Health Circular.

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the EMERGENCY AMBULANCE SERVICES COMMITTEE Standing Orders

Sub Groups

Management Group The overall purpose of the Management Group is to make recommendations to EASC and to ensure that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance, non-emergency patient transport services and Emergency Medical Retrieval & Transfer Service for the purpose of jointly exercising those functions will establish the joint committee.	**Terms of Reference**  EASC Management Group ToR approve Approved EASC Meeting September 2019
Emergency Medical Retrieval and Transfer Services (EMRTS) Delivery and Commissioning Group	Awaiting review
Non-Emergency Patient Transport Service (NEPTS) Delivery Assurance Group	Awaiting review

Annex 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

Terms of Reference to be included when available

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 12th December 2019**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Internal Audit Progress Report - 1st September 2019 to 30th November 2019**
Cyfarwyddwr Cyfrifol: Responsible Director:	Dawn Sharp – Acting Board Secretary
Awdur yr Adroddiad Report Author:	Dave Harries – Head of Internal Audit
Craffu blaenorol: Prior Scrutiny:	The progress report has been discussed with and agreed by the Acting Board Secretary and details the individual opinions issued by internal audit.
Atodiadau Appendices:	• Appendix b: Progress Report • Appendix c and d: Welsh Language Measure Limited Assurance Report (Welsh and English) • Appendix e: Patients Monies Limited Assurance Report

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive the progress report;
- Note the approval via Chairs Action of the removal of the three reviews from the 2019/20 plan and;
- Discuss the two Limited Assurance Reports noting that the relevant Officers have been invited to attend.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The progress report is produced in accordance with the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management and the Board.

Cefndir / Background:

The report summarises nine assurance reviews finalised since the last Committee meeting in September 2019, with the recorded assurance as follows:

- Reasonable assurance (yellow) – seven; and

- Limited assurance (amber) – two.

The report also details:

- Reviews issued at draft reporting stage as well as work in progress;
- Follow-up status of seventeen recommendations subject to follow-up review in the period; and
- Recommendation for removal from the 2019/20 plan three reviews relating to:
  - Compliance with Standing Financial Instructions – Procuring goods and services: Pharmacy EDS;
  - Cluster governance arrangements; and
  - Continuing Healthcare.

Asesiad / Assessment & Analysis

Strategy Implications

The Internal Audit plan for 2019/20 has been approved by the Audit Committee in March 2019.

Financial Implications

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

Risk Analysis

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

Legal and Compliance

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

Impact Assessment

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

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

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 September 2019 to 30th November 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 2019/20 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 Acting 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
Health & Safety Review completed August 2019 with Executive approval October 2019 *The Strategic Occupational Health & Safety Group, under the stewardship of the Executive Director of Workforce & OD, has been re-established and met on two recent occasions [May and June 2019] coupled with the pro-active steps taken to re-energise the health and safety agenda within and across the Health Board. Reporting and assurance*	Reasonable	1	1	-	Gap Analysis The gap analysis of legislative compliance has been introduced to support the improvement plan and subsequent proposed 3 year strategy. Corporate Health & Safety visited a cross section of 50 Health Board premises including Secondary Care, Mental Health, and Community Services. Within our sample testing we set out to identify that the gap analysis was undertaken robustly; consistently administered and that the outputs of the analysis are accurately recorded. The sites and departments we visited, the gap analysis were well attended however a more consistent approach to who attends is needed. Opening questions on sections regarding identification of the policies were worded differently which could affect the weighting of the question; below are some of the questions identified and table 2 details the scoring guide:

Title	Assurance Level	High	Medium	Low	Key Messages
from directorates/ divisions must however improve to provide assurance to the Executive and Board.					• *Is there a policy/procedure in place for the control of waste?* • *Are you aware of the location of the procedure and guidance for DSE?* • *Is there a Policy in place and is it being implemented?* The responses tended to consist of *"Yes on the intranet"* which may result in a higher score being applied - By standardising on a question's style in relation to policies (closed/open) would aid Health & Safety colleagues to apply a score based on the evidence provided as opposed to verbal assurance. <u>Governance</u> We sought to establish the reporting lines in place within the Health Board concerning Health & Safety, thus identifying the assurance through to the Board. At the point of writing the report, Policy HS01 - Health & Safety Policy was out of date and required reviewing. In reviewing the policy, consideration needs to be given to amend section 8 due to the restructuring of the Health & safety governance process. We were unable to establish that any meetings for the Strategic Health and Safety Committee (SHSC) [to which the Divisions/Areas & Corporate Functions will provide assurance to] had taken place in 2018. Due the above we were unable to evidence Divisions/Areas & Corporate Functions reporting into the SHSC. In addition, for both the May and June 2019 meetings of the SHSC, we could find no evidence of directorates/areas providing assurance. We noted Divisions/Areas & Corporate Functions were scheduled to provide

Title	Assurance Level	High	Medium	Low	Key Messages
					assurance to the Strategic Occupational Health & Safety Group (SOHSG). At the time of this review there had only been two SOHSG meetings 31st May 2019 and 28th June 2019. In reviewing the draft minutes of the 31st May 2019 meeting, no issues of significance were noted and we received the agenda only for the 28th June 2019 [which we attended].
Compliance with Standing Financial Instructions – Procuring goods and services: Estates GRAMMS Review completed August 2019 with Executive approval September 2019 *One issue identified around compliance with the quotation register – Recommendation made to reinforce operational awareness of the procedure.*	Reasonable	1	-	-	Following the findings of an Internal audit review carried out in 2018/19, the Operational Estates Department took the opportunity to update their procedure covering the use and need for quotations in the estates procurement process. A revised version of the procedure was published in December 2018 and was distributed by the Head of Operational Estates (Acting) to the respective Operational Estates Senior Managers. We were provided with an extract from the GRAMMS system which identified 75 purchase orders (PO) in total placed between 1st April and 28th Jun 2019 with a value between £3,000 and £25,000 excluding VAT. From the 75 purchase orders identified as raised post 1st April 2019, we chose a sample of 30 orders, 10 for each of the respective Estates areas (East, Central & West). Initial testing involved reviewing supporting documentation as included within the GRAMMS system. The review identified overall compliance with the operational procedure however we did identify one instance where we noted that the quotation book records that the quotations for one order were opened by the Business Support Unit, however we understand that this was not the case, and that the Operation Procedure No 01 is

Title	Assurance Level	High	Medium	Low	Key Messages
					explicit in detailing how quotations submitted should be dealt with.
Compliance with Standing Financial Instructions – Procuring goods and services: Therapy Manager Review completed August 2019 with Executive approval September 2019 *Only two orders did not comply with procurement rules and positive management action was noted to address the control issues in the short term pending the service moving onto e-financials.*	Reasonable	1	-	-	Therapy Manager is used by the Orthotics Department for the procurement and payment of orders for appliances. Of the nine thousand five hundred and eleven (9,511) orders generated by Therapy Manager, only two orders were for £5,000 or more. We liaised with the respective Heads of Podiatry & Orthotics to clarify and seek evidence relating to two orders/payments made for £5,040 (East) and £9,060 (Central). The Orthotics service cannot demonstrate value for money in procuring the two orders raised in excess of £5,000 as they were not, at the time of this review, complying with the requirements of the Standing Financial Instructions (SFIs). Since this review commenced and the sample identified, the service appears to have been pro-active in addressing the issue of compliance with the SFIs, which we recognise as positive in addressing the significant financial and budgetary control weakness – this is reflected and the key driver for the assurance rating but we have not corroborated the service's assertion of change. We also recognise the planned move from Therapy Manager to E-Financials is due in the near future. A catalogue will be available with fixed prices, thus ensuring the all-Wales price is applied, with the potential benefit of delivering financial savings to the Health Board along with timelier financial reporting and accrual data. The service relied on clinical estimates to drive the order instead of seeking formal quotes from the supplier to which they are

Title	Assurance Level	High	Medium	Low	Key Messages
					held – The estimates in both orders were considerably below the actual cost.
GDPR: Follow-up of the Information Commissioners Office (ICO) review Review completed October 2019 with Executive approval October 2019 *Robust control over the action plan with clear timelines for implementation – limited evidence of regular reporting to Committee on progress.*	Reasonable	-	1	-	Whilst the report recommendations span both Information Governance and Records Management the process is managed by the Health Board Head of Information Governance (recently appointed to Deputy Head of Health Records role). <u>Governance and Reporting</u> The ICO Audit Summary report was presented and discussed at the August 2018 Finance and Performance Committee, and was included in the Chair's report to the Board. The Digital and Information Governance Committee (previously the Information Governance and Informatics Committee) was established in September 2018 and was authorised by the Board to *"….consider the information governance and informatics implications for the Health Board of internal and external reviews and reports"*. Whilst we found references to the ICO report within the Committee minutes, the Information Governance Strategy, and within the Health Board corporate risks (CRR10B), we found no evidence that a detailed progress update has been provided to the Committee. <u>Management of Recommendations</u> We found that the Health Board has robust arrangements in place to implement the ICO report recommendations. The Health Board has established a comprehensive action plan to manage and track the recommendations. We reviewed the action plans and noted the following:

Title	Assurance Level	High	Medium	Low	Key Messages
					• All recommendations made in the ICO report were recorded on the action plan. • An owner had been assigned to each recommendation and an implementation date had been specified. • Agreed actions were noted for each recommendation and a progress update had been provided where necessary. • Applicable evidence was recorded where relevant. To verify action plan progress we selected fifteen recommendations for review and was limited to recommendations where the agreed actions had been noted as having been completed. We found no issues or limitations, noting the impact that the National Blood Inquiry has had on document retention. All supporting evidence noted on the action plan was made available for review and supported the assertions made. <u>Policies and Procedures</u> The Health Board has robust procedure and guidance documents in place to support staff and organisational compliance with information governance legislation. However we did note that the review date had lapsed on the following policies: • IG01 – Records Management Policy • IG04 – Access to Information Policy
Environmental Sustainability Review completed July 2019 with Executive approval September 2019 *Some data issues*	Reasonable	-	2	-	<u>Statement meets requirements of Welsh Government guidance</u> The Health Board has followed the required reporting format as set out in both the NHS Wales Manual for Accounts 2018-19 and HM Treasury Guidance for reporting, in particular regarding the compilation of the data for inclusion in the performance tables.

Title	Assurance Level	High	Medium	Low	Key Messages
identified and rectified; no sustainability strategy still evident.					In previous years, we have commented on the lack of any explicit detail regarding an overarching corporate environmental strategy within the Sustainability report. This continues to be the case and we were informed by the Capital and Systems Planning Manager that further work on the draft policy is still needed. <u>Completeness of data</u> Management have been informed of amendments required following our review of source documents and the consistency of that information with the sustainability report. An error in the "Business Travel" data reported was amended by management during the audit and the report was updated to address other issues found in the audit testing. <u>Follow up</u> It was reported in last year's audit report that there was no commentary in respect of discussion of performance/trends as detailed in the respective tables. This has now been rectified and the 2018/19 annual sustainability report provides trend year to synopsis across a number of tabulated topics.
Statutory Compliance: Fire Safety Review completed August 2019 with Executive approval October 2019 *Review of fire folders identified variances in the information held*	Reasonable	1	1	-	<u>Monitoring and Control arrangements for the Health Board</u> Welsh Health Circular (2006) 74 requires an effective fire policy that sets a clear direction for the organisation to follow. Fire policy (ES04) has been developed in accordance with the requirements of Welsh Health Circular WHC (2006) 74 [endorsed by Quality Safety and Experience

Title	Assurance Level	High	Medium	Low	Key Messages
and contractual issues existed in the servicing of some firefighting equipment.					Committee in 2011 (per the Policy cover sheet)]. During our on-site testing within the hospitals some of the fire folders specific to the department contained an out of date fire Policy. We also identified: • Fire reports have been evidenced within West and Central areas going to the Hospital Management Teams (HMT). The fire officer (East) stated that they were stopped from attending the East HMT meetings over two years ago, any points of interest is raised verbally to the East Senior Operational Estates Manager. • Evidence of pre-planned maintenance (PPM) has been provided; The Fire Legislation Assurance officer stated that once the PPM has been undertaken, the task is signed off by the maintenance officer. The Fire Legislation Assurance officer is in the process of including this as part of their Estate Department's audit. <u>Compliance with site specific documentation</u> The review of documentation at the six sites included the main entrance and two wards (District General Hospitals) and three community sites one from each area. The Corporate Fire Department (CFD) has developed fire folders at or near the main entrances of all the hospitals we visited; this was further embedded by fire specific folders for wards within the acute hospitals. Whilst noting the CFD are in the process establishing a consistent approach throughout the Health Board towards the fire folders, folders did vary with regards to the information within. We also identified:

Title	Assurance Level	High	Medium	Low	Key Messages
					• Fire plans were in place for all sites, floors and departments however all plans have not been updated taking into account new services which have arrived on the Hospital sites. • We established that there are no planned practical fire evacuation drills taking place; the fire officers informed us they are using a walk through/talk through exercise with staff on the wards. • We were advised that there was contract issues in servicing of fire extinguishers as well as servicing/maintenance of fire alarms. Within Central and East areas visited, all fire extinguishers were found to be out of date [within the East, we were informed there has been no servicing/maintenance on the fire alarms due to contract issues. As a point of note we were informed that contracts were in the process of being arranged]. • Risk assessments were in place within all areas visited, however not all were up to date and required reviewing. We were provided with Operational Estates quarter one performance report which states: <u>Response procedures and Responsibilities</u> The Health Board demonstrates a planned and systematic approach to implementing the fire policy via a range of initiatives including audits, risk assessment, walk through/talk through and fire training which remained ongoing at the time of review. Training for contractors - we were unable to verify that training for contractors happens/induction programme taking place for contractors who work on Health Board premises.

Title	Assurance Level	High	Medium	Low	Key Messages
					Governance We sought to establish the reporting lines in place within the Health Board concerning fire safety, thus identifying the assurance through to the Board. Fire Safety Management Group We were unable to establish that any meetings for both the Fire Safety Management Group (FSMG) and the Health and Safety Committee (HSC) [to which the FSMG reports] had taken place in 2018. We were informed and provided with evidence that the FSMG have now resumed [with the first meeting taking place on the 4th June 2019]. The terms of reference (ToR) for the Fire Safety Management Group were provided, however only included the scope and duties of the group – it was not in the Health Board's model template format. We note from the FSMG Actions record that the ToR are set to be reviewed with a target completion date of 31st January 2020. There has been a restructure of Health & Safety governance where the FSMG is scheduled to report to the Strategic Occupational Health & Safety Group (SOHSG). However within the *Governance Sub Structures* of the SOHSG ToR, there is no reference to the Fire Safety Management Group. We were able to see the annual Fire Safety Audit for 2018 report having been presented to the Group [28th June 2019] along with the Fire Safety Policy/Procedure. We noted minuted discussion around the annual report however we cannot identify any issues of significance/Chair's update

Title	Assurance Level	High	Medium	Low	Key Messages
					report from the Fire Safety Management Group meetings from either the 4th March or 4th June 2019 meetings.
Ysbyty Gwynedd Emergency Department Review completed July 2019 with Executive approval November 2019 *Regular reporting of project progress was evident however the project was delayed and issues around snagging were identified.*	Reasonable	2	10	-	<u>Project Governance</u> The Project Execution Plan (PEP) was updated in January 2019 at the start of stage 5 in line with the requirements of the Health Board's Procedure for Management of Capital Projects. The Project Implementation Board met on a monthly basis. The agendas and minutes of meetings demonstrated that the Board was furnished with key documents and reports in line with those expected and detailed within the Terms of reference. <u>Budgetary/Cost Management</u> Generally sound control arrangements were evidenced, including detailed monthly commercial reports provided by the cost adviser. Cost issues were additionally reported by the project manager to the Project Implementation Board, and upwards to the Finance and Performance Committee. Monthly CRL reports were included as part of the monthly returns submitted to Welsh Government. The Finance & Performance Committee meetings received copies of monthly Capital Reports prepared by the Assistant Director-Strategy (Capital) in conjunction with the Capital Accountant; together with monthly Capital reports specific to larger projects including those for Emergency Department development. <u>Change Management</u> The defined change control process to manage requests for change [as defined within the Project Execution Plan] was in accordance with the requirements of the

Title	Assurance Level	High	Medium	Low	Key Messages
					contract operated at the project. This facilitated internal acceptance/ approval of the proposed changes in accordance with delegated limits, prior to issue to the external advisers to action. The status of compensation events were reported on a monthly basis within the Cost Adviser's report which was tabled at the Project Board Meeting and within the monthly return to Welsh Government. <u>Technical & Operational Commissioning Arrangements</u> The project has suffered delays resulting in both Phases 2 and 3 being delivered later than originally programmed (with associated cost pressures).The minutes of the Project Implementation Board and reports provided to the Finance & Performance Committee indicated that the programme of commissioning applied at the earlier phases of the development had contributed to the reported delays. Concern about the timely remediation of identified snagging issues was echoed in the comments we received from the Clerk of Works. We were further advised that Snagging / defect issues identified prior to handover remained outstanding going into the 12 month defect inspection.
Adroddiad Archwilio Mewnol Terfynol - Mesur y Gymraeg (Cymru) 2011/Welsh Language (Wales) Measure 2011 Review completed September 2019 with Executive approval November 2019	Limited	2	1	-	The Bilingual Skills Strategy mandates certain Health Board posts as Welsh language essential. The following posts are deemed as such: Switchboard Staff, Patient Booking Centres / Call Centre Staff and Receptionists. <u>Welsh Essential Posts</u> During the period 1st April 2018 and 31st March 2019 the Health Board advertised 2,847 vacant posts. Of these, 59 (2%) were advertised as Welsh language essential with

Title	Assurance Level	High	Medium	Low	Key Messages
Nid yw strategaeth sgiliau dwyieithog y Bwrdd Iechyd yn cydymffurfio a swyddi hynny a nodir fel Cymraeg hanfodol. *Health Board Bi-lingual skills strategy is not being complied with for those posts stipulated as Welsh essential.*					the remaining 2,788 (98%) advertised as Welsh language desirable. Of the 59 posts advertised as Welsh essential, 14 were posts mandated Welsh Essential per the Bilingual Skills Strategy - the other 45 were posts that the requesting managers had themselves deemed Welsh essential. We reviewed the Welsh language skills of successful applicants and found the following: • 45 individuals had been employed against the relevant position numbers between 1st April 2018 and 31st March 2019. • Of these, 25 (56%) had scored themselves between level 0 and level 2 on the ESR Welsh language skills self-assessment tool despite the posts being advertised as Welsh essential (20 had assessed themselves at level 0). • 19 had assessed themselves between level 3 and level 5 (15 of which were level 5). • One employee had not completed the self-assessment, however was later confirmed to be level 5. We enquired whether the 25 appointed applicants that had self-assessed their Welsh language skills between level 0 and level 2 had enrolled on any of the available Welsh language courses; at the time of review only 2 of the 25 appointed applicants had enrolled on a Welsh language course. <u>Justification Approval</u> The Workforce Information Systems Manager reviewed the 2,788 posts advertised as Welsh language desirable and identified a further 54 posts that should

Title	Assurance Level	High	Medium	Low	Key Messages
					have been designated Welsh Language essential per the Bilingual Skills Strategy. We again reviewed the Welsh language skills and Welsh language course enrolment of successful applicants to these posts and noted the following: • 42 individuals had been employed against the relevant position numbers between 1st April 2018 and 31st March 2019. • 37 (88%) had assessed themselves between level 0 and level 2 on the ESR Welsh language skills self-assessment tool (33 had assessed themselves at level 0). • 4 staff member that had assessed themselves between levels 0 and 2 had enrolled on Welsh language courses. • 4 had assessed themselves between level 3 and level 5. • One employee had not completed the self-assessment. We selected a random sample of 12 posts (22%) that should have been advertised as Welsh language essential and contacted the relevant requesting managers for evidence of justification approval. The following findings were noted for the ten managers who responded (two did not reply): • Only one manager was able to provide evidence that a justification request for the Welsh essential post had been submitted and authorised by the relevant Head of Workforce (the relevant post was approved by the Head of Workforce – East). • None of the remaining nine managers in our sample had submitted a justification to the relevant Head of Workforce

Title	Assurance Level	High	Medium	Low	Key Messages
					requesting the Welsh essential posts to be advertised as Welsh desirable. • Five managers stated that they were not aware that the posts advertised were deemed Welsh language essential. • Four stated that they had submitted the advert request via TRAC and had not been challenged or asked for justification. <u>Policies and Procedures</u> The Workforce policy and related guidance documents refer the reader to the Bilingual Skills Strategy, the Strategy requirements are not explicitly stated in the policy document. <u>Reporting</u> We noted that data relating to posts that should have been advertised as Welsh essential but were not; number of justifications submitted and approved; and successful applicant Welsh language skills were not included in the 2018/19 Monitoring Report. We also found some inconsistency between information reported in the Monitoring Report and that of supporting documentation. In the Monitoring Report Ward Clerks are included in a list of posts whereby the ability to speak Welsh will default as essential, however are not specified as Welsh essential posts in the Bilingual Skills Strategy.
Patients Monies (18/19) Review completed May 2019 with Executive approval September 2019	Limited	3	2	-	<u>Disclaimer Notices and Patient Disclaimer Forms</u> A number of wards did not display Disclaimer Notices in patient and visitor areas and as such were non-compliant with procedure. A review of a random sample of Patient Disclaimer forms across those wards

Title	Assurance Level	High	Medium	Low	Key Messages
Health Board controls were operating effectively.					and community hospitals included in the audit identified that a number of disclaimer forms had not been completed upon admission of the patient; information was often incomplete and in some cases, the form had not been completed in line with procedure or adequately signed and witnessed. Completion of documentation and procedural compliance Issues of compliance with using and recording within official property books existed across a number of wards and hospitals visited as part of the review.

Work in Progress Summary

4. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Partnership governance - Section 33 Agreements	Discussion draft report issued 15th November 2019 with no comments received. Formal draft report issued.	22nd November 2019

Fieldwork

5. The following reviews are currently in progress:

- Budget setting – Review has commenced and focuses on compliance with the budget setting strategy for Secondary Care – East (Wrexham Maelor).
- Delivery of savings against identified schemes – Focusing on Secondary Care – Central (Glan Clwyd), we have met with the interim Chief Finance Officer to progress the review.
- Salary overpayments – We were requested to temporarily pause the review following an increase in overpayments – We have sought to re-commence the review.
- HASCAS & Ockenden external reports: Recommendation progress and reporting – Initial meeting held on 13th November 2019 to identify the evidence required for the eleven recommendations closed and reported to the Health Board.
- Quality Impact Assessment – Brief agreed and testing will commence imminently.

- Safeguarding – Work in progress to follow-up implementation of our 2018 review.
- Decontamination – Planning meeting agreed for December 2019.
- Deprivation of Liberty Safeguards (DoLS) – Testing has commenced.
- Quality Improvement Strategy - Hospital site visits to review Quality/Welcome Boards taking place and review of reporting to Board/Committees in progress.
- Cyber security – We have met with the Head of ICT Services and received evidence to support the review.
- Non-emergency patient transport service (NEPTS) – The draft report is set to be issued imminently.
- NHS Wales staff survey – delivering the findings – We have commenced the review of evidence supporting progress of a sample of operational implementation plans.
- Joint follow-up with Conwy County Borough Council Internal Audit Service: Conwy Community Mental Health Team (CMHT) – Follow-up is complete and our draft findings are being presented to management for discussion.

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
Ysbyty Gwynedd A&E	Attendance at Project Implementation Board	Closed - Verified
Ysbyty Gwynedd A&E	Project Director	Closed - Verified
Ysbyty Gwynedd A&E	Supply Chain Partner- Financial Stability	Closed - Verified
Ysbyty Gwynedd A&E	Contract Documentation	Closed - Verified
Ysbyty Gwynedd A&E	Cost Control (Equipment Budget)	Closed - Verified
Ysbyty Gwynedd A&E	KPI Reporting	Closed - Verified
Ysbyty Gwynedd A&E	Cost Control (Compensation Events)	Closed - Verified
Tendering for goods and services – Estates Department	Management review of working practices at Wrexham Maelor Estates	Closed - Verified
Tendering for goods and services – Estates Department	Declarations of Interest	Closed - Verified

Review Title	Recommendation Title	Follow-up status
Tendering for goods and services – Estates Department	Operational management scrutiny	Closed - Verified
Tendering for goods and services – Estates Department	Framework contract delivering value for money	Closed - Verified
Tendering for goods and services – Estates Department	Financial governance	Closed - Verified
Tendering for goods and services – Estates Department	Pre-order Verification	Closed - Verified
Implementing the Falls strategy	Review the DATIX reporting system and the reporting of patient falls	Closed - Verified
Primary Care GP Leases: Assigning leases to the Health Board	Reviewing of the business cases for GP leases	Closed - Verified
National Projects and impacts of delays	Monitoring progress	Closed - Verified
Business Continuity Arrangements	Business Continuity Management Strategy is being met	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. The review on the Ysbyty Gwynedd Emergency Department has been finalised in the period and a summary of the findings is included in reports issues section (table 1) above.

Delivering the Plan

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

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

12. The following reviews have been identified for deferment from the 2019/2020 original plan and have been agreed in principle with the Board Secretary prior to Audit Committee approval:

    - Compliance with Standing Financial Instructions – Procuring goods and services: Pharmacy EDS

      The review of source data for this review has identified no individual transaction

of £5,000 or more which required competitive quotation in accordance with the Standing Financial Instructions and is recommended for removal from the plan.

- Cluster governance arrangements

  Following development of the draft brief and issued for management consideration, we were advised of proposals being considered to develop integrated health & social care localities which potentially will have significant delegated responsibilities for planning and providing for the population. The localities are the same footprint as current clusters. We were told that it is unclear, currently, whether they incorporate the current primary care clusters, or run parallel.

- Continuing Healthcare

  Following issue of the draft brief, we were advised that the National Commissioning Collaborative (NCC) has been commissioned to begin a programme of work to review and improve CHC governance processes and contracting. As part of the first 30 days in the 90 day plan, the NCC will observe every CHC panel and feedback the opportunities for improvement. In order to test the outcomes/improvement following implementation of any agreed recommendations, it is proposed that this review be deferred to 2020/21

It is recommended that the three reviews are removed from the 2019/20 plan for future planning consideration.

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

14. Table 4 is reporting a positive status across all indicators although management response to draft report has decreased to 70% [20%] 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 Acting 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	Green	70%	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 2019-20

Planned output	Outline timing	Status	Assurance
Corporate governance, risk and regulatory compliance			
Annual Governance Statement	Q1	Complete – Head of internal audit annual report.	N/A
Welsh Risk Pool Claims Management Standard	Q4		
Health and Safety	Q1-2	Final report issued.	Reasonable
Welsh Language (Wales) Measure 2011	Q1	Final report issued.	Limited
~~Health Board governance arrangements – Quality & Safety~~	~~Q2-3~~	Recommended for deferment.	Recommended for deferment – This review would duplicate that of the Wales Audit Office.
Compliance with Standing Financial Instructions – Procuring goods and services: Estates - GRAMMS	Q1	Final report issued.	Reasonable
Compliance with Standing Financial Instructions – Procuring goods and services: Therapies – Therapy Manager	Q1-2	Final report issued.	Reasonable
~~Compliance with Standing Financial Instructions – Procuring goods and services: Pharmacy EDS~~	Q1-2	Brief agreed with operational management.	Recommended for removal - The review of information from the system has confirmed that no individual transaction was in excess of £5,000 requiring a competitive quotation/
~~Compliance with Standing Financial Instructions – Procuring goods and services: Community Dental Services~~	Q1-2	Brief agreed with operational management.	Recommended for removal - The review of information from Finance has confirmed that no individual transaction was in excess of £5,000 requiring a competitive quotation/
Strategic planning, performance management and reporting			
Performance measure reporting to the Board – Accuracy of information	Q2-3		
Partnership governance - Section 33 Agreements	Q2-3	Draft report issued.	
Financial governance and management			
Delivery of savings against identified schemes	Q2-3	Work in progress.	
Budget Setting	Q2-3	Work in progress.	
Salary overpayments	Q3	Work in progress.	
Quality and Safety			
Annual Quality Statement	Q1	Final report issued.	Reasonable

Planned output	Outline timing	Status	Assurance
HASCAS & Ockenden external reports – Recommendation progress and reporting	Q1-2	Work in progress.	
Quality Impact Assessment	Q2	Work in progress.	
Safeguarding	Q2-3	Work in progress.	
Decontamination	Q3	Meeting scheduled for December 2019.	
Deprivation of Liberty Safeguards (DoLS)	Q3	Work in progress.	
Quality Improvement Strategy	Q2-3	Work in progress.	
Information governance and security			
Welsh Community Care Information System (WCCIS)	Q4		
GDPR – Follow-up of the Information Commissioners Office (ICO) review	Q2	Final report issued.	Reasonable
~~Caldicott – Principles into Practice (CPiP) self-assessment~~	~~Q2~~	Deferred.	Approved for deferment by Audit Committee - Planned changes in the reporting tool and migration to a new process are taking place, as advised, in 2019/20.
Cyber security	Q3	Work in progress.	
Operational service and functional management			
Managed General Practitioner Practices	Q4		
~~Cluster governance arrangements~~	Q3-4	Deferred.	Recommended for removal - Proposals being considered to develop integrated health & social care localities which potentially will have significant delegated responsibilities for planning and providing for the population. The localities are the same footprint as current clusters we were told that it is unclear, currently, whether they incorporate the current primary care clusters, or run parallel.
~~Continuing Health Care~~	Q3	Deferred.	Recommended for deferment to 2020/21 as the planned scope would duplicate that of the National Commissioning Collaborative (NCC) which the Health Board have engaged. This will allow for any system/process changes agreed by the Health Board following this external review to be embedded.
Non-Emergency Patient Transport Service (NEPTS)	Q3	Draft report issued.	
Workforce management			

Planned output	Outline timing	Status	Assurance
Roster management	Q4		
NHS Wales staff survey – delivering the findings	Q3-4	Draft brief issued.	
Recruitment	Q4		
Capital and estates management			
Environmental sustainability report	Q1	Final report issued.	Reasonable
Carbon Reduction Commitment Order	Q1	Final report issued.	Substantial
Statutory Compliance: Fire Safety	Q1-2	Final report issued.	Reasonable
Ysbyty Gwynedd Emergency Department	Q1	Final report issued.	Reasonable
~~Capital Systems: Primary Care benefits realisation~~	Q1	Deferred.	Gateway 5 review will provide assurance to the Health Board.
North Denbighshire Community Hospital	Q4		
Ysbyty Wrexham Maelor Hospital – Backlog maintenance risk management	Q4		
Substance Misuse Action funds	Q3-4		
Compliance with the public sector internal audit standards – Contingency/assurance reviews			
Ysbyty Gwynedd Emergency Department Patient Monitors	Q1	Final report issued.	Assurance not applicable

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

Welsh Language (Wales) Measure 2011

Final Internal Audit Report

BCU 2019/20

November 2019

NHS Wales Shared Services Partnership

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Review reference:	BCU-1920-04
Report status:	Final Internal Audit Report
Fieldwork commencement:	14th June 2019
Fieldwork completion:	28th August 2019
Draft discussion report issued:	5th September 2019
Draft report issued:	13th September 2019
Management response received:	25th October 2019
Final report issued:	5th November 2019
Auditor/s:	Senior Internal Auditor Head of Internal Audit
Executive sign off:	Executive Director of Public Health
Distribution:	Head Of Welsh Language Services Workforce Information Systems Manager Associate Director Workforce Performance & Improvement Acting Board Secretary Statutory Compliance, Governance & Policy Manager
Committee:	Audit Committee

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

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

Disclaimer notice - Please note:

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

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

1. Introduction and Background

The Welsh Language Act 1993 established the principle that when providing services and administering justice for the people in Wales, the Welsh and English language should be treated on an equal basis.

The Welsh Language Measure (Wales) 2011 was given Royal Assent on 9th February 2011, giving the Welsh language official status in Wales and outlining the new legal context for the language. The Measure established the Office of Welsh Language Commissioner, and made provision for specifying standards on the Welsh language.

The Health Board was issued its Compliance Notice – Section 44 Welsh Language (Wales) Measure 2011 on 30th November 2018, with all Standards imposed from 30th May 2019.

The Health Board Bilingual Skills Strategy has been developed to support effective workforce planning to deliver bilingual services according to individual choice and the needs of the population, whilst maintaining compliance with the requirements of the statutory instrument.

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 action the requirements of the Bilingual Skills Strategy and ensure compliance with the Welsh Language Measure (Wales) 2011. Our approach to this review was to identify and evaluate controls in place and highlight potential weaknesses.

The review focussed on the following:

- Management and administration of vacant posts deemed Welsh language Essential;
- Vacancy justification;
- Supporting policies and guidance notes; and
- Accuracy and consistency of reporting.

3. Associated Risks

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

- Failure to comply with policy and/or Statutory requirements;
- Limiting access to Welsh speakers for patients; and
- Inconsistent or incomplete reporting.

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 Welsh Language (Wales) Measure 2011 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	Welsh essential posts		✓		
2	Justification approval		✓		
3	Policy and procedures			✓	
4	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 no issues that are classified as a weakness in the system control/design for the Welsh Language (Wales) Measure 2011.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system/control for the Welsh Language (Wales) Measure 2011.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided, responses during discussions and on documents provided to us.

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

To support compliance with the Welsh Language (Wales) Measure 2011, the Health Board has developed a Bilingual Skills Strategy which is underpinned by relevant Health Board Workforce policies. The Strategy is designed to, *"enable effective workforce planning and recruitment to ensure the delivery of bilingual services through the medium of Welsh and English, according to individual choice and the needs of the population in the area"*.

The Strategy states that the aim of the skills strategy is:

"*…to ensure that BCUHB has the sufficient number of staff with the appropriate Welsh language skills, to provide a healthcare service to the public bilingually, according to the needs of the local community."*

As part of the requirements, the Strategy mandates certain Health Board posts as Welsh language essential. The following posts are deemed as such: Switchboard Staff, Patient Booking Centres / Call Centre Staff and Receptionists.

This review focuses solely on the management and administration of Welsh essential posts, and compliance with Section 5 of the Bilingual Skills Strategy, WP1 BCUHB Policy for Safe Recruitment Selection Practices, and WP1a BCUHB Safe Recruitment Selection Practices Guidelines.

Welsh Essential Posts

The Health Board utilise the TRAC recruitment system to facilitate the recruitment process. In order to advertise a post, managers must complete and submit a comprehensive electronic vacancy request detailing the post requirements (including Welsh language requirements) for authorisation. Authorised request forms are then manually reviewed by Workforce and Organisational Development prior to being put out to advert.

We were advised that in instances where Welsh essential posts are submitted for advert as Welsh desirable, Workforce and Organisational Development staff return the vacancy requests back to requestors for amendment, or seek justification as to why the posts aren't going out as Welsh essential.

During the period 1st April 2018 and 31st March 2019 the Health Board advertised 2,847 vacant posts. Of these, 59 (2%) were advertised as Welsh language essential with the remaining 2,788 (98%) advertised as Welsh language desirable.

Of the 59 posts advertised as Welsh essential, 14 were posts mandated Welsh Essential per the Bilingual Skills Strategy - the other 45 were posts that the requesting managers had themselves deemed Welsh essential.

We reviewed the Welsh language skills of successful applicants and found the following:

- 45 individuals had been employed against the relevant position numbers between 1st April 2018 and 31st March 2019.
- Of these, 25 (56%) had scored themselves between level 0 and level 2 on the ESR Welsh language skills self-assessment tool despite the posts being advertised as Welsh essential (20 had assessed themselves at level 0).
- 19 had assessed themselves between level 3 and level 5 (15 of which were level 5).
- One employee had not completed the self-assessment, however was later confirmed to be level 5.

We enquired whether the 25 appointed applicants that had self-assessed their Welsh language skills between level 0 and level 2 had enrolled on any of the available Welsh language courses provided by the Health Board.

The Health Board Welsh language department confirmed that at the time of review only 2 of the 25 appointed applicants had enrolled on a Welsh language course.

Justification Approval

The Workforce Information Systems Manager reviewed the 2,788 posts advertised as Welsh language desirable and identified a further 54 posts that should have been designated Welsh Language essential per the Bilingual Skills Strategy.

We again reviewed the Welsh language skills and Welsh language course enrolment of successful applicants to these posts and noted the following:

- 42 individuals had been employed against the relevant position numbers between 1st April 2018 and 31st March 2019.
- 37 (88%) had assessed themselves between level 0 and level 2 on the ESR Welsh language skills self-assessment tool (33 had assessed themselves at level 0).
- 4 staff member that had assessed themselves between levels 0 and 2 had enrolled on Welsh language courses.
- 4 had assessed themselves between level 3 and level 5.
- One employee had not completed the self-assessment.

The Bilingual Skills Strategy states that:

"There will be the option to submit a Vacancy justification, indicating why the posts cannot be advertised Welsh essential. This will require approval by the Head of Workforce. The justification will need to consider the impact on the position and also on the team to be able to deliver comprehensive bilingual service. When recruiting managers have advertised posts with Welsh language skills as essential but have been unsuccessful in appointing a Welsh speaking candidate, these posts may be re-advertised within a 6 month period with Welsh speaking skills as desirable. These posts will be subject to audit to ensure that

the correct process has been followed and that there is adequate evidence that there would be a justifiable reason as to why the post was not advertised as Welsh Essential (please note that because the appointment is Urgent will not be considered a reason).”

We provided details of the 54 posts that should have been advertised as Welsh essential to the Heads of Workforce to confirm whether they had reviewed and approved a justification as to why the posts could not be advertised as Welsh essential.

The Head of Workforce – West responded (on behalf of the Heads of Workforce) that they did not retain records of justifications and that evidence of approval should be retained by the requesting managers. We enquired what format the requests were made and were advised that both requests and authorisation were made via e-mail. We requested copies of sent e-mail correspondences authorising the requests however none were provided for review.

We selected a random sample of 12 posts (22%) that should have been advertised as Welsh language essential and contacted the relevant requesting managers for evidence of justification approval. The following findings were noted:

- We received a response from ten of the twelve requesting managers contacted.
- Based on the responses received it was apparent that the requirements of the Bilingual Skills Strategy were not being adhered to.
- Only one manager was able to provide evidence that a justification request for the Welsh essential post to be advertised as Welsh desirable had been submitted and had been considered and authorised by the relevant Head of Workforce (the relevant post was approved by the Head of Workforce – East).
- None of the remaining nine managers in our sample had submitted a justification to the relevant Head of Workforce requesting the Welsh essential posts to be advertised as Welsh desirable.
- Five managers stated that they were not aware that the posts advertised were deemed Welsh language essential.
- Four stated that they had submitted the advert request via TRAC and had not been challenged or asked for justification.

Policies and Procedures

The Health Board has robust procedure and guidance documents in place to support adherence to the Welsh Language (Wales) Measure 2011 and to support the recruitment process.

As previously noted, Welsh language requirements with regard to recruitment are outlined in the Bilingual Skills Strategy which is underpinned by Workforce recruitment policies.

However whilst the Workforce policy and related guidance documents refer the reader to the Bilingual Skills Strategy, the Strategy requirements are not

explicitly stated in the policy document.

Reporting

Workforce recruitment data is reported as part of the Health Board Welsh Language Services Annual Monitoring Report. The report was presented to the Board during the July 2019 Board meeting. Aggregate staff Welsh language skill levels by service; overall Welsh language training statistics; and summary recruitment data stating the number of Welsh essential posts and Welsh desirable posts advertised were included within the report.

However we noted that data relating to posts that should have been advertised as Welsh essential but were not; number of justifications submitted and approved; and successful applicant Welsh language skills were not included in the 2018/19 Monitoring Report.

We also found some inconsistency between information reported in the Monitoring Report and that of supporting documentation. In the Monitoring Report Ward Clerks are included in a list of posts whereby the ability to speak Welsh will default as essential, however are not specified as Welsh essential posts in the Bilingual Skills Strategy.

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 – Post Requirements (Operating effectiveness)	Risk
During the period 1st April 2018 and 31st March 2019 the Health Board advertised 2847 vacant posts. Of these, 59 (2%) were advertised as Welsh language essential with the remaining 2788 (98%) advertised as Welsh language desirable. We reviewed the Welsh language skills of the successful applicants for the Welsh essential posts and found the following: • 45 individuals had been employed against the relevant position numbers between 1st April 2018 and 31st March 2019. • Of these, 25 (56%) had assessed themselves between level 0 and level 2 on the ESR Welsh language skills self-assessment tool despite the posts being advertised as Welsh essential (20 had assessed themselves at level 0). • 19 had assessed themselves between level 3 and level 5 (15 of which were level 5). • One employee had not completed the self-assessment, however was later confirmed to be level 5. The Health Board Welsh language department confirmed that at the time of review only 2 of the 25 appointed applicants that had self-assessed their Welsh language skills between level 0 and level 2 had enrolled on a Welsh language course.	Failure to adhere to Strategy and policy requirements. Post being filled by unsuitable candidates. Lack of transparency.
Recommendation	**Priority level**
Management should review current practice and put in place controls to ensure that essential post requirements are either met or that training is undertaken allow successful applicants to meet the requirements.	**High**

Management Response	Responsible Officer/ Deadline
Welsh Language Requirements is essential question on the new Establishment Control Form, all vacancies that require approval, must complete this form. If the manager selects the incorrect Language Level, the Establishment Control Team make a note on the form. When the post then goes out to advert, a further check is made by both the EC Team and the Advert Team.	Workforce Information Systems Manager August 2019

Finding - ISS.2 – Exception justification (Operating effectiveness)	Risk
Our review identified 54 posts that had been advertised as Welsh desirable despite being deemed Welsh essential per the Bilingual Skills Strategy. We sought evidence of justification and approval from both Heads of Workforce and requesting managers and found the following: • There was no formal process in place for managing justification requests and Head of Workforce approval for advertising Welsh essential posts as Welsh desirable. • Heads of Workforce confirmed that they did not retain evidence of justifications or approval. • Only one manager from a sample of 12 was able to provide evidence that a justification request for the Welsh essential post to be advertised as Welsh desirable had been submitted and had been considered and authorised by the relevant Head of Workforce (the relevant post was approved by the Head of Workforce – East). • Requesting managers stated that they were either unaware that the post was deemed Welsh essential, or had issued a standard TRAC vacancy request and had not been challenged.	Failure to adhere to Strategy and policy requirements. Lack of transparency.
Recommendation	**Priority level**
Management should review current practice and put in place controls to ensure that the requirements of the Bilingual Skills Strategy are met.	**High**

Given the current development of new vacancy justification forms, we urge managers to consider the possibility of building controls into the process e.g. removing the ability to change Welsh essential posts to Welsh desirable; building in and formalising the authorisation process for posts that cannot be advertised as Welsh essential.	
Management Response	**Responsible Officer/ Deadline**
In line with the changes above, there will be further development of the Portal to include when posts are re-advertised. All future re-advertisements will be signed off and agreed by the Workforce Information Systems Manager until portal has a process in place. This will be recorded centrally for monitoring purposes.	Workforce Information Systems Manager April 2020 Workforce Information Systems Manager 1 December 2019

Finding - ISS.3 – Policy and reporting (Operating effectiveness)	Risk
Whilst the Health Board has robust policies, guidance documents, and reporting in place to support adherence to the Welsh Language (Wales) Measure 2011, the following issues and limitations were noted: • Bilingual Skills Strategy requirements are not explicitly stated in the policy documentation; • The requirements of the Bilingual Skills Strategy with regard to vacancy justifications were not adhered to by Workforce staff or requesting managers. • There appeared to be a lack of awareness around the requirements of the Bilingual Skills Strategy. • Recruitment data reported to the Board in the Welsh Language Services Annual Monitoring Report is limited. • Ward clerks are reported as Welsh essential posts in the Monitoring Report however are not specified as such in the Bilingual Skills Strategy.	Inconsistent practice. Lack of transparency.
Recommendation	**Priority level**
Management should: • Consider whether current practice meets the requirements of the Bilingual Skills Strategy.	**Medium**

• Review the Bilingual Skills Strategy to ensure the requirements are consistent with current working practice and systems in place. • Consider whether current reporting provides sufficient assurance to the Board.	
Management Response	**Responsible Officer/ Deadline**
The Bilingual Skills Strategy will be reviewed in line with the Welsh Language Standards. There are however developments in Trac which will be live by 1st December to ensure that the HB can report easily.	Head Of Welsh Language Services/Workforce Information Systems Manager January 2020 Workforce Information Systems Manager December 2020

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.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Mesur y Gymraeg (Cymru) 2011

Adroddiad Archwilio Mewnol Terfynol

Bwrdd Iechyd Prifysgol Betsi Cadwaladr 2019/20

Tachwedd 2019

Partneriaeth Cydwasanaethau GIG Cymru

Cynnwys **Tudalen**

Cyfeirnod yr adolygiad:	BCU-1920-04
Statws yr adroddiad:	Adroddiad Archwilio Mewnol Terfynol
Cychwyn y gwaith maes:	14 Mehefin 2019
Cwblhau'r gwaith maes:	28 Awst 2019
Cyhoeddi adroddiad trafod drafft:	5 Medi 2019
Cyhoeddi adroddiad drafft:	13 Medi 2019
Derbyn ymateb y rheolwr:	25 Hydref 2019
Cyhoeddi yr adroddiad terfynol:	5 Tachwedd 2019
Archwiliwr/Archwilwyr:	Uwch Archwilydd Mewnol Pennaeth Archwilio Mewnol
Cymeradwyaeth y weithrediaeth:	Cyfarwyddwr Gweithredol Iechyd y Cyhoedd
Dosbarthu:	Pennaeth Gwasanaethau'r Gymraeg Rheolwr Systemau Gwybodaeth am y Gweithlu Cyfarwyddwr Cyswllt Perfformiad a Gwelliant y Gweithlu Ysgrifennydd y Bwrdd Dros Dro Rheolwr Cydymffurfiaeth, Llywodraethu a Pholisi Statudol
Pwyllgor:	Y Pwyllgor Archwilio

Mae Gwasanaethau Archwilio a Sicrwydd yn cydymffurfio â holl Safonau Archwilio Mewnol y Sector Cyhoeddus fel y'u dilyswyd trwy'r asesiad ansawdd allanol a gynhaliwyd gan Sefydliad yr Archwilwyr Mewnol.

CYDNABYDDIAETH

Hoffai Gwasanaethau Archwilio a Sicrwydd GIG Cymru gydnabod yr amser a'r cydweithrediad a roddwyd gan reolwyr a staff yn ystod yr adolygiad hwn.

Rhybudd ymwadiad – Sylwch:

Paratowyd yr adroddiad archwilio hwn at ddefnydd mewnol yn unig. Caiff adroddiadau Gwasanaethau Archwilio a Sicrwydd eu paratoi, yn unol â Strategaeth a Chylch Gorchwyl y Gwasanaeth, a chânt eu cymeradwyo gan y Pwyllgor Archwilio.

Caiff adroddiadau archwilio eu paratoi gan staff Gwasanaethau Archwilio a Sicrwydd Partneriaeth Cydwasanaethau GIG Cymru, a chânt eu cyfeirio at Aelodau Annibynnol neu swyddogion, gan gynnwys Swyddogion Atebol dynodedig. Fe'u paratoir yn unswydd at ddefnydd Bwrdd Iechyd Prifysgol Betsi Cadwaladr ac nid oes unrhyw gyfrifoldeb gan Archwilwyr Mewnol Gwasanaethau Archwilio a Sicrwydd am unrhyw gyfarwyddwr neu swyddog yn unigol, neu am unrhyw drydydd parti.

1. Cyflwyniad a Chefndir

Sefydlwyd egwyddor o dan Ddeddf yr Iaith Gymraeg 1993 y dylid trin y Gymraeg a'r Saesneg yn gyfartal wrth ddarparu gwasanaethau a gweinyddu cyfiawnder i bobl yng Nghymru.

Rhoddwyd Cydsyniad Brenhinol i Fesur y Gymraeg (Cymru) 2011 ar 9 Chwefror 2011, gan roi statws swyddogol i'r Gymraeg yng Nghymru ac amlinellu'r cyd-destun cyfreithiol newydd ar gyfer yr iaith. Sefydlodd y Mesur Swyddfa Comisiynydd y Gymraeg, a darparu ar gyfer nodi safonau yn ymwneud â'r Gymraeg.

Cyhoeddwyd Hysbysiad Cydymffurfio i'r Bwrdd Iechyd – Adran 44 o Fesur y Gymraeg (Cymru) 2011 ar 30 Tachwedd 2018, a daeth yr holl Safonau i rym ar 30 Mai 2019.

Datblygwyd Strategaeth Sgiliau Dwyieithog y Bwrdd Iechyd i gefnogi cynllunio gweithlu effeithiol, a hynny er mwyn darparu gwasanaethau dwyieithog yn unol â dewis yr unigolyn ac anghenion y boblogaeth trwy gynnal cydymffurfiaeth â gofynion yr offeryn statudol.

2. Cwmpas ac Amcanion

Amcan cyffredinol yr adolygiad oedd darganfod a oes amgylchedd rheoli cadarn ar waith yn y Bwrdd Iechyd i weithredu gofynion y Strategaeth Sgiliau Dwyieithog a sicrhau cydymffurfiaeth â Mesur y Gymraeg (Cymru) 2011. Ein dull o ymdrin â'r adolygiad hwn oedd nodi a gwerthuso rheolaethau sydd ar waith a thynnu sylw at wendidau posibl.

Canolbwyntiodd yr adolygiad ar y canlynol:

- Rheoli a gweinyddu swyddi gwag sy'n ystyried bod y Gymraeg yn hanfodol
- Cyfiawnhau swyddi gwag
- Polisïau a nodiadau canllaw ategol
- Cywirdeb a chysondeb adrodd

3. Risgiau Cysylltiedig

Y risgiau posibl a ystyriwyd ar ddechrau'r adolygiad oedd y canlynol:

- Methu â chydymffurfio â'r polisi a/neu'r gofynion Statudol
- Cyfyngu mynediad cleifion i siaradwyr Cymraeg
- Adrodd anghyson neu anghyflawn

BARN A CHANFYDDIADAU ALLWEDDOL

4. Barn Sicrwydd Cyffredinol

Mae'n ofynnol i ni roi barn ar ddigonolrwydd ac effeithiolrwydd y system rheolaeth fewnol sy'n cael ei hadolygu. Mae'r farn yn seiliedig ar y gwaith a gyflawnir, fel y nodir yng nghwmpas ac amcanion yr adroddiad hwn. Darperir sgôr sicrwydd gyffredinol sy'n disgrifio effeithiolrwydd y system rheolaeth fewnol sydd ar waith. Bydd hyn yn rheoli'r risgiau sy'n gysylltiedig â'r amcanion y sonnir

amdanynt yn yr adolygiad hwn.

Sicrwydd cyfyngedig yw lefel y sicrwydd a roddir ynghylch effeithiolrwydd y system rheolaeth fewnol sydd ar waith i reoli'r risgiau sy'n gysylltiedig ag adolygiad Mesur y Gymraeg (Cymru) 2011.

SGÔR	DANGOSYDD	DIFFINIAD
Sicrwydd Cyfyngedig		Gall y Bwrdd fod yn **weddol sicr** bod y trefniadau sydd ar waith i sicrhau llywodraethiant, rheolaeth risg a rheolaeth fewnol, yn y meysydd hynny sy'n cael eu hadolygu, wedi eu dylunio'n addas a'u bod wedi cael eu rhoi ar waith yn effeithiol. Mae angen tynnu sylw rheolwyr at faterion mwy arwyddocaol, **gydag effaith gymedrol ar amlygiad risg gweddilliol,** hyd nes y cânt eu datrys.

Mae lefel gyffredinol y sicrwydd y gellir ei rhoi i'w hadolygu yn dibynnu ar ddifrifoldeb y canfyddiadau fel y'u cymhwysir yn erbyn yr amcanion adolygu penodol ac felly dylid eu hystyried yn y cyd-destun hwnnw.

5. Crynodeb o Sicrwydd

Disgrifir crynodeb o sicrwydd a roddir yn erbyn yr amcanion unigol yn y tabl isod:

Crynodeb o Sicrwydd					
1	Swyddi lle mae'r Gymraeg yn hanfodol		✓		
2	Cymeradwyo cyfiawnhad		✓		
3	Polisi a gweithdrefnau			✓	
4	Adrodd			✓	

** Nid yw'r sgoriau uchod o reidrwydd yn cael eu hystyried i'r un graddau wrth gynhyrchu barn yr archwiliad.*

Dyluniad y Systemau/Rheolaethau

Nid yw canfyddiadau'r adolygiad wedi tynnu sylw at unrhyw faterion rheoli/dylunio sy'n cael eu hystyried yn wendid o ran Mesur y Gymraeg (Cymru) 2011.

Gweithredu'r System/Rheolaethau

Mae canfyddiadau'r adolygiad wedi amlygu tri mater sy'n cael eu hystyried yn wendid yng ngweithrediad y system reoli/ddylunio ar gyfer Mesur y Gymraeg (Cymru) 2011.

6. Crynodeb o Ganfyddiadau'r Archwiliad

Mae'r prif ganfyddiadau'n cael eu nodi yn y Cynllun Gweithredu Rheoli.

Mae'r adroddiad hwn yn seiliedig ar yr wybodaeth a ddarparwyd, ymatebion yn ystod trafodaethau a dogfennau a ddarparwyd inni.

Rydym wedi dibynnu'n llwyr ar y dogfennau, yr wybodaeth a'r esboniadau a ddarparwyd ac eithrio lle nodir yn wahanol. Nid ydym wedi gwneud unrhyw waith i wirio dilysrwydd yr wybodaeth a ddarperir.

Er mwyn cefnogi cydymffurfiaeth â Mesur y Gymraeg (Cymru) 2011, mae'r Bwrdd Iechyd wedi datblygu Strategaeth Sgiliau Dwyieithog sy'n cael ei hategu gan bolisïau Gweithlu perthnasol y Bwrdd Iechyd. Mae'r Strategaeth wedi'i chynllunio i *"alluogi cynllunio a recriwtio gweithlu effeithiol i sicrhau'r gwaith o ddarparu gwasanaethau dwyieithog trwy gyfrwng y Gymraeg a'r Saesneg, yn unol â dewis yr unigolyn ac anghenion y boblogaeth yn yr ardal honno".*

Mae'r Strategaeth yn nodi mai nod y strategaeth sgiliau yw:

"...sicrhau bod gan Fwrdd Iechyd Prifysgol Betsi Cadwaladr nifer digonol o staff sydd â sgiliau iaith Gymraeg priodol, i ddarparu gwasanaeth gofal iechyd i'r cyhoedd yn ddwyieithog a hynny yn unol ag anghenion y gymuned leol."

Fel rhan o'r gofynion, mae'r Strategaeth yn mandadu swyddi penodol y Bwrdd Iechyd fel rhai lle mae'r Gymraeg yn hanfodol. Mae'r swyddi canlynol yn cael eu hystyried fel rhai lle mae'r Gymraeg yn hanfodol: Staff y Switsfwrdd, Canolfannau Apwyntiadau Cleifion / Canolfan Alwadau Staff a Derbynyddion.

Mae'r adolygiad hwn yn canolbwyntio'n gyfan gwbl ar reoli a gweinyddu swyddi lle mae'r Gymraeg yn hanfodol, a chydymffurfiaeth ag Adran 5 o'r Strategaeth Sgiliau Dwyieithog, WP1 Polisi Bwrdd Iechyd Prifysgol Betsi Cadwaladr ar gyfer Arferion Dethol Recriwtio Diogel a WP1a Canllawiau Arferion Dethol Recriwtio Diogel Bwrdd Iechyd Prifysgol Betsi Cadwaladr.

Swyddi lle mae'r Gymraeg yn Hanfodol

Mae'r Bwrdd Iechyd yn defnyddio'r system recriwtio TRAC i hwyluso'r broses recriwtio. Er mwyn hysbysebu swydd, rhaid i reolwyr gwblhau a chyflwyno cais electronig cynhwysfawr i'w awdurdodi ar gyfer swydd wag sy'n manylu ar ofynion y swydd (gan gynnwys gofynion iaith Gymraeg). Mae ffurflenni cais sydd wedi'u hawdurdodi yn cael eu hadolygu â llaw gan Adran y Gweithlu a Datblygu Sefydliadol cyn cael eu hysbysebu.

Mewn achosion lle caiff swyddi eu hysbysebu fel 'Cymraeg Hanfodol' pan ddylent gael eu hysbysebu fel 'Cymraeg Dymunol', cawsom ein cynghori y dylai staff y Gweithlu a Datblygu Sefydliadol ddychwelyd y ceisiadau am swyddi yn ôl i'r rhai sy'n gofyn amdanynt i'w newid, neu gael cyfiawnhad pam nad yw'r swyddi'n cael eu hysbysebu fel rhai lle mae'r Gymraeg yn hanfodol.

Yn ystod y cyfnod rhwng 1 Ebrill 2018 a 31 Mawrth 2019, hysbysebodd y Bwrdd Iechyd 2,847 o swyddi gwag. O'r rhain, cafodd 59 (2%) eu hysbysebu fel swyddi lle roedd y Gymraeg yn hanfodol gyda'r 2,788 a oedd yn weddill (98%) wedi'u hysbysebu fel swyddi lle roedd y Gymraeg yn ddymunol.

O'r 59 o swyddi a hysbysebwyd lle roedd y Gymraeg yn hanfodol, roedd 14 yn swyddi lle roedd y Gymraeg yn hanfodol dan fandad Strategaeth Sgiliau Dwyieithog. Roedd y 45 swydd arall yn rhai lle roedd rheolwyr sy'n gwneud ceisiadau am swyddi yn ystyried y Gymraeg yn hanfodol.

Gwnaethom adolygu sgiliau Cymraeg yr ymgeiswyr llwyddiannus a chanfod y canlynol:

- Cafodd 45 o unigolion eu cyflogi yn erbyn niferoedd y swyddi perthnasol rhwng 1 Ebrill 2018 a 31 Mawrth 2019.
- O'r rhain, sgoriodd 25 (56%) eu hunain rhwng lefel 0 a lefel 2 ar offeryn hunanasesu sgiliau iaith Gymraeg ar ESR er bod y swyddi'n cael eu hysbysebu fel rhai lle roedd y Gymraeg yn hanfodol (roedd 20 wedi asesu eu hunain ar lefel 0).
- Roedd 19 wedi asesu eu hunain rhwng lefel 3 a lefel 5 (roedd 15 ar lefel 5).
- Ni chwblhaodd un gweithiwr yr hunanasesiad. Fodd bynnag, yn ddiweddarach, cadarnhawyd ei fod ar lefel 5.

Ymholom p'un a oedd y 25 o ymgeiswyr a gafodd eu penodi ac a oedd wedi hunanasesu eu sgiliau Cymraeg rhwng lefel 0 a lefel 2 wedi cofrestru ar unrhyw rai o'r cyrsiau iaith Gymraeg a oedd ar gael gan y Bwrdd Iechyd.

Cadarnhaodd Adran Gymraeg y Bwrdd Iechyd mai dim ond 2 o'r 25 o ymgeiswyr a benodwyd oedd wedi cofrestru ar gwrs iaith Gymraeg ar adeg yr adolygiad.

Cymeradwyo Cyfiawnhad

Adolygodd Rheolwr Systemau Gwybodaeth am y Gweithlu y 2,788 o swyddi a hysbysebwyd fel rhai lle roedd y Gymraeg yn ddymunol a nodi 54 o swyddi eraill a ddylai fod wedi'u hysbysebu fel rhai lle roedd y Gymraeg yn hanfodol o dan y Strategaeth Sgiliau Dwyieithog.

Gwnaethon ni, unwaith eto, adolygu sgiliau Cymraeg ymgeiswyr llwyddiannus a'r nifer a oedd wedi cofrestru ar gyfer cyrsiau iaith Gymraeg y swyddi hyn a nodi'r canlynol:

- Roedd 42 o unigolion wedi'u cyflogi yn erbyn niferoedd y swyddi perthnasol rhwng 1 Ebrill 2018 a 31 Mawrth 2019.
- Roedd 37 (88%) wedi asesu eu hunain rhwng lefel 0 a lefel 2 ar yr offeryn hunanasesu sgiliau Cymraeg ar ESR (roedd 33 wedi asesu eu hunain ar lefel 0).
- Roedd 4 aelod o staff a oedd wedi asesu eu hunain rhwng lefelau 0 a 2 wedi cofrestru ar gyfer y cyrsiau iaith Gymraeg.
- Roedd 4 wedi asesu eu hunain rhwng lefel 3 a lefel 5.

- Ni wnaeth un gweithiwr gwblhau'r hunanasesiad.

Mae'r Strategaeth Sgiliau Dwyieithog yn nodi'r canlynol:

"Bydd dewis i gyflwyno cyfiawnhad dros swyddi gwag, gan nodi pam na all y swyddi gael eu hysbysebu fel rhai lle mae'r Gymraeg yn hanfodol. Bydd angen cymeradwyaeth gan Bennaeth y Gweithlu. Bydd angen i'r cyfiawnhad ystyried yr effaith ar y swydd yn ogystal ag ar y tîm er mwyn gallu darparu gwasanaeth dwyieithog cynhwysfawr. Pan fydd rheolwyr recriwtio wedi hysbysebu swyddi lle mae'r Gymraeg yn hanfodol ond wedi bod yn aflwyddiannus wrth benodi ymgeisydd sy'n siarad Cymraeg, gallai'r swyddi gael eu hail-hysbysebu o fewn cyfnod o 6 mis lle mae'r Gymraeg yn ddymunol. Bydd y swyddi hyn yn amodol ar archwiliad i sicrhau bod y broses gywir wedi'i dilyn a bod tystiolaeth ddigonol y byddai rheswm cyfiawnadwy pam nad oedd y swydd wedi'i hysbysebu fel un a oedd â'r Gymraeg yn hanfodol (nodwch, ni fydd dweud bod y penodiad yn un brys yn cael ei ystyried fel rheswm digonol)."

Darparom fanylion o'r 54 o swyddi a ddylai fod wedi'u hysbysebu gyda'r Gymraeg yn hanfodol i Benaethiaid y Gweithlu i gadarnhau p'un a oeddent wedi adolygu a chymeradwyo cyfiawnhad dros pam nad oedd y swyddi'n gallu cael eu hysbysebu fel rhai lle roedd y Gymraeg yn hanfodol.

Ymatebodd Pennaeth Gweithlu'r Gorllewin (ar ran Penaethiaid y Gweithlu) drwy ddweud nad oedd ganddynt gofnodion o gyfiawnhad ac y dylai tystiolaeth o gymeradwyo gael ei chadw gan y rheolwyr sy'n gwneud ceisiadau am swyddi. Ymholom ar ba ffurf cafodd y ceisiadau eu gwneud a chawsom wybod bod y ddau gais a'r awdurdodiad wedi'u gwneud trwy e-bost. Gwnaethom gais am gopïau o ohebiaeth a anfonwyd dros e-bost yn awdurdodi'r ceisiadau, ond ni ddarparwyd unrhyw gopïau i'w hadolygu.

Dewisom ar hap sampl o 12 swydd (22%) a ddylai fod wedi'u hysbysebu fel rhai gyda'r Gymraeg yn hanfodol a gwnaethom gysylltu â'r rheolwyr sy'n gwneud ceisiadau am swyddi perthnasol am dystiolaeth o gymeradwyo cyfiawnhad. Nodwyd y canfyddiadau canlynol:

- Derbyniom ymateb gan ddeg o'r deuddeg rheolwr sy'n gwneud ceisiadau am swyddi y cysylltwyd â hwy.
- Yn seiliedig ar yr ymatebion a dderbyniwyd, roedd yn amlwg nad oedd gofynion y Strategaeth Sgiliau Dwyieithog yn cael eu dilyn.
- Dim ond un rheolwr oedd yn gallu darparu tystiolaeth bod cais am gyfiawnhad wedi'i gyflwyno ac wedi'i ystyried a'i awdurdodi ar gyfer swydd lle roedd y Gymraeg i fod yn hanfodol ond wedi'i hysbysebu fel swydd lle roedd y Gymraeg yn ddymunol gan Bennaeth y Gweithlu perthnasol (roedd y swydd berthnasol wedi'i chymeradwyo gan Bennaeth Gweithlu'r Dwyrain).
- Doedd dim un o'r naw rheolwr oedd ar ôl yn ein sampl wedi cyflwyno cyfiawnhad i Bennaeth y Gweithlu perthnasol yn gwneud cais i hysbysebu swyddi lle roedd y Gymraeg i fod yn hanfodol yn rhai lle roedd y Gymraeg yn ddymunol.

- Roedd pump o reolwyr wedi nodi nad oeddent yn ymwybodol bod y swyddi a hysbysebwyd yn cael eu hystyried fel rhai lle roedd y Gymraeg yn hanfodol.
- Roedd pedwar wedi nodi eu bod wedi cyflwyno'r hysbyseb trwy TRAC ac nad oedd eu cais wedi'i herio na'i gwestiynu o ran cael cyfiawnhad.

Polisïau a Gweithdrefnau

Mae gan y Bwrdd Iechyd weithdrefnau cadarn a dogfennau canllaw yn eu lle i gefnogi ymlyniad wrth Fesur y Gymraeg (Cymru) 2011 ac i gefnogi'r broses recriwtio.

Fel y nodwyd yn flaenorol, mae gofynion yr iaith Gymraeg mewn perthynas â recriwtio wedi'u hamlinellu yn y Strategaeth Sgiliau Dwyieithog sy'n sail i bolisïau recriwtio'r Gweithlu.

Fodd bynnag, wrth i bolisi'r Gweithlu a dogfennau canllaw cysylltiedig gyfeirio'r darllenydd at y Strategaeth Sgiliau Dwyieithog, nid yw gofynion y Strategaeth yn cael eu nodi'n benodol yn nogfen y polisi.

Adrodd

Adroddir ar ddata recriwtio'r Gweithlu fel rhan o Adroddiad Monitro Blynyddol Gwasanaethau Iaith Gymraeg y Bwrdd Iechyd. Cafodd yr adroddiad ei gyflwyno i'r Bwrdd yn ystod cyfarfod y Bwrdd ym mis Gorffennaf 2019. Cynhwyswyd y canlynol yn yr adroddiad: y gwaith o gasglu lefelau sgiliau iaith Gymraeg staff yn ôl gwasanaeth, ystadegau cyffredinol hyfforddiant yr iaith Gymraeg a chrynodeb o ddata recriwtio yn nodi nifer y swyddi a hysbysebwyd lle mae'r Gymraeg yn hanfodol a swyddi lle mae'r Gymraeg yn ddymunol.

Fodd bynnag, gwnaethom nodi na chynhwyswyd data yn ymwneud â swyddi a ddylai fod wedi'u hysbysebu fel rhai lle roedd y Gymraeg yn hanfodol ond nad oeddent wedi, sawl cyfiawnhad a gafodd ei gyflwyno a'i gymeradwyo na sgiliau iaith Gymraeg ymgeiswyr llwyddiannus yn Adroddiad Monitro 2018/19.

Gwnaethom hefyd ganfod anghysondeb rhwng yr wybodaeth a gyflwynwyd yn yr Adroddiad Monitro ac mewn dogfennau ategol. Yn yr Adroddiad Monitro, mae Clercod Wardiau yn cael eu cynnwys mewn rhestr o swyddi lle bydd y gallu i siarad Cymraeg yn hanfodol. Fodd bynnag, nid ydynt wedi'u dynodi fel swyddi lle bydd y Gymraeg yn hanfodol yn y Strategaeth Sgiliau Dwyieithog.

7. Crynodeb o Argymhellion

Yng nghanfyddiadau'r archwiliad, mae argymhellion yn cael eu manylu yn Atodiad A ochr yn ochr â'r cynllun gweithredu rheoli a'r amserlen weithredu.

Mae crynodeb o'r argymhellion hyn yn cael eu hamlinellu isod, a hynny fesul blaenoriaeth.

Blaenoriaeth	U	C	I	Cyfanswm
Nifer yr argymhellion	**2**	**1**	**0**	**3**

Canfyddiad – ISS.1 – Gofynion y Swydd (Effeithiolrwydd gweithredu)	Risg
Yn ystod y cyfnod rhwng 1 Ebrill 2018 a 31 Mawrth 2019, hysbysebodd y Bwrdd Iechyd 2,847 o swyddi gwag. O'r rhain, cafodd 59 (2%) eu hysbysebu fel swyddi lle roedd y Gymraeg yn hanfodol gyda'r 2,788 a oedd yn weddill (98%) wedi'u hysbysebu fel swyddi lle roedd y Gymraeg yn ddymunol. Gwnaethom adolygu sgiliau Cymraeg yr ymgeiswyr llwyddiannus ar gyfer y swyddi lle roedd y Gymraeg yn hanfodol a chanfod y canlynol: • Cafodd 45 o unigolion eu cyflogi yn erbyn niferoedd y swyddi perthnasol rhwng 1 Ebrill 2018 a 31 Mawrth 2019. • O'r rhain, roedd 25 (56%) wedi asesu eu hunain rhwng lefel 0 a lefel 2 ar yr offeryn hunanasesu sgiliau iaith Gymraeg ar ESR er bod y swyddi'n cael eu hysbysebu fel rhai lle roedd y Gymraeg yn hanfodol (roedd 20 wedi asesu eu hunain ar lefel 0). • Roedd 19 wedi asesu eu hunain rhwng lefel 3 a lefel 5 (roedd 15 ar lefel 5). • Ni chwblhaodd un gweithiwr yr hunanasesiad. Fodd bynnag, yn ddiweddarach, cadarnhawyd ei fod ar lefel 5. Cadarnhaodd Adran Gymraeg y Bwrdd Iechyd mai dim ond 2 o'r 25 o ymgeiswyr a benodwyd ac a oedd wedi hunanasesu eu sgiliau iaith Gymraeg rhwng lefel 0 a lefel 2 ar adeg yr adolygiad oedd wedi cofrestru ar gwrs iaith Gymraeg.	Methu â glynu at y Strategaeth a gofynion y polisi. Y swydd yn cael ei llenwi gan ymgeiswyr anaddas. Diffyg tryloywder.

Argymhelliad	Lefel blaenoriaeth
Dylai rheolwyr adolygu arferion presennol a rhoi rheolaethau yn eu lle i sicrhau bod gofynion hanfodol swydd yn cael eu bodloni neu bod hyfforddiant yn cael ei ddarparu i alluogi ymgeiswyr llwyddiannus i fodloni'r gofynion.	**Uchel**
Ymateb y Rheolwyr	**Swyddog Cyfrifol/Dyddiad cau**
Mae Gofynion yr Iaith Gymraeg yn gwestiwn hanfodol ar y Ffurflen Rheoli Sefydliad newydd, ac mae'n rhaid i'r holl swyddi gwag y mae angen eu cymeradwyo gwblhau'r ffurflen hon. Os yw'r rheolwr yn dewis y lefel iaith anghywir, gall y Tîm Rheoli Sefydliad wneud nodyn o hyn ar y ffurflen. Pan fydd y swydd yn cael ei hysbysebu, caiff gwiriad pellach ei wneud gan y Tîm Rheoli Sefydliad a'r Tîm Hysbysebu.	Rheolwr Systemau Gwybodaeth am y Gweithlu Awst 2019

Canfyddiad – ISS.2 – Cyfiawnhau eithriad (Effeithiolrwydd gweithredu)	Risg
Gwnaeth ein hadolygiad nodi 54 o swyddi oedd wedi'u hysbysebu fel swyddi lle roedd y Gymraeg yn ddymunol er gwaethaf cael eu hystyried fel rhai lle roedd y Gymraeg yn hanfodol o dan y Strategaeth Sgiliau Dwyieithog. Cawsom dystiolaeth o gyfiawnhad a chymeradwyaeth gan Bennaeth y Gweithlu a'r rheolwyr sy'n gwneud ceisiadau am swyddi a chanfod y canlynol: • Doedd dim proses ffurfiol yn ei lle o ran rheoli ceisiadau cyfiawnhad a chymeradwyaeth gan Bennaeth y Gweithlu ar gyfer hysbysebu swyddi lle mae'r Gymraeg yn hanfodol fel rhai lle mae'r Gymraeg yn ddymunol. • Cadarnhaodd Penaethiaid y Gweithlu nad oeddent wedi cadw tystiolaeth o gyfiawnhad neu gymeradwyaeth. • Dim ond un rheolwr o sampl o 12 oedd yn gallu darparu tystiolaeth bod cais am gyfiawnhad wedi'i gyflwyno ac wedi'i ystyried a'i awdurdodi ar gyfer swydd lle roedd y Gymraeg i fod yn hanfodol ond wedi'i hysbysebu fel swydd lle roedd y Gymraeg yn ddymunol gan Bennaeth y Gweithlu perthnasol (roedd y swydd berthnasol wedi'i chymeradwyo gan Bennaeth Gweithlu'r Dwyrain). • Nododd rheolwyr sy'n gwneud ceisiadau am swyddi eu bod naill ai'n anymwybodol bod y swydd i fod i gael ei hysbysebu fel un lle mae'r Gymraeg yn hanfodol, neu eu bod wedi cyhoeddi cais am swydd wag safonol ar TRAC nad oedd wedi cael ei herio.	Methu â glynu at Strategaeth a gofynion y polisi. Diffyg tryloywder.

Argymhelliad	Lefel Blaenoriaeth
Dylai rheolwyr adolygu arferion presennol a rhoi rheolaethau ar waith i sicrhau bod gofynion y Strategaeth Sgiliau Dwyieithog yn cael eu bodloni. O ystyried datblygiad presennol ffurflenni cyfiawnhau swyddi gwag newydd, rydyn ni'n annog rheolwyr i ystyried y posibilrwydd o adeiladu rheolaethau i'r broses e.e. cael gwared ar y gallu i newid swyddi lle mae'r Gymraeg yn hanfodol i rai lle mae'r Gymraeg yn ddymunol; adeiladu a ffurfioli'r broses awdurdodi ar gyfer swyddi na ellir eu hysbysebu fel rhai lle mae'r Gymraeg yn hanfodol.	**Uchel**
Ymateb y Rheolwyr	**Swyddog Cyfrifol/Dyddiad cau**
Yn unol â'r newidiadau uchod, bydd datblygiad pellach o'r Porth i'w gynnwys pan fydd swyddi'n cael eu hail-hysbysebu. Bydd yr holl ail-hysbysebion yn y dyfodol yn cael cymeradwyo a'u cytuno gan Reolwr Systemau Gwybodaeth am y Gweithlu nes y bydd gan y porth broses ar waith. Bydd hyn yn cael ei gofnodi'n ganolog at ddibenion monitro.	Rheolwr Systemau Gwybodaeth am y Gweithlu Ebrill 2020 Rheolwr Systemau Gwybodaeth am y Gweithlu 1 Rhagfyr 2019

Canfyddiad – ISS.3 – Polisi ac adrodd (Effeithiolrwydd gweithredu)	Risg
Er bod gan y Bwrdd Iechyd bolisïau cadarn, dogfennau canllaw, a'r gwaith o adrodd yn eu lle i gefnogi ymlyniad â Mesur y Gymraeg (Cymru) 2011, nodwyd y materion a'r cyfyngiadau canlynol: • Nid yw gofynion y Strategaeth Sgiliau Dwyieithog yn cael eu nodi'n benodol yn nogfen y polisi; • Ni lynwyd wrth ofynion y Strategaeth Sgiliau Dwyieithog mewn perthynas â chyfiawnhau swyddi gwag gan staff y Gweithlu neu reolwyr sy'n gwneud ceisiadau am swyddi. • Ymddangosai fod diffyg ymwybyddiaeth yn ymwneud â gofynion y Strategaeth Sgiliau Dwyieithog. • Mae data recriwtio a adroddir i'r Bwrdd yn Adroddiad Monitro Blynyddol Gwasanaethau'r Gymraeg yn gyfyngedig. • Mae Clercod Wardiau yn cael eu hysbysebu fel swyddi lle mae'r Gymraeg yn hanfodol yn yr Adroddiad Monitro, ond nid yw'n cael ei nodi felly yn y Strategaeth Sgiliau Dwyieithog.	Arfer anghyson. Diffyg tryloywder.
Argymhelliad	**Lefel Blaenoriaeth**
Dylai rheolwyr wneud y canlynol: • Ystyried p'un a yw arfer presennol yn bodloni gofynion y Strategaeth Sgiliau Dwyieithog.	**Canolig**

• Adolygu'r Strategaeth Sgiliau Dwyieithog i sicrhau bod y gofynion yn cyd-fynd ag arferion gwaith presennol a bod systemau yn eu lle. • Ystyried a yw adrodd presennol yn darparu sicrwydd digonol i'r Bwrdd.	
Ymateb y Rheolwyr	**Swyddog Cyfrifol/Dyddiad cau**
Bydd y Strategaeth Sgiliau Dwyieithog yn cael ei hadolygu yn unol â Safonau'r Gymraeg. Fodd bynnag, bydd datblygiadau yn TRAC a fydd yn fyw erbyn 1 Rhagfyr i sicrhau y gall y Bwrdd Iechyd adrodd yn hawdd.	Pennaeth Gwasanaethau'r Gymraeg/Rheolwr Systemau Gwybodaeth am y Gweithlu Ionawr 2020 Rheolwr Systemau Gwybodaeth am y Gweithlu 2020

Atodiad B – Barn Sicrwydd a Chynllun Gweithredu Sgorio Risg

Sgorau Sicrwydd Archwilio

 **Sicrwydd cadarn** – Gellir rhoi **Sicrwydd Cadarn** i'r Bwrdd fod y trefniadau sydd ar waith i sicrhau llywodraethiant, rheoli risg a rheoleth fewnol, yn y meysydd hynny sydd wedi eu hadolygu, wedi eu dylunio'n addas ac wedi eu rhoi ar waith yn effeithiol. Nid oes ond ychydig o faterion y mae angen mynd i'r afael â nhw, ac mae'r rhain yn ymwneud â chydymffurfio neu ymgynghori, ag **effaith fach ar amlygiad risg gweddilliol**.

 **Sicrwydd rhesymol** – Gall y Bwrdd fod yn **rhesymol o sicr** fod y trefniadau sydd yn eu lle i sicrhau llywodraethiant, rheolaeth risg a rheolaeth fewnol, yn y meysydd hynny sydd wedi eu hadolygu, wedi eu dylunio'n addas ac wedi eu rhoi ar waith yn effeithiol. Mae angen tynnu sylw rheolwyr at rai materion o ran dylunio rheolaeth neu gydymffurfio, gydag **effaith isel i gymedrol ar amlygiad risg gweddilliol,** hyd nes y cânt eu datrys.

 **Sicrwydd cyfyngedig –** Gall y Bwrdd fod yn **weddol sicr** fod y trefniadau sydd yn eu lle i sicrhau llywodraethiant, rheolaeth risg a rheolaeth fewnol, yn y meysydd hynny sydd wedi eu hadolygu, wedi eu dylunio'n addas ac wedi eu rhoi ar waith yn effeithiol. Mae angen tynnu sylw rheolwyr at faterion mwy arwyddocaol **gydag effaith gymedrol ar amlygiad risg gweddilliol,** hyd nes y cânt eu datrys.

 **Dim sicrwydd –** Nid oes gan y Bwrdd **unrhyw sicrwydd** bod y trefniadau sydd yn eu lle i sicrhau llywodraethiant, rheolaeth risg a rheolaeth fewnol, yn y meysydd hynny sydd wedi eu hadolygu, wedi eu dylunio'n addas ac wedi eu rhoi ar waith yn effeithiol. Mae angen gweithredu er mwyn mynd i'r afael â'r fframwaith rheoli cyfan yn y maes hwn sydd ag **effaith uchel ar amlygiad risg gweddilliol** hyd nes y caiff ei ddatrys.

 **Caiff sicrwydd amherthnasol** ei roi i adolygiadau a chaiff cymorth ei ddarparu i reolwyr sy'n rhan o'r cynllun archwilio mewnol, lle nad yw'r diffiniadau sicrwydd **yn briodol** ond lle maent yn berthnasol i'r dystiolaeth lle mae'r farn gyffredinol yn cael ei ffurfio.

Blaenoriaethu Argymhellion

Er mwyn cynorthwyo rheolwyr i ddefnyddio ein hadroddiadau, rydym yn categoreiddio ein hargymhellion yn ôl eu lefel blaenoriaeth fel a ganlyn.

Lefel Blaenoriaeth	Esboniad	Camau rheoli
Uchel	Cynllun rheoli allweddol gwael NEU ddiffyg cydymffurfio eang â rheolaethau allweddol. YN OGYSTAL Â Risg sylweddol i gyflawni amcan system NEU dystiolaeth o golled sylweddol, gwall neu gamddatganiad.	Ar unwaith*
Canolig	Mân wendidau yn nyluniad y rheolaethau NEU ddiffyg cydymffurfio â rheolaethau sefydledig. YN OGYSTAL Â Pheth risg i gyflawni amcan system.	O fewn Mis*
Isel	Potensial i wella dyluniad system i wella effeithlonrwydd neu effeithiolrwydd rheolaethau. Yn gyffredinol, mae'r rhain yn faterion arfer da i'w hystyried gan y rheolwyr.	O fewn Tri Mis *

* Oni nodir / cytunir ar amserlen fwy priodol yn yr aseiniad.

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

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

Betsi Cadwaladr University Health Board

Patients Monies

Final Internal Audit report

BCU 2018/19

September 2019

NHS Wales Shared Services Partnership

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1. Introduction and Background

Following an initial scoping review, we sought to provide a level of assurance on the management and control of patient's monies across a sample of Health Board sites.

The Health Board has Patient Property Procedure F01 in place to provide procedural requirements to management and staff for the collection, documentation, safe storage and transfer of patient's property including patient's monies and bankcards.

Health providers have a common law duty to provide security and control over money and valuables handed in by patients for safekeeping. Patients' monies and property are not usually a financially material item in the accounts of a Health Board, but represent a sensitive and often emotive issue, which takes up management and administrative time disproportionate to its financial impact.

2. Scope and Objectives

The main custodial role over patients' monies involves the secure handling and accurate recording of items deposited for safekeeping.

The objective of the audit was 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. Assurance that this objective was being achieved was obtained by evaluating the following system control objectives:

System control objectives include:

- To ensure there are up to date policies and procedures in place for the management of patient's monies and bank cards;
- Documents of prime entry are adequately controlled with one property book allocated per ward that is not shared or transferred;
- Monies and bank cards handed in for safe-keeping are properly secured, recorded and accounted for completely and accurately in line with policy;
- Monies and property returned to patients or next-of-kin are recorded completely and accurately;
- There is adequate physical security and available lockable facilities for the safe storage of patient's monies and bank cards in the General Office and on wards; and
- Disclaimer notices are clearly displayed on wards.

3. Associated Risks

The risks identified at the outset of this review were:

- Policies and procedures are not in place, up to date and impact on service delivery;
- Documentation is not adequately controlled or completed in line with Health Board (HB) requirements and is not accurate/incomplete;

- A single record is not maintained and exposes information to loss and inconsistent record keeping;
- Monies and property returned to patients or next-of-kin are not recorded completely and accurately;
- Facilities in General Offices and on wards may not be adequate for purpose and expose patient's monies to potential theft;
- Disclaimer notices are not displayed and impact on claims and complaints;
- Non-compliance with procedure exposes patient's monies to theft and HB staff to challenge and HB to criticism.

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 **Patient Monies** review is Limited assurance.

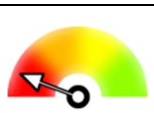
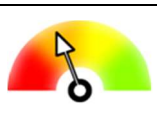
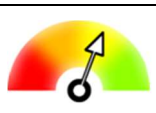
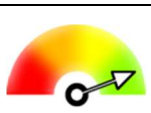
RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with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

Assurance Summary					
2	Disclaimer Notices and Patient Disclaimer Forms		✓		
3	Completion of documentation and procedural compliance		✓		
4	Patients Property Books		✓		
5	Physical Security		✓		

** 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 Patient Monies.

Operation of System/Controls

The findings from the review have highlighted five issues that are classified as weakness in the operation of the designed system/control for Patient Monies.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan in Appendix A.

Policies and procedures

The Patient Property Procedure F01 is out of date and due for review. General Office procedures were up to date and audit acknowledge that Finance have drafted a Missing Property Procedure which will be incorporated into F01 once reviewed.

Disclaimer Notices and Patient Disclaimer Forms

A number of wards did not display Disclaimer Notices in patient and visitor areas and as such were non-compliant with procedure. These included Ward 2 Ysbyty Glan Clwyd (YGC), Hebog Ward Ysbyty Gwynedd (YG) and Eryri Community Hospital.

The Safe Clean Care Campaign has promoted a de-cluttering exercise on all wards and it would appear that items were removed from ward walls and notice boards in response to this.

A review of a random sample of Patient Disclaimer forms across those wards and community hospitals included in the audit identified that a number of disclaimer forms had not been completed upon admission of the patient; information was

often incomplete and in some cases, the form had not been completed in line with procedure or adequately signed and witnessed.

Completion of documentation and procedural compliance

Padarn Ward, Eryri Community Hospital was not in receipt of an official property book. An unofficial property form was in use and used to note patient property brought in upon admission.

Property books were in use on Bersham Ward, Ysbyty Wrexham Maelor (YWM) however, it was evident that the property book was used to note clothing and other property upon admission or upon death of the patient. There was little evidence of the safe custody of property and monies or transfer of deceased patient's property to General Office.

There was evidence that monies noted on the two property forms were not handed in for safe custody to the General Office. Audit confirmed that £30.60 (form 18847) had been transferred directly to the Bereavement Office. £175 was noted on (form 20106) however there was no audit trail to indicate what had happened to these patients monies (this issue has been reported to colleagues in the Finance Directorate in advance of the report).

Property books appeared to be used on Ward 2 YGC, as a record of patient property upon admission and death with some safe custody evident albeit limited.

Two books were in use at the time of the review on Hebog Ward YG. Forms appeared to be used to list property and clothing rather than for safe custody. Information was often incomplete.

Deeside Community Hospital do not operate a safe custody facility. Despite having an official property book, albeit an out of date version, wards use an unofficial property form called "Event of death check list" to record deceased patient's property. We were informed that property and monies are handed back to relatives and not administered through General Office. The form does not require a signature or witness.

Property and monies are not routinely handed in for safe custody in Colwyn Bay Hospital. The property book appears to be an old version and there was evidence of property forms presenting incomplete information with a lack of detail and no signatures. We were informed that property and monies are handed back to relatives and not routinely administered through General Office. There is however an example where General Office have corresponded with relatives upon the death of a patient [It would appear that monies and other valuables were transferred to the relatives and clothes and other property returned to the ward for re-use].

Patients Property Books

At the time of the audit official property books were not in use in Eryri Hopsital, although it was noted that books had been ordered. Both Eryri and Deeside Community Hospitals had introduced forms to administer patient property upon admission and death respectively. Neither were in line with procedural requirements. Old versions of the property book were in use in several

locations. Two property books were evident on both Branwen Ward in Deeside Community Hospital and Hebog Ward YG at the time of the audit.

Physical security

Safe facilities were on order for Branwen Ward in Deeside Community Hospital. Ward 2 YGC had been relocated to the new build section of the hospital and we were informed that the safe had not been transferred. New furniture provided on Ward 2 included bedside cabinets with keys. We were informed the cabinets and keys were for patient use. However, there is currently no mechanism in place to ensure the patient signs a disclaimer form and returns the key upon discharge. Eryri Hospital provide patients with bedside cabinets for the safe storage of property but do not routinely complete patient disclaimer forms.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**3**	**2**	**0**	**5**

Finding - ISS.1 - Disclaimer notices and patient property Disclaimer forms (Operating effectiveness)	Risk
Disclaimer notices were not displayed on a number of wards. From a sample of patient property disclaimer forms randomly selected for review on wards and in community hospitals the following issues were raised: • Forms had not been completed or signed; • Incomplete and inappropriate completion of forms; • Unofficial forms used (forms that did not form part of the procedure F01); • Forms not adequately signed or witnessed.	Non-compliance with policy.
Recommendation	**Priority level**
Wards and Hospitals should display Disclaimer Notices in line with the requirements of procedure F01 and ensure in-patients sign the official disclaimer form to indemnify the Health Board against loss and damage to articles retained by the patient whilst on the ward.	**High**
Management Response	**Responsible Officer/ Deadline**
Ensure appropriate notices are displayed in all Patient facing areas, appropriate forms are available, issued and recorded within the patient records signed and dated accordingly.	Site Directors of Nursing October 2019

Finding - ISS.2 - Completion of documentation and Procedural compliance (Operating effectiveness)	Risk
The following issues were noted during the course of the audit across the wards and community hospitals selected for review: • There was a perceived lack of understanding of the Patient's Property Procedure and inappropriate use of patient property books; • Poor completion of patient property forms presenting inaccurate and incomplete information with forms not being adequately signed or witnessed; • The safe custody of patient's property and monies was not routinely practiced in a number of wards and hospitals; • Two hospitals had adopted unofficial property forms that are completed upon admission/death respectively noting clothing, valuables and monies belonging to the patient; • Evidence that monies and valuables noted on the property forms were not handed in for safe custody to General Offices and in one case there was no audit trail to indicate what had happened to the property; • Evidence that monies noted on property forms were being handed direct to Bereavement Services, Mortuary and patient family members contrary to procedure F01; • There is an example where General Office corresponded with relatives who agreed to hand property of the deceased back to the ward for re-use. Monies and other items with monetary value were posted to the relative. Official forms were not signed in the appropriate way.	Non-compliance with procedure and as a result putting patient's property and monies at risk.

Recommendation	Priority level
The Patients property procedure should be reviewed, updated and circulated to all hospitals and wards to ensure they are receipt of up to date procedural requirements. In addition, Finance may wish to consider providing training sessions to Hospitals and Wards to ensure staff are aware of procedural responsibility and the completion of documentation.	**High**
Management Response	**Responsible Officer/ Deadline**
A Task and Finish Group including Nursing and Finance staff will be established in order to review and update the existing patients property procedure F01. Following distribution of the updated procedure to all hospitals and wards notices will be posted on the intranet weekly bulletins and "Things You Need to Know" with training sessions being provided as required.	Site Directors of Nursing Financial Accountant - Control November 2019

Finding - ISS.3 - Physical security (Operating effectiveness)	Risk
The following issues were noted during the course of the audit: • Ward 2 YGC did not have a safe facility. The ward had been relocated and the ward safe had not been transferred; • New bedside cabinets have been made available to patients on Ward 2 YGC. A key is provided to enable patients to secure property and monies. At present	Physical security of patient's property and monies may be compromised with inadequate facilities or non-compliance with procedure.

there is no a mechanism to ensure a patient disclaimer is signed, the key is accounted for and returned upon discharge; • Eryri hospital provide patients with bedside cabinets for the safe storage of property but do not routinely ask patients to sign and complete a patient disclaimer form.	
Recommendation	**Priority level**
Hospital management must ensure: • Wards have a safe facility in place to ensure the temporary safe custody of patient's property and monies. • Patients must be asked to sign a disclaimer form to indemnify the Health Board against loss or damage to articles retained by the patient whilst in hospital. • A mechanism should be introduced to ensure bedside cabinet keys are signed for and returned upon discharge.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Scope of all Patient areas to ensure there is appropriate safe storage facilities available for securing belongings. An initial audit of compliance with the updated patient monies procedure will be co-ordinated by the General Office Manager.	Site Directors of Nursing October 2019 General Office Manager January 2020

Finding - ISS.4 - Patients property books (Operating effectiveness)	Risk
The following issues were noted during the course of the audit: • Official property books were not available for use on wards in one community hospital; • Unofficial property documentation was being used in two community hospitals; • Old versions of the property book were in use in several locations; • Two books were in use on two wards.	Non-compliance with procedure.
Recommendation	**Priority level**
Finance must ensure that all wards and hospitals are in receipt of official up to date documentation and that it is being completed in line with procedure F01.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Additional supplies of official property books have recently been ordered and these will be issued via General Offices and Hospital Administration teams. Guidance on completion of property books will be provided by the General Office Manager who will also monitor on-going compliance as part of routine hospital visits.	Financial Accountant - Control September 2019

Finding - ISS.5 - Patients Property Procedure F01 (Operating effectiveness)	Risk
Patient property procedure F01 is out of date and was due for review in April 2013. It is noted that the Director of Nursing is responsible for the procedure; however, safe custody and other administrative requirements are the responsibility of Finance.	Staff are not provided with up to date policy and procedural requirements.
Recommendation	**Priority level**
Departmental responsibility for the review and update of F01 should be discussed and agreed between Nursing and Finance. An up to date procedure should be circulated around the Health Board endorsing an official consistent approach to the administration of patient's property and monies.	**High**
Management Response	**Responsible Officer/ Deadline**
A Task and Finish Group including Nursing and Finance staff will be established in order to review and update the existing patients property procedure F01. Following distribution of the updated procedure to all hospitals and wards notices will be posted on the intranet weekly bulletins and "Things You Need to Know" with training sessions being provided as required.	Site Directors of Nursing Financial Accountant - Control November 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.

Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee 12th December 2019**
Cyhoeddus neu Breifat: **Public or Private:**	All Wales Audit Office (WAO) papers will be in the public agenda of the committee with the exception of the Review of ICT Assets. That report will be in the agenda of the private session of the committee because it identifies some technical details of infrastructure.
Teitl yr Adroddiad **Report Title:**	Wales Audit Office Audit Programme Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dawn Sharp, on behalf of the Executive Team
Awdur yr Adroddiad **Report Author:**	Andrew Doughton, Amanda Hughes and Mike Usher
Craffu blaenorol: **Prior Scrutiny:**	All final Wales Audit Office reports on Betsi Cadwaladr University Health have passed through a clearance process with the lead Executive Director. National report clearance processes are agreed with the appointed national key contact for the work.
Atodiadau **Appendices:**	• Appendix b: WAO Update report • Appendix c: Integrated Care Fund – North Wales Regional Partnership Board report • Appendix d: Review of Public Services Boards report • Appendix e: Implementing the Well Being of Future Generations Act report • Appendix f: BCUHB Response to Implementing the Well Being of Future Generations Act report • Appendix g: Primary Care Services in Wales report • Appendix h: BCUHB Structured Assessment 2019 report
Argymhelliad / Recommendation:	
The Audit Committee is requested to: • Note the content of the audit progress update. • Receive and discuss the Integrated Care Fund report to the North Wales Partnership Board. • Receive and discuss the national review of public service boards*. • Receive and discuss the Wellbeing of Future Generations report and BCUHB response.	

- Receive and discuss the Primary Care Services in Wales report
- Receive and discuss the Structured Assessment report
- Note the ICT Asset management report. The report has already been presented to the Digital Information and Governance Committee for assurance purposes (Included within the private session of the meeting)

*Given the complexity of progress tracking cross-sector recommendations made to public service boards, we recommend that assurance on progress against recommendations is provided in the form of a narrative report to appropriate committee.

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

Sefyllfa / Situation:

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

Cefndir / Background:

Asesiad / Assessment

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

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

Risk Analysis
The progress report may record issues/risks, identified as part of a specific review, the findings of which should be used to inform the Health Boards Risk Strategy and associated risk registers.

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

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

Wales Audit Office reports are screened for accessibility. Those reports published on the www.audit.wales website are available in Welsh and English.

WALES AUDIT OFFICE
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Auditor General for Wales

Audit Committee Update – **Betsi Cadwaladr University Health Board**

Date issued: December 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 was completed in accordance with required deadlines and the Auditor General issued his opinion on the financial statements on 11 June 2019, prior to them being laid the following day. Since the last Audit Committee, the financial audit work on the Charitable Funds accounts was also completed and the Auditor General issued his opinion on the financial statements on 9 October 2019, following their approval by the Charitable Funds Committee on 4 October 2019.

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	June 2019
Whole of Government Accounts submission	May 2019	June 2019	June 2019
Audit of Charitable Funds Financial Statements report	July 2019	September 2019	October 2019
Opinion on the Charitable Funds Financial Statements	September 2019	September 2019	October 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**
Operating theatres	Our work found that there is good evidence that management and use of operating theatres is improving, however, there is a need to build on this improvement by having a greater focus on surgical productivity, and by addressing estate and workforce challenges at some sites.	August 2019	Deborah Carter	September 2019
Integrated care fund – North Wales Regional Partnership Board	We found: • limited use of the fund on a regional basis with a preference for using the fund for work on a sub-regional basis, rather than across North Wales. • Due to the number of local authorities in the region, the size of the North Wales RPB membership can create challenges in decision-making and gaining consensus. • North Wales RPB members felt strongly that the fund is used to fund the right projects, but acknowledge that capturing consistent and comparable outcomes is challenging.	September 2019	Mark Wilkinson	December 2019
Review of legacy systems and infrastructure – ICT Asset Management Review	The Health Board is improving its operational ICT asset management approach but is struggling to allocate sufficient resources for technology replacement.	November 2019	David Fearnley	Digital and Information Governance Committee - November 2019[1]

[1] Note: There is sensitive information within the ICT Asset Management report relating to ICT infrastructure. We have therefore recommended that the report should be handled in the private session of the committee.

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**
Well Being of Future Generations (Wales) Act 2015	The Health Board has made progress in applying the sustainable development principle and the five ways of working, although differences in stakeholder priorities remain.	October 2019	Mark Wilkinson	December 2019
Structured Assessment	The Health Board is still grappling with many of the key challenges we identified in last year's structured assessment. There is evidence of improvements in respect of some important quality metrics as well as a commitment and action to address long-standing problems with finance and key aspects of performance. However, much of the latter is geared towards short-term solutions which are not yet securing the scale of improvement needed.	December 2019	Gary Doherty	December 2019

Ongoing work and work due to start in 2019 and 2020				
Topic	**Focus of the work**	**Status**	**Executive Lead**	**Expected date of final report**
Orthopaedic Services follow-up	This work is examining the progress made in orthopaedic services since our 2015 all-Wales review. This includes assessing whether recommendations and areas that 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.	Fieldwork ongoing	TBC	November 2019

Ongoing work and work due to start in 2019 and 2020				
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/ Deborah Carter	March 2020
Refurbishment/ Asbestos removal at Ysbyty Glan Clwyd	The Auditor General plans to issue a report that focuses on the events that contributed to the unanticipated escalation in the cost of the refurbishment project at Ysbyty Glan Clwyd. Much has already been written about these events. However, the Auditor General's report will consider whether the Health Board and NHS Wales more widely have identified and addressed the range of issues that arose. We anticipate that the report will be laid before the Public Accounts Committee early in 2020, and we shall also keep the BCU Board informed of our key findings and relevant recommendations'.	Fieldwork ongoing	Mark Wilkinson	May 2020
Local audit review: Continuing Healthcare management arrangements	We will undertake a focussed review to determine whether the Health Board's Continuing Healthcare (CHC) management arrangements are fit for purpose. This review will consider the extent to which the corporate CHC function is able to maintain strategic oversight and monitor compliance and performance of continuing healthcare services. Note: the function of the multi-disciplinary team and independent review panel is not within the scope of this review.	Not yet started	Chris Stockport	June 2020

Ongoing work and work due to start in 2019 and 2020				
Topic	**Focus of the work**	**Status**	**Executive Lead**	**Expected date of final report**
Local audit review: Ophthalmology services	Our review will assess the economy, efficiency and effectiveness of ophthalmology services. This will consider the services provided in the acute setting, wider service developments and modernisation and also local implementation of national requirements, such as the eye care measure.	Not yet started	TBC	July 2020
Review of interim director appointment arrangements	The Auditor General will undertake a review of the arrangements that were taken to appoint interim directors. The review will consider: • the governance and procurement processes, including contract approvals • the extent that the Health Board considered how it will demonstrate that good value for money is being obtained from these appointments.	In progress	Sue Green	To be confirmed

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**
Integrated Care Fund – July 2019	Since the inception of the fund, the Welsh Government has made a total of £270 million available up to March 2019 and with a further £115 million allocation for 2019-20. The Auditor General found that the fund has had a positive impact, supporting improved partnership working and better integrated health and social care services. However, aspects of the way the fund has been managed at national, regional and project levels have limited its potential to date. There is little evidence of successful projects yet being mainstreamed and funded as part of public bodies' core service delivery. Of the project leads surveyed, 75% identified that there were challenges in mainstreaming their project. The report also finds that the Welsh Government has not set any specific expectation on how to capture information about outcomes.
A joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board – November 2019	Following well-publicised concerns about maternity services at the Health Board, the joint review examined the organisation's overall approach to quality governance. The report highlights the need for stronger and broader leadership in respect of quality and patient safety. The work found that directorate-level arrangements for oversight of quality and safety of services need to be strengthened and made more consistent with more clearly defined roles and responsibilities and better business processes. Crucially there needs to be a shift in organisational approach to enable directorates to take better ownership of responses to concerns and complaints. More broadly, reviewers found gaps in key governance arrangements associated with the management and identification of risk, and the provision of information to support effective scrutiny by the board and its committees. The need for improvements in the way incidents are classified and reported was also highlighted. Whilst the review has highlighted a significant number of concerns, it does note that the Health Board has started to take actions to address them. It also highlights the impact that new leadership is starting to have in tackling what is a considerable set of challenges.

Recent publications / planned publications	
Topic	**Update**
Primary Care services in Wales – October 2019	The Auditor General's work found that while the NHS and Welsh Government are taking a range of steps to strengthen primary care, change needs to happen at greater pace and scale to tackle longstanding challenges and ensure vital services are fit for the future. There remains growing pressure on the traditional model of primary care and patients are experiencing continued difficulties in accessing appointments with a GP. The report sets out national-level recommendations for Welsh Government and the National Primary Care Board, including: • Consulting with health boards, to agree an approach to clarify and standardise the way that primary care expenditure is recorded and reported; and • Driving implementation of the Primary Care Model for Wales and developing, collecting and publishing regular data to help gauge progress; • Involving the public more in primary care changes.
Review of Public Services Boards – October 2019	On behalf of the Auditor General for Wales, we have examined how PSBs are operating. This is a phase one review on partnership working which will be followed up by a further report in 2020. Overall, we have concluded that Public Services Boards are unlikely to realise their potential unless they are given freedom to work more flexibly and think and act differently. In particular, our work has found that: • Public bodies have not taken the opportunity to effectively organise, resource and integrate the work of PSBs • PSBs are not being consistently scrutinised or held to account • Despite public bodies valuing PSBs, there is no agreement on how their role should operate now or in the future.
Public sector counter fraud arrangements	The Auditor General for Wales is undertaking a review of the effectiveness of counter fraud arrangements across the public sector in Wales, with a view to publishing his findings in June of next year. That publication will be informed by fieldwork across a range of public sector organisations, including all NHS bodies. The fieldwork to inform the national report is underway and is drawing on information and intelligence that has already been gathered as part of our structured assessment. The review forms part of the Auditor General for Wales's wider programme of value for money examinations, and is therefore not being funded from local audit fees.

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
How technology is enabling collaborative working across public services – This seminar showcased a range of digital tools and how they can improve collaboration between public services. The seminar shared examples of organisations that are maximising the use of digital technology, enabling them to deliver services that promote independence, prevention, combat social isolation and community wellbeing. The link above provides access to additional materials used in the session.
Forthcoming events
Accountability and governance in partnership services - Further details on this event will be available in due course 27 Feb 2020 - 9:00am - 1:00pm 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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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

WALES AUDIT OFFICE
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Archwilydd Cyffredinol Cymru
Auditor General for Wales

Integrated Care Fund – **North Wales Regional Partnership Board**

Audit year: 2018

Date issued: September 2019

Document reference: 1531A2019-20

This document has been prepared for Betsi Cadwaladr University Health Board, Denbighshire County Council, Conwy County Borough Council, Flintshire County Council, Gwynedd Council, Isle of Anglesey Council and Wrexham County Borough Council as part of work performed in accordance with statutory functions.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

The team who delivered the work comprised Anne Beegan, Fflur Jones and Matthew Brushett under the direction of Matthew Mortlock.

Contents

Introduction

1 The Integrated Care Fund (the fund) is allocated by the Welsh Government across Wales. The aim of the fund is to drive and enable integrated working between social services, health, housing and the third sector and independent providers to develop sustainable services.

2 Since establishing the fund for 2014-15, the Welsh Government has distributed £270 million across Wales between 2014-15 and 2018-19. In 2019-20, the fund is £115 million.

3 Initially focused on supporting older people, and particularly the frail elderly, the scope of the fund has extended over time to include other population groups and projects as set out in Exhibit 1.

Exhibit 1: the scope of the Integrated Care Fund

Exhibit source: Wales Audit Office

4 The Welsh Government distributes the fund across Wales to the seven Regional Partnership Boards (RPBs). The RPBs are responsible for overseeing and managing the use of the fund in their area.

5 On behalf of the Auditor General for Wales, we have examined whether the fund is being used effectively to deliver sustainable services that achieve better outcomes for service users. We have focused on whether the Welsh Government is effectively managing the fund to deliver against its intentions, and whether RPBs are demonstrating effective use of the fund. We also considered whether the projects supported by the fund are making a clear difference at a local level.

6 In July 2019, we published our national report **Integrated Care Fund**. We concluded that **the fund has had a positive impact, supporting improved partnership working and better integrated health and social care services. However, aspects of the way the fund has been managed at national, regional and project levels have limited its potential to date. There is little evidence of successful projects yet being mainstreamed and funded as part of public bodies' core service delivery.**

7 This supplementary report, which should be read in conjunction with the national report, sets out more detail about our findings for North Wales Regional Partnership Board. It builds on feedback that we provided to the RPB following completion of our fieldwork.

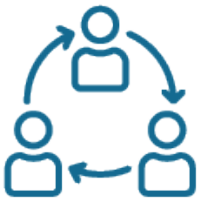
8 The RPB brings together the six local authorities in North Wales (Conwy County Borough Council, Denbighshire County Council, Flintshire County Council, Gwynedd Council, Isle of Anglesey Council and Wrexham County Borough Council), Betsi Cadwaladr University Health Board, and representatives of the third sector and independent providers.

	Part 1 summarises partnership working in relation to the fund
	Part 2 summarises how the fund is used in the region
	Part 3 summarises the regional governance arrangements for the fund
	Part 4 summarises the overall impact of the fund in improving outcomes for service users

9 In undertaking this work, we have identified a number of areas that we think the North Wales RPB could improve upon at a regional level. These are set out throughout this report. We have not made specific recommendations for the RPB; however, the national report contains a number of recommendations which apply to all RPBs.

10 We have also identified examples of practice from across Wales which the North Wales RPB can learn from.

11 Finally, we have also identified some key questions that Board members of Health Boards and scrutiny members of local authorities could explore with lead officers responsible for the fund to maintain a close handle on how the fund continues to be used across the region.



Detailed report

Partnership working

12 Our national report has identified that **the fund has helped to bring organisations together to plan and provide services.** Health and social care partnerships have been around for some time but integrated working prior to the fund was limited. We found that the fund has provided the impetus for regional partners to develop integrated services and to move to joint funding arrangements in the context of wider policy and legislation.

13 In North Wales, members recognised that the RPB has been on an improvement journey since being established in 2016. Partners have been open to using core and other funding such as winter pressure monies to support Integrated Care Fund projects. But, while there is generally good partnership working in North Wales, many partners recognised that partnership working needs to embed further, with many stating they were unsure if the partnership working would continue were the fund to cease.

14 As part of our survey of RPB members, we asked:

- whether the RPB facilitates good partnership working; and
- whether the partner organisations demonstrate a commitment to partnership working.

15 The responses we received from North Wales were slightly less positive than the all-Wales average but were still generally positive.

16 As part of our surveys of RPB members and project leads, we also asked about the impact of the fund on partnership working. The responses we received from North Wales generally confirmed positive views about the impact that the fund has had on strengthening partnership working. The full regional responses to the surveys can be found in Appendix 1, along with the response rates.

Detailed report

Use of the fund

17 Our national report identified that aspects of the way funding has been allocated by the Welsh Government and used by regional partners have limited the potential of the fund to date. The report highlighted that Regional Partnership Boards can find it difficult to balance local population needs with the Welsh Government's indicative allocations for target groups. It also highlights that RPBs use the fund in different ways, not all of which support a regional focus. We found that the approaches to the use of the fund vary between the regions, with limited sharing and learning of the approaches used across Wales.

Exhibit 2: approaches applied to the fund 2014-18

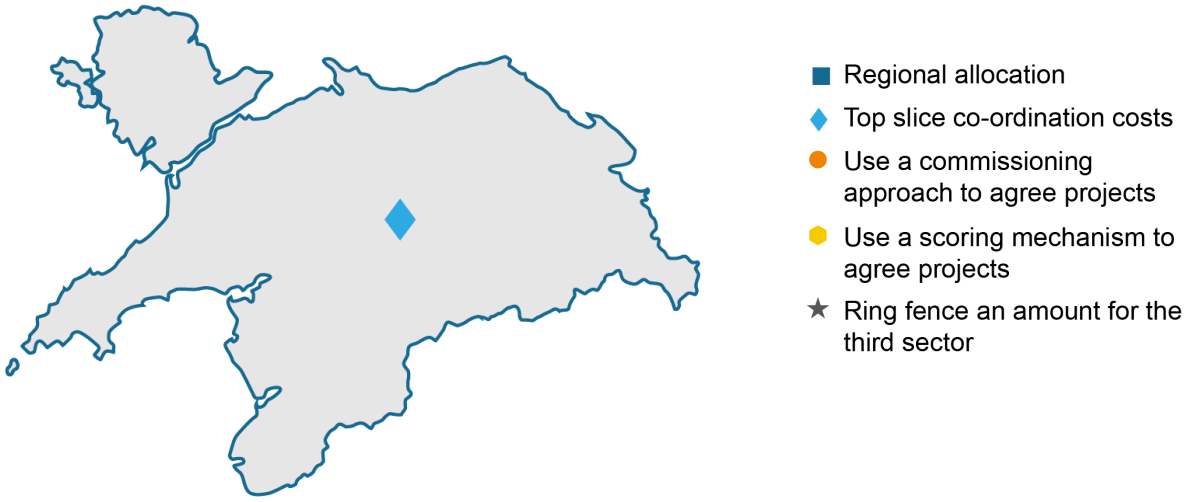


Exhibit source: Wales Audit Office

18 North Wales RPB members acknowledged that there has been limited use of the fund on a regional basis. Since the introduction of the fund, the North Wales RPB has distributed its allocation further to a county level. Many RPB members stated

they feel more comfortable working on a sub-regional basis[1] of one or two local authority areas, rather than across North Wales.

19 In North Wales, the fund is top-sliced to fund co-ordination and project management roles. Previously, the North Wales RPB also ring-fenced a proportion of the fund specifically for the third sector, but this came to an end as the number of target groups of the fund expanded. Third sector representatives told us they felt they have insufficient access to the fund and that they benefit predominantly when spending on other projects slip.

20 Some RPBs recently began allocating the fund by commissioning thematic groups to identify a programme of work that the fund can support, rather than openly seeking bids from member organisations. The North Wales RPB seeks and approves bids through its sub-group structures. However, while we noted good practice in terms of a developed due diligence check-list, none of the discussion for approving bids that we observed used a scoring mechanism to ensure fair allocation. Projects put forward did broadly align with partners' corporate objectives on prevention and integration although we found no requirement that projects needed to link to the strategic objectives of the RPB and local wellbeing objectives to support implementation of the **Wellbeing of Future Generations (Wales) Act 2015**.

21 Our work also highlights that the RPBs have developed varying approaches for managing underspends. In North Wales, the RPB sub-groups also have varying approaches to managing underspends. Initially, sub-groups anticipate slippage and give larger allocations to projects than their allocated budget. In-year, some sub-groups allocate underspends according to a reserve list of approved projects, other sub-groups automatically divert underspends to high-priority and high-demand projects such as set-up, step-down beds. Finally, the North Wales RPB also invites short notice bids from the third sector for projects which can be delivered in a short timescale.

Areas for improvement

- Look for ways to ensure fair access to the Integrated Care Fund for the third sector
- Ensure appropriate use of the due diligence check-list for approving Integrated Care Fund projects
- Ensure underspends are allocated efficiently and effectively in-year

[1] Sub-regional working for the fund was observed as three geographical areas: Gwynedd and Anglesey; Conwy and Denbighshire; and Flintshire and Wrexham.

Detailed report

Governance arrangements

22 Our national report has identified that governance arrangements for the fund need to be further developed to strengthen central oversight and ensure greater consistency across the regions. The report highlights that RPBs frequently delegate responsibility for the fund to a sub-group and there is limited scrutiny of the use of the fund by health boards and local authorities. The report also identifies that the rigour of project management varies between RPBs and organisations, and few projects involve service users at the outset.

23 In the North Wales RPB, various groups at a sub-regional level feed into Integrated Service Boards or to thematic groups, which report to a Leadership Group and then to the RPB. The fund is also discussed at an Integrated Care Fund Leads meeting, which brings together financial and operational leads for the fund from the RPB sub-groups to share and discuss information. There is also a WCCIS[2] Board and an Autism Service Strategic Group which discusses those aspects of the fund.

24 All the RPBs have representation from the statutory bodies, although representation from housing prior to the 2018 amendment to the Social Services and Well-being (Wales) Act 2014 was variable. Due to the number of local authorities in the region, the size of the North Wales RPB membership can create challenges in decision-making, discussions and gaining consensus. Uniquely North Wales has co-opted additional members to its RPB with representatives from fire, police and the ambulance service. While this is positive in advancing partnership working, it is possible that it could sometimes create further difficulties in decision-making. Carer and service user representatives identify that their contributions to decisions can often be limited because discussions and decisions are often taking place outside of the RPB meetings and without their involvement.

25 The North Wales RPB members do not consistently communicate discussions back to their own organisations, for example, on the allocation and impact that the fund is having within the region.

26 The North Wales RPB has taken some steps to link its work with local Public Service Boards (PSBs), for example, through some common memberships in both the RPB and one of the four local PSBs. In addition, the format of the impact assessment for the North Wales RPB Area Plan encouraged the RPB to consider the Well-being of Future Generations (2015) Act and to link in with the area's Public Service Boards, where possible. We found scope to further clarify and improve links between the RPB and the four North Wales PSBs on a regular and ongoing basis, such as by identifying how the PSBs link to the North Wales RPB structure.

27 In recognition of the need to avoid gaps or duplication between the RPB and PSBs, and in light of recommendations within **A Healthier Wales: Our Plan for Health**

[2] Welsh Community Care Information System (WCCIS)

and Social Care[3], the RPB was exploring further opportunities to link with partner PSBs at the time of our review.

28 At a project level, we found both strengths and weaknesses in the management of funded projects (Exhibit 3).

Exhibit 3: Strengths and weaknesses in management of projects

Strengths	Weaknesses
✓ A requirement for project leads to work and report against agreed goals targets	× Not all projects are supported by a project plan, particularly for projects rolled-forward from previous years and projects in receipt of underspend
✓ Project leads want to engage service users when planning projects	× Project management methods vary
✓ Locally there appear to be generally good oversight arrangements for funded projects, based on adopting arrangements from the host organisation	× No risk management framework in place for the programme and lack of consistent and ongoing risk management of local projects
	× Delays in communication from area leads to project leads about application and approvals processes

Exhibit source: Wales Audit Office fieldwork

29 In common with many other regions, North Wales RPB is consistently unable to collate, scrutinise and sign-off project monitoring information by the tight deadline required by the Welsh Government. Sign-off often takes place before the RPB has been able to scrutinise monitoring returns.

Areas for improvement

- Building on the work to date, make more effective links with all four Public Service Boards
- Improve timeliness of communication between area leads and project leads
- Seek assurance that risks relating to funded projects are identified and managed effectively at a local and programme level
- Develop mechanisms for reporting back to individual organisations in a more consistent way

[3] **A Healthier Wales**, published in June 2018, is the Welsh Government's long-term plan for health and social services in Wales.

Detailed report

Outcomes for service users

30 Our national report has identified that despite positive examples, the overall impact of the fund in improving outcomes for service users remains unclear, with little evidence of successful projects yet being mainstreamed. The report highlights that RPBs identify a range of positive case studies, but there is little evidence that successful projects have yet been mainstreamed and funded as part of public bodies' core service delivery.

31 North Wales RPB members felt strongly that the fund is used to fund the right projects, and that the focus is on outcomes when overseeing the use of the fund. The North Wales regional partners are getting better at capturing performance data for the projects, but acknowledge that capturing consistent and comparable outcomes, rather than output data remains a challenge.

32 Similar to other RPB areas, North Wales RPB members continue to struggle to successfully share information which makes demonstrating impact and outcomes from a multi-agency view very difficult. Project leads are increasingly attempting to demonstrate the impact of projects through case studies, including through the use of video stories.

33 In common with other RPBs, in North Wales there are few examples of projects being mainstreamed due to financial and savings pressures. Project leads find it particularly difficult to quantify financial savings due to the preventative nature of projects. Such projects aim to manage demand and improve services and it is difficult to quantify these outcomes as a financial saving. A number of projects do not have a clear exit strategy should the funding cease. Routine evaluation of projects is not in place although some evaluation does take place at a local level on an ad hoc basis. Many projects are continuously rolled forward from previous years, limiting opportunities to use the fund to develop new and innovative projects. While still reliant on the fund, a number of the projects are now considered as part of core services.

Exhibit 4: challenges identified with mainstreaming projects through our project lead survey in North Wales

Exhibit source: Wales Audit Office survey of project leads

34 While shared learning is easier with fewer partners, the North Wales RPB has developed a mechanism through the Integrated Care Fund Leads Group to share learning within the region. The forum brings together representatives from the sub-groups in the North Wales sub-regions to discuss areas of commonality. However, despite this group, we observed that project leads operating at a local level are unaware of similar projects in other areas of North Wales. The North Wales RPB has not engaged in shared learning between itself and neighbouring RPBs which creates a risk of missed opportunities in developing and delivering projects that maximise the use of the fund. The North Wales RPB acknowledged it could do more in terms of sharing learning and good practice, including sharing learning from similar projects run in the different areas across the RPB.

Areas for improvement

- Develop exit strategies for all Integrated Care Fund projects
- Explore opportunities to learn from good practice in other regions

Appendix 1

Key findings from our surveys of RPB members and project leads

Our survey of North Wales RPB members[4][5] identified that

		Across Wales...
	5 out of 7 agreed that partner organisations demonstrate a commitment to partnership working	84%
	3 out of 7 agreed that there were appropriate links with other regional groups and forums, such as Public Service Boards, to ensure that there were no overlaps or gaps in responding to legislative requirements	56%
	3 out of 6 agreed that the ring fencing of the fund for the national initiatives was helpful	53%
	3 out of 5 agreed that the templates provided by the Welsh Government for quarterly reporting capture the right information	34%
	3 out of 6 agreed that there was helpful ongoing communication between the RPBs and the Welsh Government to understand any changes to the fund	63%
	5 out of 7 agreed that proposals put forward for the RPB to approve are generally good quality	80%
	5 out of 7 agreed that the RPB sets enough time aside for effective scrutiny of the delivery of the projects supported by the fund	57%
	2 out of 7 agreed that there is a clear process for monitoring and managing project underspends and overspends within the RPB structure	72%
	4 out of 7 agreed that the RPB and its sub-group focusses on outcomes when scrutinising the projects	69%
	4 out of 7 agreed that the fund is funding the right projects	64%
	5 out of 7 agreed that the projects funded were making a difference to service users	87%

[4] Only seven of the 26 (27%) RPB members invited to take part in our RPB member survey responded.

[5] Not all members responding answered every question.

Our survey of project leads[6] across North Wales identified that

		Across Wales...
	12 out of 14 (86%) identified that their project(s) had received funding in previous years	71%
	4 out of 15 (27%) identified that their project(s) received additional funding as well as the Integrated Care Fund	48%
	13 out of 15 (87%) identified that their project(s) clearly linked to national strategic priorities, including the Well-Being of Future Generations (Wales) Act	92%
	11 out of 15 (73%) identified that there was a risk management framework for their project(s)	58%
	15 out of 15 (100%) identified that they had received appropriate guidance from managers to support them in delivering the project(s)	89%
	8 out of 15 (53%) identified that they were required to include an exit strategy as part of their project plans	40%
	8 out of 15 (53%) identified that there was a single point of accountability for delivery of the project(s)	78%
	5 out of 15 (33%) identified that their project(s) started on time	32%
	6 out of 15 (40%) identified that there was a mechanism to measure the financial benefits of the project(s)	40%
	7 out of 15 (47%) identified that they had been able to demonstrate the impact of the project(s)	60%
	10 out of 15 (67%) identified that the fund is helping to provide sustainable and improved services in their region	66%
	5 out of 13 (38%) identified that there were challenges in mainstreaming the project(s)	75%
	13 out of 15 (87%) identified that the project(s) was making a difference to service users	91%

[6] Only 15 of the 71 (21%) project leads invited to take part in our project lead survey responded.

Appendix 2

Examples of notable practice

In undertaking our work, we have identified a number of areas of practice which other RPB areas could learn from.

Across the **Cwm Taf Morgannwg** regional footprint, development work has been undertaken between the Regional Partnership Board and the Cwm Taf Public Service Board to identify areas of crossover between the partnerships, and to agree the responsibility of each. To strengthen these arrangements, a representative from the RPB sits on the PSB as a non-voting member and vice versa, ensuring communication between the partnerships.

The **West Wales** Regional Partnership Board has developed a strategic approach to using underspend. When allocating money to new projects at the beginning of the financial year, the unsuccessful projects are ranked using the same scoring mechanism as the successful projects. The highest scoring projects are identified and agreed as to be delivered via any underspend that occurs. This approach means that the regional partnership board is not trying to use up underspend at the end of the year on short term interventions.

Following an internal review, the **Cardiff and Vale** Regional Partnership Board has developed a performance dashboard to monitor the Integrated Care Fund. The dashboard supports quarterly reporting of planned and actual levels of activity, impact and outcomes being achieved by the fund using a RAG rated system to visually identify projects that are off track.

In the **Greater Gwent** Regional Partnership Board, roles and responsibilities of the RPB and its subgroups are set out in a memorandum of understanding. Signed by all partners, the document sets out their shared intention to work together in a spirit of co-operation for the benefit of residents living in Gwent. The memorandum includes a conflict resolution process which has supported open and honest discussions between partners should conflict arise.

These examples are not exhaustive. Further examples can be found in the materials produced following our recent Good Practice Exchange webinars '**Key Issues for Regional Partnership Boards**' which are available to view on our website **audit.wales**

Appendix 3

Key questions for Board and scrutiny members

To enable Board members of Health Boards and scrutiny members of local authorities to maintain a close handle on how the fund is used across the region, we have identified some examples of questions that could be used with lead officers responsible for the fund and lead officers who are members on the RPB.

Partnership working

- Is the organisation challenging existing working practices and actively seeking new opportunities through the fund to work in partnership with its regional partners?
- Is the organisation considering options to utilise funding more effectively, for example by combining various funding streams, where appropriate, to support services to achieve greater impact?

Use of the fund

- Is the organisation through its representatives on the RPB effectively engaging with relevant stakeholders, including the public, to inform its plans for the use of the fund?
- Is the organisation through its representatives on the RPB ensuring third sector organisations are equal partners and have fair access to the Integrated Care Fund at the beginning of the financial year and in-year?
- Is the organisation through its representatives on the RPB ensuring the approach to assessing, prioritising and approving services in receipt of the Integrated Care Fund is robust?
- Is the organisation through its representative on the RPB ensuring that the fund is used in a way that maximises value for money (for example, by reducing administrative costs)?
- Is there an effective approach to managing fund underspends in-year?

Governance arrangements

- Is there a mechanism in place to ensure the organisation is regularly kept up-to-date about the work of the RPB and its sub-groups in relation to the fund?
- Is there a robust risk management framework in place for the services funded through the Integrated Care Fund, and who would be responsible for any unforeseen issues with projects?
- How does the organisation and the RPB get assurance that the approved Integrated Care Fund projects are managed effectively and that the reporting of approved projects is accurate?

Outcomes for service users

- Is the organisation working with its RPB partners to evaluate what difference funded initiatives have made in terms of outcomes for the regional population?
- Is the organisation working in partnership with its RPB partners to demonstrate outcomes from a multi-agency view?
- Are there services continually funded through the Integrated Care Fund which would significantly impact on the organisation if they were to cease ie those now considered core services?
- Is the organisation mainstreaming Integrated Care Fund projects that have demonstrated a positive impact?
- Is the organisation supporting the RPB to facilitate shared learning within the region to enable continuous improvement of project development and management, and the roll-out of successful localised projects?
- Is the organisation supporting the RPB to engage with other regions to share information and learn lessons from other examples and experiences of the Integrated Care Fund?

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Auditor General for Wales

Review of Public Services Boards

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

This report has been prepared for presentation to the National Assembly under the Government of Wales Act 2006 and the Public Audit (Wales) Act 2004

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Summary report

Public Services Boards are unlikely to realise their potential unless they are given freedom to work more flexibly and think and act differently

1 The Well-being of Future Generations (Wales) Act 2015 (the 'Act') sets out the Welsh Government's ambitions to improve the social, cultural, environmental and economic wellbeing of Wales. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to help prevent problems such as poverty, health inequalities and climate change.

2 The Act establishes statutory Public Services Boards (PSBs) which have replaced the voluntary Local Service Boards in each local authority area. Each board is required to assess the state of economic, social, environmental and cultural wellbeing in its area and set objectives that are designed to maximise its contribution to the national wellbeing goals.

3 The Statutory Members of each PSB are the local council, the local health board, the fire and rescue authority and Natural Resources Wales. In addition to these statutory members, each PSB will invite the following to participate: Welsh Ministers, chief constables, the police and crime commissioner for their area, certain probation services, national park authority (if applicable), and at least one body representing relevant local voluntary organisations. PSBs can also invite other public service organisations to participate, for example, education providers such as colleges and universities and housing associations, and private bodies such as business forums.

4 PSBs are promoted by the Welsh Government as the key body collectively responsible for improving the wellbeing of communities across Wales and currently there are 19 PSBs – Exhibit 1.

5 The Act requires each PSB to undertake a local wellbeing assessment every five years. PSBs are also required to prepare and publish a plan (the 'local wellbeing plan') setting out their objectives and the steps they will take to meet them. The plan must set out why the PSB feels their objectives will contribute, within their local area, to achieving the national wellbeing goals and how it has taken regard of their assessment of local wellbeing in setting its objectives and steps to take. All PSBs completed wellbeing assessments and published Local Wellbeing Plans in line with the statutory deadlines.

Exhibit 1 – PSBs in Wales

There are 19 PSBs: one in each local authority except for a Cwm Taf PSB which covers Merthyr Tydfil and Rhondda Cynon Taf (set up before Bridgend was realigned with the Cwm Taf footprint), a combined PSB for Gwynedd and Isle of Anglesey and a joint PSB for Conwy and Denbighshire.

Public Service Boards

1 Carmarthenshire
2 Ceredigion
3 Conwy and Denbighshire
4 Gwynedd and Isle of Anglesey
5 Monmouthshire
6 Pembrokeshire
7 Powys
8 Blaenau Gwent
9 Bridgend
10 Caerphilly
11 Flintshire
12 Merthyr Tydfil and Rhondda Cynon Taf
13 Neath Port Talbot
14 Swansea
15 Torfaen
16 Wrexham
17 Vale of Glamorgan
18 Cardiff
19 Newport

6 When producing their assessments of local wellbeing and Local Wellbeing Plan, PSBs must consult widely. The PSB should seek to involve the people and communities in the area, including children and young people, Welsh speakers and those with protected characteristics, in all aspects of its work. Each PSB will carry out an annual review of its plan showing its progress. Currently there are 101 wellbeing objectives set across the 19 PSBs, ranging from two in Gwynedd and Isle of Anglesey to 15 in Wrexham. There are also 462 underlying supporting steps and actions to deliver the 101 wellbeing objectives. The 101 wellbeing objectives 'best fit' with seven national wellbeing goals are as follows:

A globally responsible Wales – 12 wellbeing objectives

A prosperous Wales – 12 wellbeing objectives

A resilient Wales – six wellbeing objectives

A healthier Wales – 25 wellbeing objectives

A more equal Wales – 12 wellbeing objectives

A Wales of cohesive communities – 25 wellbeing objectives

A Wales of vibrant culture and thriving Welsh Language – four wellbeing objectives

Others – five wellbeing objectives (all focussed on 'transformation' of public services)

Image source: Office of Future Generations Commissioner for Wales

Source: Wales Audit Office

7 The Act also created a Future Generations Commissioner for Wales (the 'Commissioner'). The general duties of the Commissioner are to 'promote the sustainable development principle, in particular to act as a guardian of the ability of future generations to meet their needs and encourage public bodies to take greater account of the long-term impact of the things they do'. Specifically, the Commissioner is charged with monitoring and assessing the extent to which wellbeing objectives set by public bodies are being met[1].

8 On behalf of the Auditor General for Wales, we have examined how PSBs are operating; looking at their membership, terms of reference, frequency and focus of meetings, alignment with other partnerships, resources and scrutiny arrangements. This is a phase one review on partnership working which will be followed up by a further report in 2020[2]. We have not reviewed wellbeing plans and assessments. Appendix 1 sets out our audit methods, which included a survey of PSB members, a review of statutory guidance, PSB agendas, reports and minutes and interviews and focus groups with a range of PSB members and commentators. Our findings are also intended to help support the Welsh Government's and Welsh Local Government Association's current review of strategic partnerships. Overall, we have concluded that **Public Services Boards are unlikely to realise their potential unless they are given freedom to work more flexibly and think and act differently**.

1 In 2017, the Commissioner provided each of the 19 PSBs with individual feedback on their draft wellbeing assessments. The Commissioner also published **Wellbeing in Wales: Planning today for a better tomorrow**, a review summarising key issues for public bodies to learn from the initial 2017 wellbeing assessments.

2 The Phase Two review will look at the complexity of partnership delivery looking at a distinct group in society with multifaceted problems/needs who call on and access a range of different public bodies at different times to ascertain how organisations are working differently to address these needs. Our tracer is rough sleepers, a group in society with often intractable problems, who regularly call on and frequently use a wide range of public services and are challenging to provide services for because of their vulnerability, circumstances and lifestyle. This analysis will focus on determining if partners are genuinely working jointly to deliver improvement and whether public bodies are collectively taking decisions, using resources and prioritising activity to actually deliver change.

Public bodies have not taken the opportunity to effectively organise, resource and integrate the work of PSBs

9 Whilst PSBs are building on the work of Local Service Boards and generally have the right membership, some key partners are not actively involved, and irregular attendance and lack of engagement restrict progress. Most PSBs are clear on their remit, adopting the model terms of reference set out in the Act. The focus of PSB work varies widely, a reflection of local circumstances and priorities. However, Welsh Government guidance on impact assessments is not being used consistently. The advice provided by the Future Generations Commissioner is not always valued or acted on. The lack of dedicated funding is seen as limiting the potential of PSBs to make a positive and lasting impact on Welsh communities.

PSBs are not being consistently scrutinised or held to account

10 PSBs are not taking the opportunity to tell people what they are doing and develop a shared view of what needs to improve. Whilst some PSBs are providing a supportive space for reflection and self-analysis, they are not yet enhancing democratic accountability nor improving transparency. Public involvement and scrutiny arrangements are too inconsistent and variable to ensure that scrutiny of PSBs fully meets the expectations of the Welsh Government's guidance. Despite some positive and effective work to embed and make scrutiny truly effective, more work is required to ensure a consistent level of performance and impact.

Despite public bodies valuing PSBs, there is no agreement on how their role should operate now or in the future

11 There is no single or right model for how PSBs should be organised and should work. Each will reflect the context of its area, the focus of Board members and their priorities for action. Nonetheless, public bodies working across regions find it challenging to participate in numerous Boards and there remains overlap between the PSBs and the work and membership of other partnerships, in particular the Regional Partnership Boards. However, opportunities for reducing duplication are not being taken. Some partners are concerned that fewer, larger PSBs will limit the focus on communities and make accountability and decision making too distant from citizens.

12 Comparatively, PSBs have more in common with Community Planning Partnerships in Scotland but do not deliver projects and co-ordinate funding programmes like their Scottish counterparts. Strategic partnership work in England is left to each council to determine. English councils are focusing on strategically using land-use planning power, the General Power of Competence and the ability to negotiate reuse of income generated from flexing business rates to encourage growth that helps tackle problems. In both Scotland and England there is more focus on partnerships ‘doing’.

Recommendations

13 Our recommendations are intended to help support the PSB members and the Welsh Government to improve the operation, effectiveness and impact of PSBs.

Exhibit 2: recommendations

Recommendations	
R1	In Part 1 of the report we set out that understanding the impact of choices and decisions requires public bodies to fully involve citizens and stakeholders and undertake comprehensive Impact Assessments. However, we found that current practice is insufficient to provide assurance that the needs of people with protected characteristics are fully considered when reviewing choices and the voice of citizens is not sufficiently influencing decisions. **We recommend that PSBs**: • **conduct formal assessments to identify the potential impact on people with protected characteristics and the Welsh language and review agreed actions to ensure any adverse impacts are addressed;** • **improve transparency and accountability by making PSB meetings, agendas, papers and minutes accessible and available to the public;** • **strengthen involvement by working to the guidance in the National Principles for Public Engagement in Wales; and** • **feed back the outcome of involvement activity identifying where changes are made as a result of the input of citizens and stakeholders.**
R2	In Part 2 of the report we review arrangements for PSB scrutiny and conclude that there are shortcomings and weaknesses in current performance and practice. T**o improve scrutiny, we recommend that:** • **PSBs and public bodies use the findings of the Auditor General for Wales' Discussion Paper: Six themes to help make scrutiny 'Fit for the Future' to review their current performance and identify where they need to strengthen oversight arrangements and activity; and** • **PSBs ensure scrutiny committees have adequate engagement with a wider range of relevant stakeholders who can help hold PSBs to account.**

Recommendations	
R3	In Part 3 of the report we summarise the difficulty of developing, implementing and resourcing PSBs and the challenges of managing multiple partnerships that can often have overlap and duplication. **To help build capacity, consistency and resourcing of activity we recommend that:** • **PSBs take the opportunity to discharge other plan and strategy obligations through the Local Wellbeing Plan;** • **the Welsh Government enables PSBs to develop flexible models of working including:** – merging, reducing and integrating their work with other forums such as Regional Partnership Boards; and – giving PSBs flexibility to receive, manage and spend grant monies subject to PSBs ensuring they have adequate safeguards and appropriate systems in place for management of funding; effective budget and grant programme controls; and public reporting, scrutiny and oversight systems to manage expenditure.
R4	**To help build capacity, consistency and resourcing of activity we recommend that the Welsh Government and Welsh Local Government Association in their review of strategic partnerships take account of, and explore, the findings of this review.**

Part 1

Public bodies have not always taken the opportunity to effectively organise and resource the work of PSBs

1.1 Shared Purpose Shared Future – Collective role: Public Services Boards explains the Act and the work of PSBs, identifying council boundaries as the principle basis for joint working. The guidance also sets out how PSBs can merge, should collaborate to widen coverage and encourages them to operate more efficiently by providing them with the opportunity to discharge other planning and strategy reporting duties through the work of the PSB. In this part of the report we look at the evolution of PSBs and how they are meeting the expectations of the Welsh Government. We also consider their membership, focus, resourcing, operation and the evolution of PSBs from their forerunner bodies, Local Service Boards.

PSBs are building on the work of Local Service Boards and generally have the right membership, but attendance at meetings fluctuates and some key stakeholders are not always involved

1.2 The Welsh Government's Making the Connections: Delivering Beyond Boundaries published in 2006, created Local Service Boards (LSBs) within each council area. Like PSBs, LSBs were intended 'to bring together the key contributors to local service delivery, both devolved and non-devolved'[3] to improve co-operation in service planning and undertake joint action where the need is identified, and where good outcomes depend on joined-up action. The intention was for the LSBs to be an over-arching mechanism of co-ordination, bringing together the main public service providers – councils, local health boards, police, the fire and rescue services and the Welsh Government itself.

1.3 Whilst the work and focus of LSBs naturally evolved over their life, partly tailored by the expectations and requirements of revised guidance[4], they were the key forerunner to PSBs. From our review we found that many PSBs have evolved from the LSBs, building upon the foundations of the previous partnerships (for instance, Ceredigion[5] and Merthyr Tydfil[6]). In many cases the same individuals have moved from LSBs to PSBs continuing to deliver broadly the same role with the same responsibilities.

3 Welsh Assembly Government, **Making the Connections - Delivering Beyond Boundaries: Transforming Public Services in Wales**, – page 3, November 2006.

4 For example, Shared Purpose, **Shared Delivery: Guidance on Integrating Partnerships and Plans**, December 2012.

5 http://www.ceredigion.gov.uk/cpdl/CeredigionStrategicPartnerships_Public/13.5.1-EstablishmentOfCeredigionPSB.pdf

6 https://democracy.merthyr.gov.uk/documents/s31707/Committee%20Report.pdf

1.4 Most PSBs are chaired by council representatives: three by council chief executives and ten by council leaders. Of the other PSBs, two are chaired by the local health board representative, two by the chief executives of a local national park and two rotate the chairing between statutory partners. In addition to the statutory members the public bodies most frequently invited to PSB meetings are the Welsh Government, the police, probation services, national parks and representatives of the local voluntary sector. Exhibit 3 summarises the main attendees across the 19 PSBs and the frequency of their attendance at meetings.

Exhibit 3: frequency of attendance of PSB members

There is a wide variation in attendance across the 19 PSBs from statutory members and statutory invitees ranging from below 50% to 100% on individual PSBs.

PSB members	Status	Lead attended	Deputies attended	No attendance
Council leader	Statutory members	52%	33%	15%
Senior council officers	Statutory members	64%	28%	8%
Fire and rescue authority	Statutory members	54%	46%	-
Health board	Statutory members	52%	45%	3%
Natural Resources Wales	Statutory members	61%	34%	5%
Welsh Government	Statutory invitees	47%	13%	40%
Chief constable	Statutory invitees	45%	44%	11%
Police and crime commissioner	Statutory invitees	30%	28%	42%
Probation	Statutory invitees	25%	25%	50%

PSB members	Status	Lead attended	Deputies attended	No attendance
Community rehabilitation company	Statutory invitees	24%	8%	68%
National parks	Invitees	81%	-	19%
Voluntary sector representative	Statutory invitees	77%	-	23%

Source: Wales Audit Office review of minutes for PSB meetings

1.5 Exhibit 2 highlights that all statutory partners across all PSBs frequently send deputies, particularly health boards and fire and rescue authorities, who tend to be represented by area directors or area managers rather than chief executives or chief finance officers. The lack of continuity in attendance and frequency of substitutions is regularly flagged as reducing the effectiveness of PSBs.

1.6 For instance, one respondent to our call for evidence commented that 'while the Act is quite prescriptive with regards to the seniority of individuals required to sit on the Board, replacements or substitutes are still fairly common. The PSB only meets five times a year and inconsistency in representation means that it is difficult to create momentum in terms of delivering a shared vision and purpose.' Another noted that it was critical that the PSB had 'a focus on ensuring all partners who attend see the value of their role in the PSB, some attend without adding the value required, without actively supporting' and another that 'the Boards are variable and depend very much on the dynamic amongst the organisations who attend. Unless senior members of participating organisations attend, they [the Board] very quickly run out of steam.'

1.7 Despite all PSBs having voluntary sector representation, county voluntary councils' and Wales Council for Voluntary Alliance members report that the work of PSBs feels very distant from the reality of the day to day work of third sector organisations. The culture of PSBs also feels like a local authority owned agenda, notably in areas where the number of local authority representatives outweighs that of other organisations. They conclude that 'the current balance of power is reflective of the status quo, a 'two-tier' system with a clear onus on the four statutory partners versus the 'other' members; resulting in weak collective ownership of the work'[7].

1.8 PSBs also invite a wide range of other organisations to participate in and shape their work. For example, further or higher education institutions and housing associations. We found that only three PSBs have regular attendance from town and community councils – Neath Port Talbot, Torfaen and the Vale of Glamorgan – and only one PSB (Swansea) has a good level of involvement with the private sector through the Regional Business Forum. No faith groups are involved in the work of PSBs despite their value being recognised in wellbeing assessments.

PSBs are engaging with citizens, but are not involving them in their work

1.9 The legislation makes it clear that PSBs should work in a citizen-centred way, involving citizens in the co-design and delivery of wellbeing plans. PSBs have undertaken extensive stakeholder engagement activity when developing and finalising their wellbeing objectives and the Local Wellbeing Plan. For instance, questionnaire surveys in Ceredigion, Caerphilly, Pembrokeshire, Torfaen, Neath Port Talbot, the Vale of Glamorgan and Newport; and public engagement sessions and workshops in designated 'community areas' in Gwynedd and Anglesey, Bridgend, Cardiff, Neath Port Talbot, Monmouthshire, Swansea, Flintshire, Conwy and Denbighshire.

7 Submission from Third Sector Support Wales (TSSW) to the National Assembly for Wales' Equalities, Local Government and Communities Committee – inquiry in relation to Public Services Boards, May 2018.

1.10 Other notable examples of engagement include the refocusing of citizens[8] panels onto PSB activity such as the Blaenau Gwent Citizens Panel, Your Voice Wrexham, Involve Newport and the Torfaen People's Panel. The Torfaen Consultation Hub helps the public find and participate in consultations run by all public service organisations in Torfaen. And the One Cwm Taf newsletter[9] and One Newport bulletin[10] are good examples of how PSBs are informing people about what is going on, inviting comment, and promoting volunteering.

1.11 Whilst engagement activity has been time consuming and extensive it has nonetheless tended to follow traditional approaches focussed on informing rather than involving people and consequently falls short of meeting the new expectations of the Act. For example, it is unclear how such activity has been used to shape PSB priorities, the final wellbeing objectives and the actions needed to deliver change. Similalrly, stakeholders are not made aware of the impact of their contribution and we found little evidence of how PSBs are ensuring the full diversity of stakeholders are represented and take part in involvement and engagement activity. For instance, we found that only Bridgend PSB has specifically engaged with and sought to involve people with protected characteristics. Engagement activity across Wales has only occurred in English or Welsh, and not in other languages or by using British Sign Language (BSL). We conclude that PSBs are not consistently involving people who have the most to gain from public bodies taking a stronger focus on improving citizens' lives.

8 A Citizens' Panel aims to be a representative, consultative body of local residents. It is typically used by statutory agencies, particularly local authorities and their partners, to identify local priorities and to consult service users and non-users on specific issues.

9 http://www.ourcwmtaf.wales/SharedFiles/Download.aspx?pageid=286&mid=613&fileid=403

10 http://www.newport.gov.uk/oneNewport/News/One-Newport-Bulletin.aspx

Most PSBs have adopted the Terms of Reference set out in the Act

1.12 Terms of reference define the purpose and structures of the PSB and are the basis for partners agreeing to work together to accomplish a shared goal. Good terms of reference will set out the governance, functions and ambitions of the PSB and will highlight how partners and the public will be involved. They will also provide a documented basis for making future decisions because they define the:

a vision, objectives, scope and deliverables (ie what has to be achieved);

b stakeholders, roles and responsibilities (ie who will take part in it);

c resource, financial and quality plans (ie how it will be achieved); and

d work breakdown structure and schedule (ie when it will be achieved).

1.13 Whilst the Welsh Government encourages local flexibility, we found that 17 of the 19 PSBs have adopted terms of reference in line with the Act, but with little variation to take account of local circumstances. Whilst nearly all terms of reference follow the same format, we found that six do not set out how sub and working groups will be established and operate and five do not set out how people and partners will be engaged in the work of the PSB. Resources, capacity building and skills development are the major gaps in the current terms of reference. Cardiff, Caerphilly and Newport PSBs have updated their terms of reference and Swansea PSB has produced some good guidance to support the work of the PSB. The terms of reference developed by Gwynedd and the Isle of Anglesey helpfully sets out and explains how disagreement and conflict will be resolved.

PSB agendas vary widely and Welsh Government guidance on impact assessments is not sufficiently clear to direct activity in key areas

1.14 Decisions made in PSB meetings ultimately determine the success or failure of the PSB, but meetings can often run the risk of being unfocused and unproductive if they do not have a clear agenda. From our review of minutes and agendas we found that the coverage of agendas, quality of reports and the minutes are hugely variable. Between April 2016 and July 2019, we identified from PSB and council websites that PSBs have met a total of 208 times. We were, however, unable to find public information on dates of meetings, agendas, minutes and reports for 11 PSBs for some or all of this period. Indeed, two PSBs have not reported publicly on when they have met, nor have they published agendas, board papers and minutes of meetings since April 2016.

1.15 Whilst we only have a partial picture of PSB performance, we found that as of June 2019:

a PSBs had, on average, 18 core attendees at each meeting, with the number of participants ranging from 16 to 42 people;

b the average length of meetings is 2.5 hours;

c PSBs have received over 1,100 reports and over 300 formal presentations as well as regular verbal updates and tabled items;

d 'host' councils are allocated approximately 98% of the tasks for action arising from meetings; and

e each PSB has on average four sub-groups ranging from no sub-groups in four PSBs to 11 in one.

1.16 Too often reports and minutes are not clearly written and are full of jargon which can make it difficult for the public to judge the quality of decision making and the work of PSBs. Conclusions of discussions often end in the Board 'noting' items, or 'thanking' partners for contributions, and agendas regularly include matters for information not decision. And, because these tend not to be matters for action they are consequently not monitored or scrutinised in later PSB meetings. One respondent to our call for evidence noted from their experience 'the PSB has also become a bit of a 'catch all' for initiatives. Agendas have become long and discussion time limited.' Overall, we conclude that PSBs are not doing enough to report publicly and openly on their work to ensure stakeholders and citizens can judge performance and hold them to account. This weakens transparency and accountability and it is difficult to see how public bodies are collectively taking a stronger focus on improving local citizens' lives in line with national guidance and public interest.

1.17 We found that Welsh Government guidance[11] is also not clear on whether PSBs should undertake impact assessments, noting that 'a public services board is not under a duty to carry out formal impact assessments. However, they might consider it a useful way of reflecting on matters that statutory members of the board would need to consider or expect to be considering in any case if they are to meaningfully assess the well-being of their area.' Consequently, PSBs have adopted a variety of approaches to gauge and understand the potential impact of their decisions. For instance, whilst some Boards have undertaken PSB specific impact assessments, others rely on individual organisations' impact assessments. These are, however, often not specific to the PSBs' priorities or planned actions and can be unsighted by other Board members.

1.18 More generally, respondents to our call for evidence flag concerns with Welsh Government guidance and advice, perceiving it as overly bureaucratic, too prescriptive and not being sufficiently integrated with other key partnership guidance, in particular Regional Partnership Boards. For instance, one noted that 'the legislation has been very prescriptive, and it has delayed the start of work on projects. Early discussions focussed on dates when things had to be done by and perversely dates things couldn't be started until a time lapse had occurred.' Another commentator noted that to support the PSBs to flourish requires 'less nationally imposed demands and expectations; less central generated bureaucracy' and another that PSBs should have 'greater flexibility to enable the PSB to focus on initiatives rather than compliance with the guidance'.

11 https://gov.wales/sites/default/files/publications/2019-02/spsf-3-collective-role-public-services-boards.pdf

PSBs have mixed views on the benefits of the advice they receive from the Future Generations Commissioner

1.19 The Future Generations Commissioner has clearly set out to PSBs the expectation that their work should be focussed on specific issues, where the PSB is more likely to make transformative changes that can help improve people's wellbeing. Indeed, the Commissioner has asked PSBs to consider focussing more deeply on a small number of issues and to consider different ways of tackling issues rather than continuing with some of the more traditional approaches which have not proved successful in the past.

1.20 The Commissioner has also made clear that part of her role is 'continuing the conversation' and in 2016-17 sent letters of advice to PSBs in response to their wellbeing assessments, which culminated in her national report **Well-being in Wales: planning today for a better tomorrow**. The Commissioner also provided advice to PSBs on their draft wellbeing objectives in 2017-18, as PSBs were preparing their wellbeing plans.

1.21 We found that PSBs are responding very differently to this advice. Some PSBs, such as Ceredigion, Cwm Taf and Pembrokeshire, have evidently reviewed the advice – for instance, the Commissioner's 'Art of the Possible'[12] programme – and PSB partners have considered collectively how they can best use these insights to refine their work. Despite respecting the advice and guidance provided by the Commissioner and her office, minutes of some PSBs' meetings note that the length and timeliness of advice could be better and that it is often viewed as impractical and not helpful in supporting the PSB to improve.

1.22 For instance, minutes of the Newport PSB meeting of 21 November 2017 note that 'Members commented that the Commissioner's advice was overly lengthy and could usefully have provided a clearer steer on expectations and guidance models for the PSB in terms of how it could do things differently.'[13] Similarly, the Wrexham PSB meeting of 13 September 2018 noted that '[the commissioner] is asking PSBs to consider the governance between themselves and the RPBs. PSB felt advice is badly timed to consider this in detail at the moment'.[14] These are echoed by responses to our call for evidence, with feedback from one PSB member noting that the 'idealist expectations of the Future Generations Commissioner' hinder the work of the PSB.

12 The 'Art of the Possible' is one of the Commissioner's main programmes of work. It is a partnership approach to shining a light on great work that is improving wellbeing in communities across Wales.

13 http://www.newport.gov.uk/documents/One-Newport/PSB-Minutes-21-November-2017.pdf

14 https://www.wrexhampsb.org/wp-content/uploads/2016/08/WrexhamPSB-13-09-18-mins.pdf

The lack of dedicated funding limits the work and impact of PSBs

1.23 The Act requires councils to make administrative support available to the PSB – ensuring the board is established and meets regularly; preparing the agenda and commissioning papers for meetings; inviting participants and managing attendance; work on the annual report and preparation of evidence for scrutiny. However, it is for each board to determine appropriate and proportionate resourcing of their collective functions which are the responsibility of all the statutory members equally.

1.24 The main source of 'income' for PSBs is the Welsh Government's Regional Grant which is issued on a health board footprint and must be spent for the benefit of all PSBs within that region and cannot be spent on project work. We found that some PSBs have set budgets. Cwm Taf PSB has a pooled budget to support administrative work with contributions from the councils and health board. Similarly, both the councils and health board members of the Neath Port Talbot and Swansea PSBs each contribute £10,000 to cover the cost of administrative support. A number of PSBs are also seeking to align their work with other partnership groups in order to share grant funding.

1.25 Outside of this funding, the majority of partners' contribution to the PSBs is a 'contribution in kind', usually officer time and use of facilities with most expenditure being absorbed by each partner, in particular the council. This is particularly challenging for councils as they are required to service the PSB and deliver the scrutiny role which goes wider than providing support for meetings. However, it is clear that partners also do not have the capacity to take on more and resources and capacity remain a key risk. Indeed, one of the key messages from our call for evidence is in relation to resources, capacity and the need for a dedicated funding stream for PSBs.

Call for evidence feedback on major risks facing the PSB:

'The main barriers relate to issues of resources and capacity.'

'In order for the PSB to begin fulfilling its potential, it needs dedicated funding. Crucially, this needs to be allocated to the PSB … not just the local authority or the statutory partners. The allocation of shared resource to RPBs in the form of ICF & transformation fund has galvanised multi-agency, cross-sector collaboration.'

'Provide access to financial support – all partners are financially stretched and even if collaboration opportunities are identified there are still set up costs and a need for staff support.'

'The lack of direct financial resources prevents some actions being undertaken – the time and effort required to look at pooled/shared budgets is disproportionate to any success. WG should ensure that some of the funding streams are directed to PSB - ICF, Transformation funds etc. This would help recognise the role of PSB and speed up change and reconfiguration of services.'

'Dedicated funding, resources and improved clarity around expectations of PSBs relative to other collaborations would improve impact.'

'Over the past three years, the local authority has allocated significant resource to ensure the effective operation of the PSB. This is a significant burden which is not sustainable in the long term.'

'PSBs receive no direct funding, this is a limiting factor. The capacity and capabilities of each partner vary so each partner contributes in very different ways. Inevitably those partners with the broadest shoulders carry the heaviest load which is an issue at a time of austerity when all organisations are under financial pressure and struggling with limited resources.'

'The main barriers relate to issues of resources and capacity across partner organisations: lack of dedicated PSB partnership resource budget; reduced capacity across senior managers in the public sector following 6 years of austerity; and lack of additional funding from Welsh Government to deliver on the requirements of the WBFGA, particularly in comparison to that made available to deliver the SSWBA.'

Source: Wales Audit Office, Call for Evidence, May to June 2019.

Part 2

Public Services Boards are not consistently being scrutinised or held to account

2.1 The Act identifies that local councils are responsible for the formal overview and scrutiny of PSBs, and in particular the: provision of a supportive space for reflection and self-analysis; enhanced democratic accountability and improved transparency; a stronger focus on improving local citizens' lives; and place-based transformation through deeper public engagement. The three main roles of overview and scrutiny committees are set out in Welsh Government guidance and defined as:

a reviewing the PSBs' governance arrangements;

b acting as statutory consultees on the wellbeing assessment and Local Wellbeing Plan; and

c monitoring progress on the PSBs' implementation of the Local Wellbeing Plan and engagement in the PSB planning cycle.

2.2 In order to ensure democratic accountability, councils must designate a scrutiny committee to review the governance arrangements of the PSB as well as review or scrutinise the decisions made, or actions taken by the PSB, and make reports or recommendations to the Board regarding its functions or governance arrangements. It is for each council to determine what form these scrutiny arrangements take. For example, existing legislative powers can be used to put in place joint arrangements, such as 'co-opting' persons who are not members of the authority to sit on the committee, and where appropriate to appoint joint committees across more than one local authority area. The committee can require any statutory member of the Board to give evidence, but only in respect of the exercise of joint functions conferred on them as a statutory member. This includes any person that has accepted an invitation to participate in the activity of the Board.

2.3 We found a wide variation in how councils have configured their PSB scrutiny functions. Five have a dedicated PSB scrutiny committee, five include oversight within the remit of a partnership scrutiny committee, and others have established reporting lines through policy and resources scrutiny committees. Swansea has the largest scrutiny committee inviting an average of 32 people to each meeting in 2018 and 2019. However, one council has not yet designated or created a scrutiny committee for the PSB and another has only recently created a scrutiny committee, which is yet to meet. Councils that have integrated the scrutiny of the PSB with other responsibilities often have committees with very broad remits and councillors lack the capacity to consider everything they need to. As a result, the work of the PSB can take a low priority.

2.4 The timing and frequency of meetings do not help scrutiny committees to monitor progress on the PSBs' implementation of the Local Wellbeing Plan. For instance, most scrutiny committees are not timetabling their meetings to mirror the cycle of PSB meetings. The frequency of council scrutiny committee meetings also varies widely, a reflection of whether oversight has been tasked to an existing committee or to a dedicated committee focussed purely on the PSB. Consequently, some scrutiny committees meet monthly, others less frequently.

2.5 Our review of council scrutiny papers, agendas and reports found that a number of committees are focussing on internal administration, structures and procedures and not enough on providing insight or challenge to PSBs. We saw evidence that most, but not all, scrutiny committees are consulted on the PSBs' wellbeing assessment and Local Wellbeing Plan, but it is not always clear what impact their scrutiny has had. Some scrutiny committees simply note receipt of the Local Wellbeing Plan with minutes recording no or little comment or challenge.

2.6 With regard to monitoring progress on the PSBs' implementation of the Local Wellbeing Plan and engagement in the PSB planning cycle, we found big differences in how scrutiny committees are performing. There is good evidence that some scrutiny committees are effectively challenging the work of PSBs. For example, the work of Cardiff Council's Policy Review and Performance scrutiny committee when considering the PSB's Wellbeing Report 2017-18[15]. Likewise, Caerphilly provide PSB performance reports to members in advance of scrutiny meetings to help members set their lines of enquiry and to ensure that the right PSB partner officers attend meetings to answer these questions. In addition, pre-meeting discussions also allow officers to present questions under themes to sharpen the focus of scrutiny.

15 http://cardiff.moderngov.co.uk/documents/s25545/Minutes%20Public%20Pack%2003102018%20Policy%20Review%20and%20Performance%20Scrutiny%20Committee.pdf

2.7 However, these positive examples are not universal, and we found significant shortcomings in how some scrutiny committees are reviewing and scrutinising the decisions made and actions taken by PSBs. For instance, reports and updates on the work of PSBs are simply noted by some scrutiny committees, whilst other committees are not tracking the number, discussion of, discharge, and impact of the recommendations they make for PSBs to action. Scrutiny Committee papers and minutes can also be full of jargon and abbreviations which can make it difficult for councillors to examine performance, a point noted by Ceredigion's Overview and Scrutiny Co-ordinating Committee[16]. This makes it difficult for councils to demonstrate how they are discharging the expectations of the Welsh Government's guidance.

2.8 Of the councils that published annual scrutiny reports, we found little commentary on their responsibilities to scrutinise PSB governance arrangements and whether the current systems are effective or need to change. The Terms of Reference of PSBs are generally not reviewed by scrutiny committees. This is important because PSBs' governance work may evolve over time and priorities may change.

2.9 Whilst some PSB scrutiny committees encourage wider attendance at meetings this could be more inclusive to ensure stakeholders and citizens are given the opportunity to hold their PSB to account. All PSB scrutiny committees are chaired by a councillor, membership of committees is primarily made up of local councillors and there are few co-opted members from PSB partners. Consequently, the work of committees ends up with a heavy 'council focus'. Many PSBs are not open to the public , and we found that only one PSB – Swansea – encourages involvement and engagement with the public at PSB meetings through its public 'question time'. In addition, Cardiff and Swansea tabled questions from the public. Cwm Taf and Cardiff advertise PSB and scrutiny meetings in the local press and on social media and several other PSBs have dedicated public-facing websites with a good range of useful and accessible information, the best of which we consider to be Cwm Taf and Blaenau Gwent. Websites with good quality material make it easy for the public to become more informed and involved in the work of the PSB. Despite these positive examples, there is more for PSBs and public bodies to do to ensure there is effective oversight of the work of Boards.

16 http://www.ceredigion.gov.uk/cpdl/CeredigionStrategicPartnerships_Public/10.8%20Scrutiny%20Feedback%2030.11.2017.pdf

Part 3

Despite public bodies valuing PSBs, there is no agreement on how their role should evolve

3.1 There is no single or right model for how PSBs should be organised and should work. Each PSB is the sum of its members and will reflect the local context, the needs of its areas and the agreed priorities for action. Since the establishment of Public Services Boards in 2016, much of the focus of their early work has been on completing the wellbeing assessment, adopting the Local Wellbeing Plan and establishing governance and operating arrangements between partners. Most PSBs have now reached a pivotal moment, where these arrangements are well-established and are turning their attention to delivering the outcomes they have set out. It is timely, therefore that PSBs pause and consider their role and how they can ensure their work is focussed sufficiently on meeting the objectives of the Act.

Partners support the continuation of PSBs, but they have mixed views on what their future role should be

3.2 Nearly all partners responding to our call for evidence said that PSBs are the right vehicle to deliver the ambitions of the Act but also acknowledged they are only part of the solution. Whilst most partners note that PSBs will only have impact if they are allowed time and space to develop, many who responded to our call for evidence highlighted that structures also need to change to support them to flourish. Proposals included more flexibility to allow PSBs to operate without overly prescriptive guidance, exploring regional working and greater clarity over the roles and links between PSBs and Regional Partnership Boards.

‘I would not want to see wholesale change being introduced again. We have had Community Planning and Leadership Partnerships and Community Plan; then the Local Service Board and Single Integrated Plan, and now we have Public Services Board and Wellbeing Plan. We cannot just keep shuffling the deck chairs, changing the name of partnerships, and expecting change for the better. I think most people are fed up with the 5-year cycle of change of partnership, new assessments, new plans and then ‘all change’ before anything has had chance to bed in and deliver real transformation and improvement. The Well-being of Future Generations Act needs us to plan for the long term – to do that, we need a long-term commitment to PSBs, even if an element of the work moves onto a regional footing.’ – Call for evidence response.

3.3 PSB members often attend numerous partnerships and respondents to our Call for Evidence noted difficulties in aligning all priorities, and often the work of their organisation is remote and not central to delivery of wellbeing objectives or the Local Wellbeing Plan. This can be especially difficult for fire and rescue authorities who cover between four and nine PSBs; the national park authorities who work with between one and nine PSBs; and the police who operate across four and six PSBs. For example, one respondent to our call for evidence noted that 'both Swansea and NPT PSBs have very similar wellbeing plans and yet these are being developed in parallel rather than in a collaborative joined up way which ignores local authority boundaries. This is a particular issue for partners who cover more than one PSB area – it duplicates work (attendance at numerous meetings discussing the same issues in different LA areas), it means missed opportunities for greater collaboration.' Bodies working across a region consequently find it hard to resource every PSB meeting, sub group and council scrutiny meeting.

3.4 PSB members likewise find it challenging to respond to and align partnership activity under different pieces of legislation. As well as having to create PSBs, they are also required to form regional partnership boards under the Social Services and Wellbeing Act and regional delivery arrangements under the recent Violence Against Women legislation. Reducing the complexity of public service governance has long been an aim of the Welsh Government, local government and other public service partners who note that the lack of alignment between partnerships which continue to operate on different geographical boundaries can dilute impact, stretch capacity and increase complexity. Partnerships undoubtedly can help drive transformational change, but the top-down prescriptive model favoured to date, coupled with different emphases in different legislation and guidance, has not always helped Public Bodies to deliver on the ground.

3.5 This is not unique to PSBs and echoes the findings of the Auditor General's recent review on the Integrated Care Fund and the work of regional partnership boards[17]. For example, regional partnership boards operate on health-board boundaries, whereas others like the majority of PSBs operate on a local authority footprint. A number of respondents also highlighted that PSBs, unlike regional partnership boards, are not allocated resources to directly spend. This is resulting in some PSB partners choosing to prioritise the work of regional partnership boards over PSBs because the former makes decisions on where to invest and spend money and the latter does not.

17 https://www.audit.wales/system/files/publications/integrated-care-fund-report-eng.pdf

3.6 However, given the weaknesses identified in earlier sections of this report on the inadequacy of accountability and oversight arrangements, the lack of public reporting and the duplication of PSB activity with other partnerships, there are risks in allocating PSBs resources to manage. For PSBs to start to control and spend money will require changes and improvements in how PSBs work; how they publicly report; how they are scrutinised and held to account; and clear expectations on how they should manage and control PSB budgets and expenditure.

3.7 It is unsurprising that many we have spoken to and who responded to our call for evidence flag the current multifaceted partnership environment as a potential block to improvement because resources and capacity are being overextended. It is often the same individuals who are expected to contribute to and attend PSBs and regional partnership boards, putting considerable pressures on their time and resources. For instance, one respondent to our call for evidence noted that 'the partnership landscape is now rather complex ……. the PSB has found it challenging to find an area where they can add value and not duplicate other areas'. Whilst another highlighted that 'the capacity to service both PSB and RPB partnership arrangements is an issue. A single partnership arrangement would help to reduce duplication, ensure adequate officer support and provide clarity regarding governance and accountability.'

3.8 Finally, one respondent highlighted that 'the relationship between PSBs, RPBs and other bodies (City Deal, APBs) is very confusing and makes for a cluttered landscape. It is difficult for professionals to understand – let alone the public we are supposed to serve. Competing cycles – most public sector organisations are funded annually; political terms are 4/5 years and yet PSBs are trying to develop solutions for the next generation – these factors work against each other.'

3.9 There are nevertheless mixed opinions on whether PSBs should operate on local or regional footprints and whether they should merge with other partnerships. Whilst there are tensions inherent in the existing structures, there are also challenges to changing them. Whilst larger partnerships offer economy of scale, they can also become remote moving decision making and prioritisation further away from communities. The Welsh Government is also clear that not all partnership structures do the same job. Some are about case management or operational delivery across services whilst others focus on developing a shared strategic perspective and it is not always possible, or desirable, to bring these together.

3.10 As well as PSBs, the Welsh Government[18] has identified 23 other major partnership groupings, broadly aligned with the following themes:

a Economy and skills – 3

b Health and social care – 4

c Criminal justice and community safety – 8

d Children and young people – 3

e Housing – 4

f Other – 1

3.11 Though most of these emanate from, or are driven by, national requirements, how they are organised, managed and work is very much left to public bodies to determine, recognition that there is no one or right way for partnerships to organise themselves. And whilst some boards have ensured that the responsibilities of different regional and local boards are clearly defined and seek to keep duplication to a minimum, this is not universal. Even where there are opportunities to streamline the work of the PSB and discharge other plan and strategy obligations through the Local Wellbeing Plan, we found that PSBs are not necessarily taking them.

3.12 For example, whilst most councils discharge their community planning functions and priorities for child poverty through their PSBs, and others have taken the opportunity to integrate their community safety partnerships into a sub group of the PSB (Bridgend and Swansea for example), progress in other areas has been limited. Strategies relating to Violence against Women, Domestic Abuse and Sexual Violence have mostly been regionalised and are not being discharged through the Local Wellbeing Plan.

3.13 Undoubtedly, those we have spoken to and who responded to our call for evidence value the work of PSBs, but there are very different views on how they should evolve. As noted above, some favour fewer Boards operating across wider regional areas whilst others value PSBs reflecting local authority footprints and being tied more closely to communities. Others want to see PSBs and regional partnership boards being merged to reduce duplication, not least in attendance, but to also better co-ordinate work on similar priorities. It is clear that there is no single model for partnership working and each partnership needs to reflect the local circumstances, priorities and context. And it is PSBs themselves who are best placed to decide when, where and how they wish to work together, and the Act is designed to ensure they have the flexibility to do so.

18 Paper 3 (Annexe A), Working Group on Local Government, Meeting 25 January 2019.

3.14 However, given the demands on public bodies to sustain and maintain so many partnership fora, there is a clear case for rationalising the current arrangements to free up capacity and reduce duplication. And the current review commissioned by the 'Working Group on Local Government' to map strategic partnerships[19] and make recommendations for rationalisation should address this. To assist in this process, in the remainder of this section we consider how similar partnerships operate in Scotland and England and highlight key differences with Wales.

PSBs are broadly similar to Community Planning Partnerships in Scotland, but partners in Scotland also deliver projects and co-ordinate funding programmes

3.15 The approach in Wales is similar to the Community Planning[20] system in Scotland. Community planning is the process by which councils and other public bodies work together, with local communities, businesses and voluntary groups, to plan and deliver better services and improve the lives of people who live in Scotland. The Local Government in Scotland Act 2003 provides the statutory basis for community planning. Community planning is led by Community Planning Partnerships (CPPs). There are 32 CPPs, covering each council area, which include representatives from the following:

a **the council**: It has a statutory duty to 'initiate, facilitate and maintain' community planning. It is therefore responsible for taking the steps necessary to ensure community planning takes place.

b **statutory partners**: NHS boards, Scottish Enterprise, Highlands and Islands Enterprise, Police Scotland, Scottish Fire and Rescue Service and regional transport partnerships.

c **other partners**: These include other public bodies, further and higher education institutions, voluntary groups, community groups and business organisations.

19 https://www.wlga.wales/review-of-strategic-partnerships-june-2019

20 The Community Planning model has been in place for a number of years and was most recently refreshed with the Community Empowerment (Scotland) Act 2015.

3.16 Unlike PSBs, CPPs are focused on delivering projects particularly at a community level. This work can include managing and assisting in asset transfer to community groups, working with communities to both build capacity and identify solutions and also investing in infrastructure and projects. For instance, the approach to involving communities in identifying and planning responses in Glasgow[21]. CPPs are also required to specifically consider how they can help contribute to poverty reduction and they must also assess the impact of their policy choices on people with protected characteristics. Importantly, CPPs must set out what public money is being spent locally and actively seek opportunities to reduce duplication, jointly bid for external finance and pool resources.

3.17 CPPs have also acted as the co-ordinating body for national funding programmes; for instance, the Early Years Change Fund established in 2011 as a partnership fund between the Scottish Government, local government and the NHS totalling £274.25 million in investment. The CPPs provide oversight and co-ordination for this programme[22]. Consequently, CPP plans, which have a 10-year timescale, are focussed on operational delivery as well as setting the overall strategic direction for an area. There are therefore some important differences between CPPs and PSBs, namely, the former works more closely with the business sector, has oversight of funding and supports delivery of community projects. This is very different to PSBs.

21 https://www.glasgowcpp.org.uk/index.aspx?articleid=19222

22 https://www.gov.scot/publications/summary-community-planning-partnerships-cpps-early-years-change-fund-returns-9781786524355/pages/1/

Strategic partnership work in England is left to each council to determine and this has resulted in very different approaches

3.18 The approach in Wales and Scotland, however, is sharply different to England. Increasingly, councils in England are choosing not to have a local strategic partnership forum, partly a reflection of less central direction, austerity and the cost of servicing and maintaining these forums, but also because of difficulties in quantifying impact and the speed of decision making. From our research we found that approaches in England tend to focus on one key priority – learning and skills, economic growth, preventing poverty, or digital delivery. And because there are no central mandated approaches or requirements, public bodies are left to determine how they respond, which has resulted in very different approaches with little consistency between regions. For instance:

a the Derbyshire Partnership Forum[23] is one of the few remaining local strategic partnerships in England and primarily focuses on preventing poverty in rural areas. The Forum brings together over 60 public, private, voluntary and community sector organisations who work together to improve the quality of life for the people of Derbyshire. The Derbyshire Partnership integrates seven other strategic partnerships and runs a data observatory. The Derbyshire Partnership Forum is currently carrying out a fundamental review of its governance arrangements to refocus its priorities on fewer things where there are gaps in conventional service delivery and to further integrate efforts, for example, in youth safety prevention work.

b Newcastle City Council's Growing our City[24] is focussed on attracting and encouraging investment in the city to grow the economy and create a more sustainable Newcastle. Key to this is the programme of work being developed under the Newcastle City Deal[25], which supports the creation of an Accelerated Development Zone in the Newcastle and Gateshead corridor which is allowing the Council to regenerate the city centre and tackle poverty. Alongside this is the life and science and healthcare work which has levered in over £1 billion in investment and the Council's partnership with Legal and General at the Helix site.

23 https://www.derbyshirepartnership.gov.uk/home.aspx

24 https://www.newcastle.gov.uk/our-city/growing-our-city

25 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406293/Newcastle-City-Deal-Paper.pdf

c the Essex Online Partnership[26] is focusing on one key priority: to improve digital access, grow skills, and ensure all partners have access to the best integrated technology and data. The Partnership operates through a subscription model and is jointly led by Essex County Council and Essex Police. The partnership shares knowledge, resources and services to provide technology solutions, which support the business needs of each partner organisation and reduce the cost of their technology. Significantly, the partnership involves and includes networks of interest, schools and rural communities.

d Southampton Connect is an independent partnership which brings together senior city representatives seeking to address the key challenges and opportunities for Southampton and working with the city's key partners to improve the outcomes of the people of Southampton[27]. Southampton Connect is chaired by the Hampshire Chamber of Commerce and is responsible for the delivery of the Southampton City Strategy which contains many of the features of a wellbeing assessment. Partners emphasise speed of action and ability to speak with one voice as clear tangible benefits. Rough sleeping is the partnership's current priority based on public interest and local concerns.

3.19 From our analysis, one of the key differences between England and Wales is the freedom English councils have to determine their direction and purpose and the role of the private sector to support strategic activity. With less public money available to invest in services and regeneration activity, we found that English councils are focusing on strategically using their powers – in particular land use planning, the General Power of Competence[28] (which currently does not exist in Wales) and the ability to negotiate reuse of income generated from flexing business rates – to encourage inward investment that helps tackle problems. This helps to increase employment and grow council tax revenues to reinvest in public services.

26 http://www.eolp.info/

27 https://www.southampton.gov.uk/council-democracy/partnership-working/southampton-connect.aspx

28 The Localism Act 2011 introduced the general power of competence in England which enables local authorities to do things an individual may generally do but anywhere in the UK or elsewhere. The power also allows authorities to do things for a commercial purpose or otherwise, for a charge or without a charge and without the need to demonstrate that it will benefit the authority, its area or citizens of the area. The general power of competence has extended the range of services which a local authority can lawfully provide.

3.20 However, because these approaches are negotiated and agreed by the UK government on a case by case basis, there is no uniformity between councils nor a core focus for action that all councils are prioritising. Councils are essentially left to 'get on with it' with little external support, oversight or challenge, which is inherently risky, especially when things go wrong. This is very different to the Welsh Government policy for PSBs, which promotes a 'public sector led' response to addressing challenges. Whilst the Welsh Government's guidance references the private sector and businesses, they are not identified as core PSB members and their role and contribution to date in Wales are not as central to the work of PSBs, with one or two exceptions, which is different to England.

3.21 Some, but not all, of the approaches in England are also developed under the auspices of City and Growth Deals[29]. City Deals also operate in Wales and are an agreement between the UK and Welsh governments and a city or city region. It gives the city and its surrounding area certain powers and freedom to take charge and responsibility of decisions that affect their area. City and Growth Deals are focussed on stimulating economic growth across an area, but also tackling barriers by, for instance, improving transport connectivity; increasing skill levels; supporting people into work; supporting businesses; and deciding how public money should be spent. A Growth Deal is very similar in purpose but is less geographically restrictive.

3.22 There are currently two City Deals in Wales – the Cardiff Capital Region City Deal[30] and the Swansea Bay City Deal[31] – and proposals for development of Growth Deals in Mid Wales and North Wales. The local authority partners in each of the existing City Deals have established joint governance arrangements to oversee implementation of the deal. Given the potential City Deals have for making a positive impact on improving economic wellbeing it is important that their work is focused on delivering sustainable development in line with the Act, a key issue flagged by the Commissioner with public service leaders in correspondence[32]. Irrespective, they are also another major partnership that adds to what already is a complex picture of planning and delivery across the public sector.

29 City and Growth Deals have become one of the main tools for driving economic activity in the UK in recent years. A process that started with the major urban centres of England (outside London) has grown to include most of the large population centres across the UK. By their nature, these deals are unique to the area they spring from, and there is a great deal of variety in their scope and ambition.

30 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/508268/Cardiff_Capital_Region_City_Deal.pdf

31 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/611685/Swansea_City_Deal_-_English.pdf

32 https://futuregenerations.wales/wp-content/uploads/2017/03/20161212-City-deal-FinalEng.pdf

Appendices

Appendix 1 – study methodology

Appendix 1 – review methodology

Review of literature

We have reviewed a wide range of documents and media, including:

- evidence submitted to the National Assembly for Wales' Equalities, Local Government and Communities Committee inquiry in relation to Public Services Boards;
- examining national policy, statutory guidance and the Well-being of Future Generations Act guidance and legislation;
- examining all PSB meeting reports, minutes and online information from 2018 and 2019 and a sample of earlier documentation;
- checking PSB websites for accessibility and encouraging public involvement;
- reviewing financial information on PSBs;
- comparing public priorities in wellbeing assessments with wellbeing objectives;
- recording who attended PSB meetings and examining all PSB terms of reference where they exist;
- assessing if PSBs are streamlining their activity by integrating other statutory partnerships and plans/strategies;
- considering if PSBs are taking account of advice from the Future Generations Commissioner;
- reviewing all PSB related council scrutiny committee minutes, reports and annual reviews of scrutiny; and
- other relevant research and guidance from government, councils, CIPFA, and research bodies.

Comparative research

We compared guidance and strategic partnership work in Wales with approaches in England and Scotland.

Call for evidence

We undertook a call for evidence of all PSB statutory and invited members and received responses from 51 members of PSBs covering all 19 PSBs.

Interviews and focus groups

We interviewed representatives from the Future Generations Commissioners (FGC) Office, the Welsh Government, the Welsh Local Government Association and members of PSBs including council, fire and rescue authority, police and voluntary sector officers and PSB co-ordinators. We interviewed officers in councils in England and undertook fieldwork in Newcastle. We held focus groups with Wales Audit Office staff who are delivering Well-being of Future Generations audits at each of the 44 public bodies and have observed scrutiny meetings.

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

Audit year: 2019

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

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

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

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

Contents

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

Summary Report

Background

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

a. setting their well-being objectives; and

b. taking steps to meet them.

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

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

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

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

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

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

Focus of the work

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

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

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

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

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

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

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

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

Main findings

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

13 We reached this conclusion because:

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

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

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

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

Opportunities for improvement

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

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

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

Exhibit 2: opportunities for improvement.

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

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

Detailed Report

Part 1 – Corporate arrangements

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

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

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

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

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

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

23 Our findings are set out in Exhibit 3.

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

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

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

Developing core arrangements and processes

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

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

Involving citizens and stakeholders

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

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

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

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

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

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

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

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

25 We looked for evidence of:

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

26 We identified the following strengths:

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

27 We identified the following learning points:

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

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

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

28 We looked for evidence of:

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

29 We identified the following strengths:

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

30 We identified the following learning points:

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

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

31 We looked for evidence of consideration of:

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

32 We identified the following strengths:

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

33 We identified the following learning point:

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

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

34 We looked for evidence that the Health Board:

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

35 We identified the following strengths:

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

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

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

36 We identified the following learning points:

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

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

37 We looked for evidence that the Health Board has:

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

38 We identified the following strengths:

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

39 We identified the following learning points:

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

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

Appendix 2

The Step

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

Explanation of the step

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

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

Why is the Health Board doing this?

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

What is the Health Board doing to achieve this step?

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

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

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

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

The Five Ways of Working

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

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

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

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Board/Committee report template

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee** **12 December 2019**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Response to: Wales Audit Office, Implementing the Well-being of Future Generations Act Report (October 2019)**
Cyfarwyddwr Cyfrifol: Responsible Director:	**Mark Wilkinson**
Awdur yr Adroddiad Report Author:	**Sally Baxter**
Craffu blaenorol: Prior Scrutiny:	n/a
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Committee is asked to receive the report, note the progress being made in applying the sustainable development principle, and the recommendations for further development and improvement in this respect.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The Health Board, as one of the specified public bodies covered by the Well-being of Future Generations (Wales) Act 2015, is required to respond to the principles of the Act and change the way we work to address these. This includes the setting of well-being objectives to contribute towards the achievement of all seven of the national well-being goals, and the adoption of the sustainable development principle, enabled by the five ways of working (long term; prevention; integration; collaboration; involvement.) The well-being objectives of the Board were refreshed and published in the development of the Living Healthier, Staying Well strategy in 2018.

Cefndir / Background:

The report represents the fulfilment of the statutory requirement to examine public bodies to assess the extent to which they have acted in accordance with the sustainable development principle in setting objectives and taking steps to meet these. The report, whilst not requiring a formal management response, does include 5 recommendations (set out on page 6) which need to be addressed.

In developing the report, the Wales Audit Office team adopted a new approach to the examination, which involved:

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

The more participatory approach was welcomed, allowing opportunity for stakeholders to contribute directly to the work, and the opportunity to examine in more depth some of the approaches being used to deliver the step. We are grateful to the WAO team for leading the workshops and their support to the Health Board in working with the new approach. It was felt by some Health Board participants that there could have been greater clarity over the balance of focus between the two parts. However, this has been discussed with the WAO team and the learning from the approach will be taken forward in future work.

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

The recommendations will be taken forward through development of cluster, health economy and the overarching Health Board plans. All recommendations will require work in partnership with other agencies, and more specifically so recommendations I4 and I5, for which work will be taken forward through the North Wales PSBs and the RPB transformation programme.

Asesiad / Assessment & Analysis

Strategy Implications

The report is directly relevant to the Health Board's compliance with the Well-being of Future Generations Act. The "step" selected for in depth examination is identified within the key actions set out in **Living Healthier, Staying Well,** which includes the following:

- To do more to help people make healthy life choices….
- To promote healthy weight programmes

The healthy lifestyle bundle provides the platform for the work programme of the Health Improvement and Reducing Inequalities Improvement Group. However, the requirement to address preventative measures spans all Improvement Groups.

Financial Implications

There are no direct financial implications identified within the report. There are short to medium term opportunities arising for funding through the RPB's Transformation Fund programme and also through the recently announced Building a Healthier Wales allocation. However, the first recommendation is that the Health Board should "Explore opportunities to move towards a long-term funding model to help secure the implementation of new service models." (Recommendation I1.) This will need to be addressed in the context of the developing long-term financial strategy.

Risk Analysis

There are no directly identified risks arising from the report; however there are significant risks to the Health Board is the risk of failing to comply with the requirements of the WFG Act; and risk of inability to achieve sufficient transformational change to focus on prevention at all stages. These risks are already identified within the Corporate Risk Register.

Legal and Compliance

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

Impact Assessment

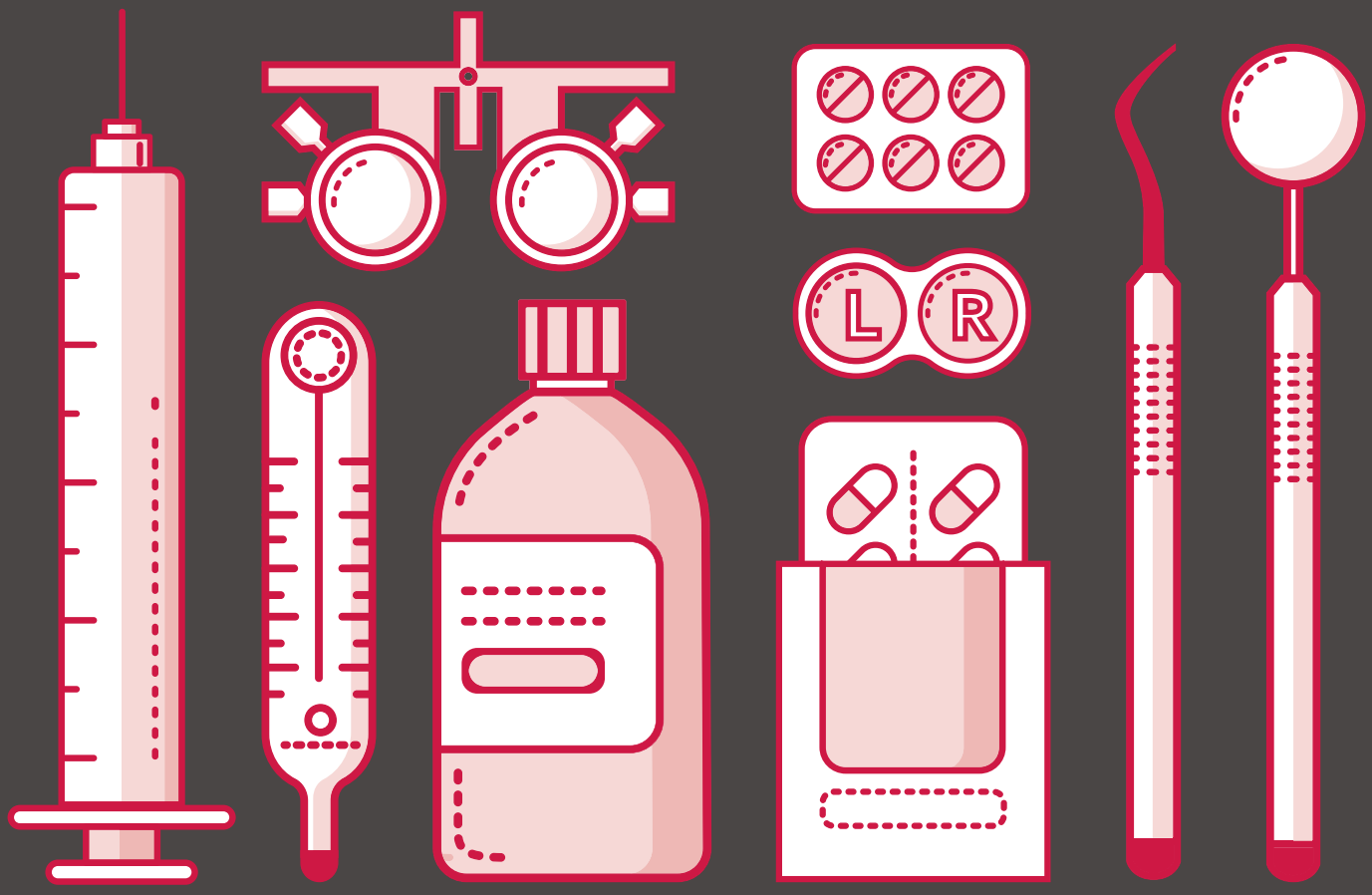
No specific impact assessments were undertaken in production of this report; however appropriate impact assessment, including Equality Impact Assessment, has been undertaken in respect of the initiatives supporting the "step."

October 2019

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Primary care services in Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



I have prepared and published this report in accordance with the Government of Wales Act 1998.

The Wales Audit Office study team comprised Nigel Blewitt, Emily Howell, Philip Jones, Stephen Lisle, Elaine Matthews, Urvisha Perez and David Poland under the direction of Dave Thomas.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

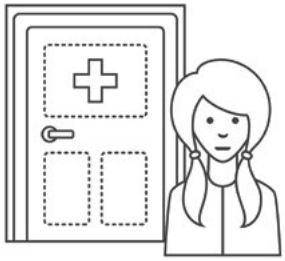
While the NHS and Welsh Government are taking a range of steps to strengthen primary care, change needs to happen at greater pace and scale to tackle longstanding challenges and ensure sustainability of these vital services.

Summary report

Background

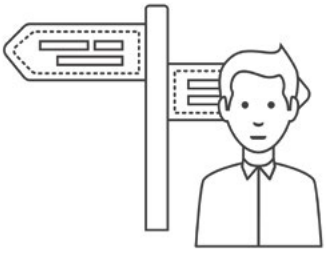
1 Primary care encompasses a wide range of services, delivered in the community by GPs, pharmacists, dentists, optometrists, as well as other professionals from the health, social care and voluntary sectors. Primary care services play a vital role in the system of health and care, as shown in Exhibit 1.

Exhibit 1 – why is primary care important?



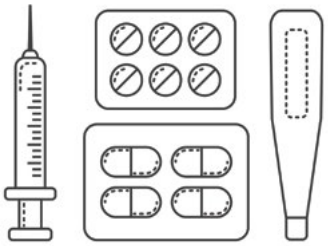
First point of contact

Primary care is the first port of call for the majority of people who use health services.



Coordinating care

Primary care has an important role in coordinating people's care. Primary care is the gateway to many other services.



Prevention and early intervention

Primary care is also important because of its focus on promoting well-being, early intervention and preventing people's conditions from getting worse.

Source: **Wales Audit Office report, A picture of primary care in Wales**, which provides more background and summary statistics about primary care services.

2 For many years Wales has had plans that aim to rebalance the system of care by moving resources towards primary and community care. The national primary care plan[1], which ran until March 2018 set out a 'social model' of care to promote physical, mental and social well-being. The core principles in the plan were: planning care locally; improving access and quality; equitable access; a skilled local workforce; and strong leadership. Delivery of that plan was supported by the following developments:

a **National workforce plan**[2]: expected health boards to build multi-professional teams for patients to access as a first port of call (see Exhibit 2).

b **Primary care clusters**: these are groups of neighbouring GP practices, other primary care services and partner organisations. There are 64 clusters and their role is to ensure planning and provision of services that are locally-led by people who understand local needs. In October 2017, the Assembly's Health, Social Care and Sport Committee published a report and made 16 recommendations following an inquiry into clusters[3].

c **National Primary Care Fund**: introduced by the Welsh Government in 2015-16, the fund supports implementation of the national primary care plan. Between 2015-16 and 2017-18, the fund allocated around £120 million to health boards towards their integrated medium-term plans and workforce development plans for primary care, and pacesetter projects. Clusters were also allocated funding that they could decide how to invest. Some of the fund is retained centrally to support national action. Since 2018-19, the Welsh Government has continued to distribute around £43 million across the health boards' annual allocations.

1 Welsh Government, **Our Plan for a Primary Care Service for Wales up to March 2018**, February 2015

2 Welsh Government, **A Planned Primary Care Workforce for Wales**, 2015

3 National Assembly for Wales, Health, Social Care and Sport Committee, **Inquiry into Primary Care: Clusters**, October 2017

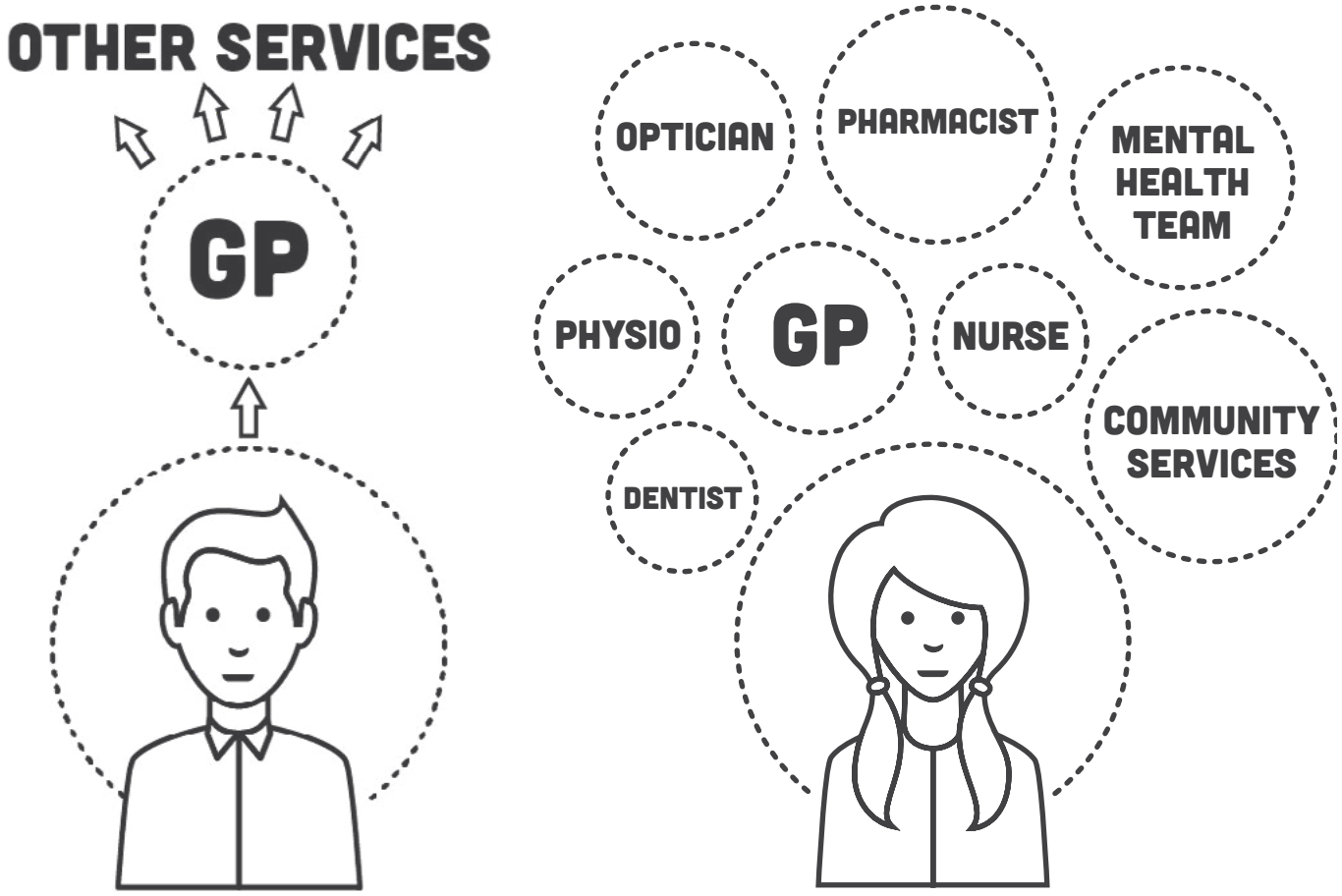
Exhibit 2 – the future model for primary care relies on building multi-professional teams

In the past

Patient goes to the GP as first port of call. The GP acts as a gateway to other services

In the future

The GP will continue to provide the first port of call for some patients. Patients will also be able to directly access many other services, thus freeing up GP time to see the sickest patients and those with complex chronic conditions.



Source: Wales Audit Office

3 Recent years have seen well-documented risks to the sustainability of primary care services, in particular GP practices. There are problems recruiting and retaining GPs, practice closures and perceptions of increased workload and poor work-life balance. There have been particular challenges with primary care out-of-hours services with our July 2018 report showing that out-of-hours services were strained and not meeting targets.

4 In June 2018, the Welsh Government published a plan for health and social care called A Healthier Wales. The plan builds on previous ambitions to shift care closer to people's homes and to bring health and social care closer together. The Welsh Government has set up a £100 million transformation fund (£50 million a year over the two years 2018-19 and 2019-20) to support projects that aim for closer working between health and social care.

5 In response to A Healthier Wales, the NHS, working with Welsh Government, has developed a Strategic Programme for Primary Care building on the work done to implement the national primary care plan since its publication in 2014. The programme consists of a strategic document, workstreams and action plans aimed at 'shifting the focus to a social model of care, ensuring timely access to primary care services when required and working seamlessly across the whole system'.

6 The Strategic Programme for Primary Care was launched in November 2018 and supports the implementation of the Primary Care Model for Wales. The model aims to ensure a whole systems approach to service redesign by setting out the key components that a good primary care system should contain. These key components include informed and empowered citizens, self-care, stronger community services, new first points of contact for patients including triage to ensure they are seen by the appropriate healthcare professional, better urgent care arrangements and stronger multi-disciplinary working. Paragraph 1.6 provides more detail on the model.

7 During 2018, the Wales Audit Office reviewed primary care services in all health boards in Wales[4]. We focused on strategic planning, investment, workforce, oversight and leadership, and performance. In early 2019, we carried out interviews and document reviews to assess the national leadership and governance arrangements for improving primary care. This report describes the main issues and areas of progress we found.

4 Reports on primary care in each health board can be found on our website at www.audit.wales.

Main findings

8 While the NHS and Welsh Government are taking a range of steps to strengthen primary care, change needs to happen at greater pace and scale to tackle longstanding challenges and ensure sustainability of these vital services.

The NHS and Welsh Government are taking a range of steps to strengthen primary care

9 While there have been plans to change primary care for many years, progress in implementing these has been limited and primary care has not always had a high enough profile within the NHS in Wales. Recent developments would suggest that the profile of primary care is increasing at both the national and local level, bringing with it, fresh opportunities and impetus for transformation.

10 A National Primary Care Board was established in March 2017 and the Primary Care Model for Wales has evolved during the past three to four years, before being formally endorsed by the National Primary Care Board in March 2018. An underpinning strategic programme was launched in November 2018. National lead roles have also been created to drive implementation of the model and the strategic programme. However, the model and the strategic programme are in their infancy so need to be kept under review.

11 Provision of innovation funding, to pump-prime change, has been a positive step. Health boards are using Welsh Government national primary care funding to test new ways of working. More work now needs to be done to spread good practice, improve evaluation of new approaches and ensure that once schemes prove themselves to be successful, they begin to receive sustainable, ongoing funding.

Change needs to happen at greater pace and scale to address longstanding challenges and ensure strained primary care services are made fit for the future

12 Despite considerable investment and many plans for primary care transformation over the years, change has not happened as quickly or as widely as intended. There remains growing pressure on the traditional model of primary care and patients are experiencing continued difficulties in accessing appointments at GP practices.

13 The Primary Care Model for Wales promotes the development of multi-professional primary care teams, to reduce the current pressures on GPs and to improve access and services for patients. However, progress on implementing the model is patchy and the pace of change needs to be increased. There is also not yet a clear approach to quantifying the extent of progress in implementing the model, and there is only limited data on the numbers and roles of staff employed in primary care.

14 The NHS in Wales aims to shift resources towards primary care. While there is evidence of some resource shifting in this way, change has not been at pace and scale. We also found that, for many reasons, it is difficult to measure exactly how much money is spent on primary care, which complicates efforts to measure progress.

15 Faster progress is needed to improve the way that performance and activity is measured. The available data suggests mixed performance across Wales. But the data are limited and the current performance measures do not provide a clear picture of how well primary care services are performing and how much activity is happening within services. Activity monitoring and planning is complicated by difficulties standardising data from independent primary care contractors.

16 Health boards have created clusters to drive local leadership and planning of primary care. An inquiry by the Health, Social Care and Sport Committee made 16 recommendations to improve clusters. Public Health Wales subsequently developed a framework to improve cluster governance[5]. We found that much work remains to be done to ensure clusters have a clear remit, sufficiently broad membership and can drive change at pace and scale.

17 More needs to be done to involve the public in changes to primary care. While some elements of the Primary Care Model for Wales have been consulted upon with the public at a local level, there has not been formal consultation or public involvement in the overall model at a national level. Now that the model is beginning to be implemented, there is also a risk that the public will not understand or agree with the new ways of working.

5 Public Health Wales, **Cluster Governance Framework: A Good Practice Guide**, October 2018

Recommendations

18 The table below sets out our national-level recommendations. We have already made local level recommendations through our reports at each health board.

Recommendations
Improving primary care data Monitoring of primary care performance and activity is limited. Current performance measures do not give an effective overview of whether patient outcomes are improved by primary care. Activity monitoring and planning is complicated by difficulties obtaining standardised data from independent contractors. **R1** The Welsh Government should work with the National Primary Care Board to agree robust measures of patient outcomes in their suite of performance measures for primary care, and in doing so, they should look to collaborate with experts in measuring whole-systems outcomes. **R2** The Welsh Government should work with independent primary care contractors to ensure the NHS in Wales has ongoing access to standardised information about their activity, to contribute to better planning and design of services.
Implementing the Primary Care Model for Wales The Primary Care Model for Wales and the Strategic Programme for Primary Care provide a direction of travel but there is not yet a clear approach to quantifying the extent of progress in implementing these changes, and data on the numbers and roles of staff employed in primary care is limited. The Welsh Government should: **R3** Strengthen its performance management of primary care within health boards by developing a method for quantifying each health board's progress in implementing the Primary Care Model for Wales. **R4** Collect and regularly publish data on the number and type of staff working as part of multi-disciplinary primary care practice teams, with a view to monitoring the implementation of the multi-professional model.

Recommendations

Keeping the strategy under review

The Strategic Programme for Primary Care is in its infancy and partnership with social care and the third sector, through Regional Partnership Boards, will be crucial to transformation. The National Primary Care Board should:

R5 Publish a review of progress in delivering the strategic programme in 2020-21. The review should seek opinions on progress from all key partners, including the Regional Partnership Boards.

Strengthening clusters

The Health, Social Care and Sport Committee's cluster inquiry made 16 recommendations. Public Health Wales subsequently led the development of a good practice guide for cluster governance. Much work remains to be done to ensure clusters have a clear remit, broad membership and are able to drive change at pace and scale. The Welsh Government should:

R6 Undertake and publish a stocktake of progress against the recommendations from the cluster inquiry and in implementing the cluster governance framework, with a view to supporting further development and maturity of clusters.

Recommendations

Shifting resources to primary care

From the existing data, it is difficult to quantify exactly how much the NHS in Wales is spending on primary care, and to assess whether health boards are succeeding in shifting resources towards primary and community care. A Welsh Health Circular[6] from July 2018 set out a new financial framework for supporting such shifts.

R7 The Welsh Government should consult with health boards, to agree an approach to clarifying and standardising the way that primary care expenditure is recorded and reported.

R8 The Welsh Government should work with health boards to evaluate, and if necessary, improve the effectiveness of the financial framework in supporting a shift in resources towards primary and community care.

R9 As part of the Joint Executive Team process, the Welsh Government should require health boards to report annually on their progress in shifting resources towards primary care. The coverage of these reports should not be limited to financial resources and should include other resources such as staff and services. Through this process, the Welsh Government should hold to account the entire executive team of health boards, not just the executive directors for primary care.

Involving the public

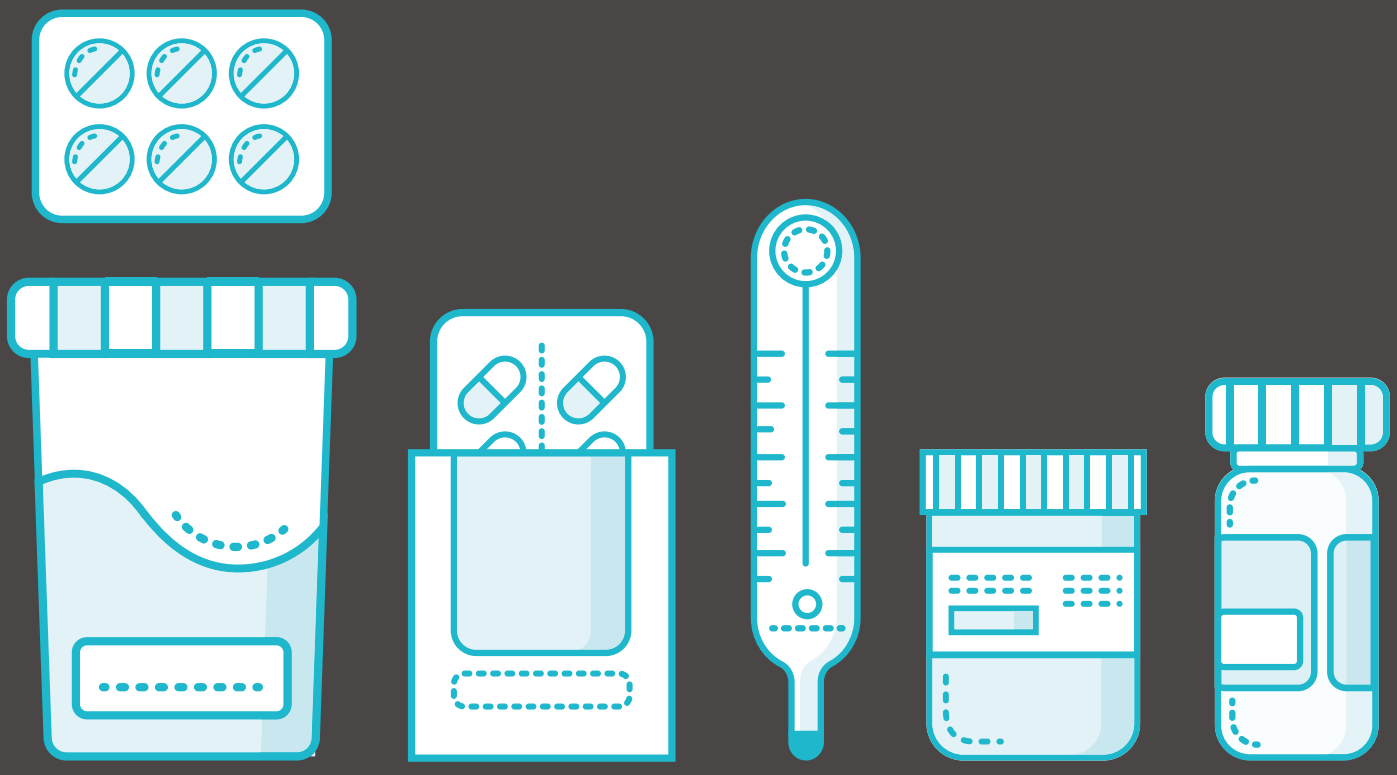
More needs to be done to involve the public in primary care changes. There is a risk that people will not understand or agree with the new ways of working. A centrally funded and led communication strategy is now in development and the Welsh Government has allocated each health board £20,000 a year since 2018-19 to improve public messaging about the model. The National Primary Care Board should:

R10 Involve the public and/or bodies that represent the public in evaluating the approaches taken by health boards to improve their public messaging on primary care, with a view to sharing learning to inform the forthcoming communication strategy.

6 Welsh Government, **Improving Value through Allocative & Technical Efficiency: A Financial Framework to Support Secondary Acute Services Shift to Community/ Primary Service Delivery, Welsh Health Circular WHC (2018) 025**, July 2018

Part 1

The NHS and Welsh Government are taking a range of steps to strengthen primary care



Primary care is becoming a greater priority for the NHS in Wales, which provides an important opportunity for transformation

1.1 Previous national plans for primary care acknowledged that primary care does not always have a high-enough profile. The 2010 document, Setting the Direction, talked about an agenda 'dominated by the acute hospital'.

1.2 Despite health boards being integrated primary and secondary care organisations since 2009, there is still some way to go until primary care has an equal profile to secondary care. However, we found evidence that primary care is becoming a greater priority. For example, two health boards have recently strengthened their leadership arrangements, meaning five health boards now have a dedicated, Board-level director for primary care[7]. Whilst this is a positive step, there is also a risk that health boards will rely too much on these directors to deliver change in primary care. If health boards are to successfully transform primary care, this will require joined-up action from all members of their executive teams.

1.3 The introduction of the National Primary Care Board, alongside the more established boards for planned care and unscheduled care, has been a positive development in raising the profile of primary care. The primary care board was set up in March 2017, has representation from many stakeholders and is providing positive, collaborative leadership of change. The board reports to the NHS Wales Executive Board and oversees the work of the Directors of Primary and Community Care Group[8].

1.4 The Welsh Government and other national bodies have taken a number of steps to raise the profile of primary care and to strengthen services. Box 1 summarises some of these steps.

7 Aneurin Bevan, Betsi Cadwaladr, Cwm Taf Morgannwg, Powys and Hywel Dda have Board-level directors responsible for primary care. Chief operating officers have responsibilities that include primary care in Cardiff and Vale and Swansea Bay.

8 The Directors of Primary and Community Care Group is a peer group of primary care directors. It has a role in implementing national primary care priorities and providing leadership for transformation in primary care.

Box 1 – Summary of national steps to address the challenges facing primary care

Pacesetter programme – The Primary Care Pacesetter Programme began in April 2015, aiming to stimulate innovation and promote primary care redesign. Twenty-four pacesetter projects were initially set up by health boards using £3.8 million a year from the National Primary Care Fund. Many of the projects employed different practitioners, like pharmacists and physiotherapists, to work in GP practices and tried out different ways for patients to contact their local practice. Fifteen additional pacesetter projects started in 2018-19 and are expected to run for two years. Further projects are being considered for pacesetter funding for 2020-2022.

Ministerial Taskforce on Primary Care Workforce – was established in 2016 to address problems with recruitment of GPs and other primary care professionals. The Minister for Health and Social Services brought together members from across all professions and took action regarding GP pay/ conditions and training and recruitment across primary care. It recently stood down as the work programme is being taken forward as part of the Strategic Programme for Primary Care.

Indemnity scheme – the Welsh Government introduced a Future Liabilities Scheme in April 2019 to try to address GP concerns about the cost of professional indemnity. The scheme covers clinical negligence liabilities that could occur due to actions of GPs and any other staff who provide primary medical services.

GP contract increase – in September 2018, GP partners received a 4% increase backdated to April 2018. Salaried GPs and dental practitioners received a 2% pay rise. Other benefits included more support for mentoring and coaching and a commitment to explore access to health board employment benefits.

Box 1 – Summary of national steps to address the challenges facing primary care

Train/Work/Live Wales campaign – launched in May 2017 to attract and train more GPs, nurses and other professionals. In addition to showcasing Wales as a great place to live, incentives of £20,000 are offered to GP trainees accepting places to train and work in hard-to-recruit areas. All trainees receive around £2,000 towards exam costs. The number of GP training places remained static at 136 for many years and until recently there were problems filling places. Almost all places were filled in 2018 and Health Education and Improvement Wales will increase the number of trainee places to 160 from 2019[9].

Primary and Community Care Development and Innovation Hub – the Hub was set up by the Primary Care Division, Public Health Wales, to coordinate support for health boards and clusters in delivering national primary care priorities. The Hub has played a major role in developing the Primary Care Model for Wales and hosts the Primary Care One website, a single point of access to important information for clusters.

Standards on access to general medical services – a set of national standards that all GP practices are expected to comply with, to develop innovative solutions and learn lessons from other practices in their cluster, to drive improvements to access[10]. The Welsh Government launched the standards on 20 March 2019 and expects GP practices to meet these standards by 31 March 2021[11].

Source: Wales Audit Office

9 Welsh Government, **Plans to increase GP training places in Wales**, June 2019

10 Vaughan Gething, Minister for Health and Social Services, **Written Statement: Access to General Medical Services**, March 2019

11 Welsh Government, **New standards for GP practices to raise and improve level of service for patients in Wales**, March 2019

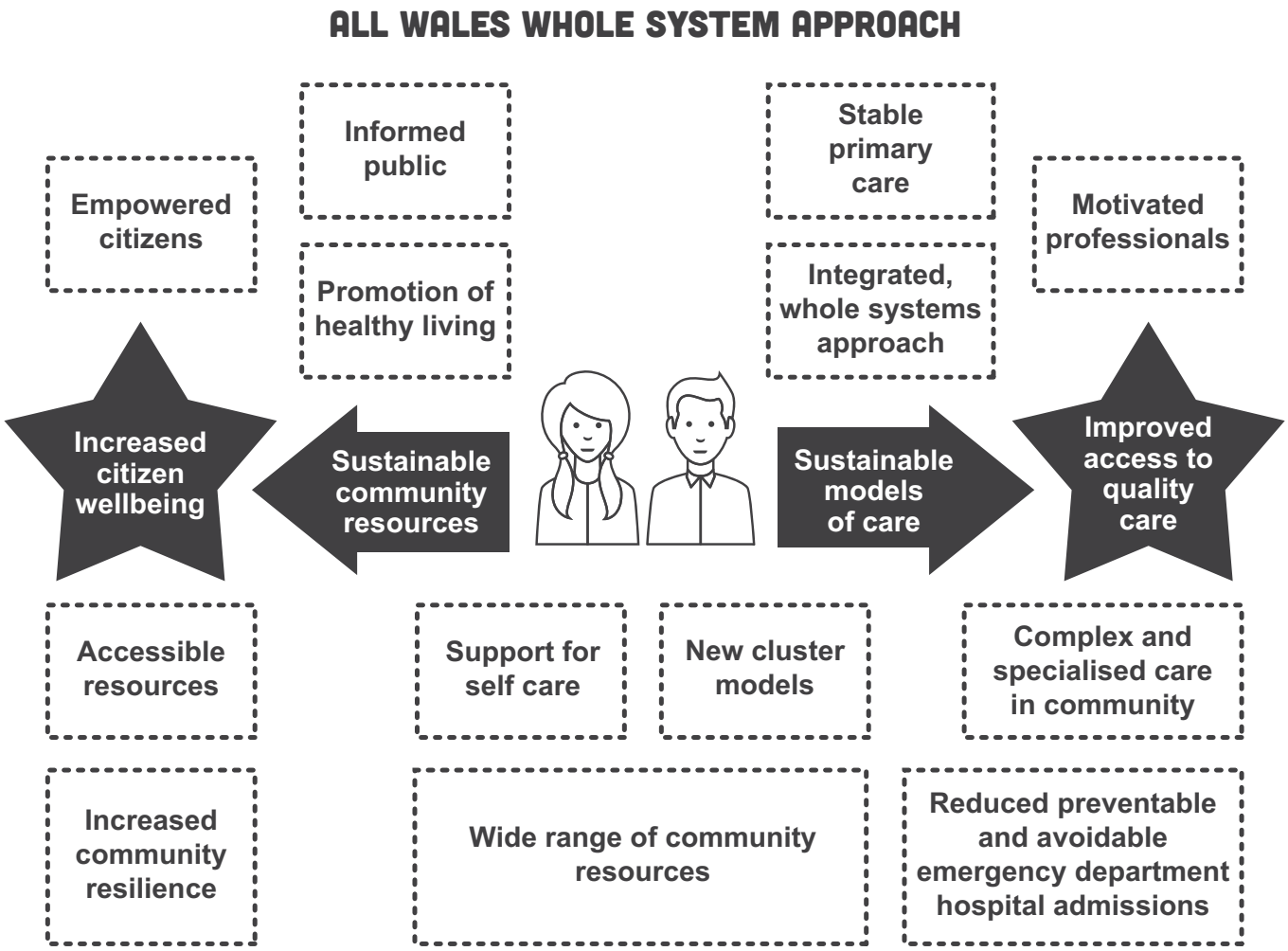
The NHS is strengthening primary care planning through a specific model, a national strategic programme and dedicated national leadership roles

1.5 The NHS in Wales is taking steps to strengthen the planning and delivery of strategic change in primary care. The NHS has introduced a tiered approach where primary care planning is happening at a national level, health board level and cluster level.

1.6 At a national level, the Primary Care Model for Wales aims to ensure a whole systems approach to service redesign. As summarised in Exhibit 3, key components of the model include informed and empowered citizens, self-care, stronger community services, new first points of contact for patients and stronger multi-disciplinary working. The model has emerged from the new ways of working that have been successful in the pacesetter programme. The model has evolved over the last three to four years, with its name changing at least twice.

1.7 During 2019-20, the Welsh Government is funding the development of a national evaluation framework to be used locally to report on the impact of the Primary Care Model for Wales. The evaluation is intended to provide interim assurance of progress in implementing the model. The Primary and Community Care Development and Innovation Hub will share learning across Wales from 2020.

Exhibit 3 – the Primary Care Model for Wales



Source: Wales Audit Office adaptation of a diagram from the **Strategic Programme for Primary Care**, November 2018

1.8 The Strategic Programme for Primary Care[12] has been established to provide key workstreams to support the implementation of the primary care model. The National Primary Care Board recognises that the model needs to evolve again to focus more on prevention and wellness, and to move towards the social model of care described in A Healthier Wales. To improve coordination and delivery of change, the strategic programme has six workstreams[13], each jointly led by a director of primary and community care and a professional lead who has specific expertise in the area of work. Each workstream is developing an action plan focused on critical areas that need further development in order to deliver the vision.

1.9 The Welsh Government has strengthened senior leadership arrangements to drive change. The chief executive of Aneurin Bevan University Health Board has lead responsibility for primary care, including primary care out-of-hours services and the 111 service[14]. There is a National Director and Strategic Programme Lead for Primary Care and a programme manager was appointed in March 2019 to drive the strategic programme. There is also a national professional lead for primary care. These arrangements are a positive step as they increase the capacity and skills dedicated to driving change in primary care.

1.10 The Welsh Government provides direction to the health boards through its guidance on the health board integrated medium-term plans. Our local work found that health board primary care plans aligned with the key aspects of the national priorities. We also found that all clusters had plans setting out priorities for improving primary care in their local area, and all health boards had primary care plans that were, to some extent, fed by the cluster plans.

1.11 Analysis by the Primary and Community Care Development and Innovation Hub, on behalf of the Directors of Primary and Community Care Group, was undertaken to review the focus on the Primary Care Model for Wales by health board executive teams and boards. The findings indicate that primary care and community services have greater prominence within health boards' integrated medium-term plans for 2018-19 than in previous years[15].

12 National Primary Care Board, **Strategic Programme for Primary Care**, November 2018

13 1. Prevention and well-being, 2. 24/7 Model, 3. Data and Digital Technology, 4. Workforce and Organisational Development, 5. Communication and Engagement, 6. Transformation and the Vision for Clusters.

14 The Welsh Ambulance Services NHS Trust has responsibility for the service delivery and provision of 111 call handling and triage.

15 Public Health Wales, **Review of Health Board IMTPs (2018-19): Primary Care Transformation Perspective**, November 2018

New ways of working are emerging but there is a need to spread good practice, improve evaluation and ensure sustainable funding for successful schemes

1.12 The Primary Care Pacesetter Programme began in April 2015, aiming to stimulate innovation. In 2015-16, as part of the £43 million National Primary Care Fund[16], the Welsh Government allocated £3.8 million to health boards, on a recurring basis, for the projects which make up the national pacesetter programme. Twenty-four projects were initially set up to test out new ways of working in primary care. Many of the projects employed different practitioners, like pharmacists and physiotherapists, to work in GP practices and tried out different ways for patients to contact their local practice. Fifteen new projects were started in 2018-19 and are expected to run for two years[17]. Further project are being considered for pacesetter funding for 2020-2022.

1.13 Our work in health boards highlighted three main issues with pacesetters:

- **Slow spread of good practice** – we found that health boards and clusters were piloting new ways of working but in many cases, good practice had not spread far beyond the original pilot.
- **Limited evaluation of new ways of working** – we found limitations in approaches to evaluating new ways of working, such as a lack of a standardised methodology to provide evidence of positive outcomes and to inform decisions on whether to expand these ways of working.
- **Difficulties in mainstreaming funding** – we found that health boards can struggle to sustain and mainstream successful schemes once the pacesetter programme funding ends.

16 The main items within the £43 million fund included £26 million to support the delivery of health board plans for primary and community care, £10 million for the clusters, and £3.8 million for the pacesetters. There was also funding to encourage specific services, such as anticoagulation services and services for wet age-related macular degeneration, to shift from hospitals to community settings.

17 The list of all projects can be found at the following links: **www.primarycareone.wales.nhs.uk/projects** and **www.primarycareone.wales.nhs.uk//page/95999**

1.14 In June 2018, the University of Birmingham published an independent appraisal of the pacesetter programme, commissioned by the Primary and Community Care Development and Innovation Hub on behalf of the Directors of Primary and Community Care Group. It concluded that the programme had been a 'valuable experience' for those leading individual projects, and for health boards. The appraisal also found a need for:

- greater clarity about the objectives and sustainability plans for each project;
- better governance for the programme, involving a wider range of stakeholders;
- more time for health boards to develop their project proposals;
- more patient and community input when designing the projects;
- project management and evaluation support for those leading projects;
- a better evaluation framework for the projects; and
- more structured opportunities for sharing learning between health boards.

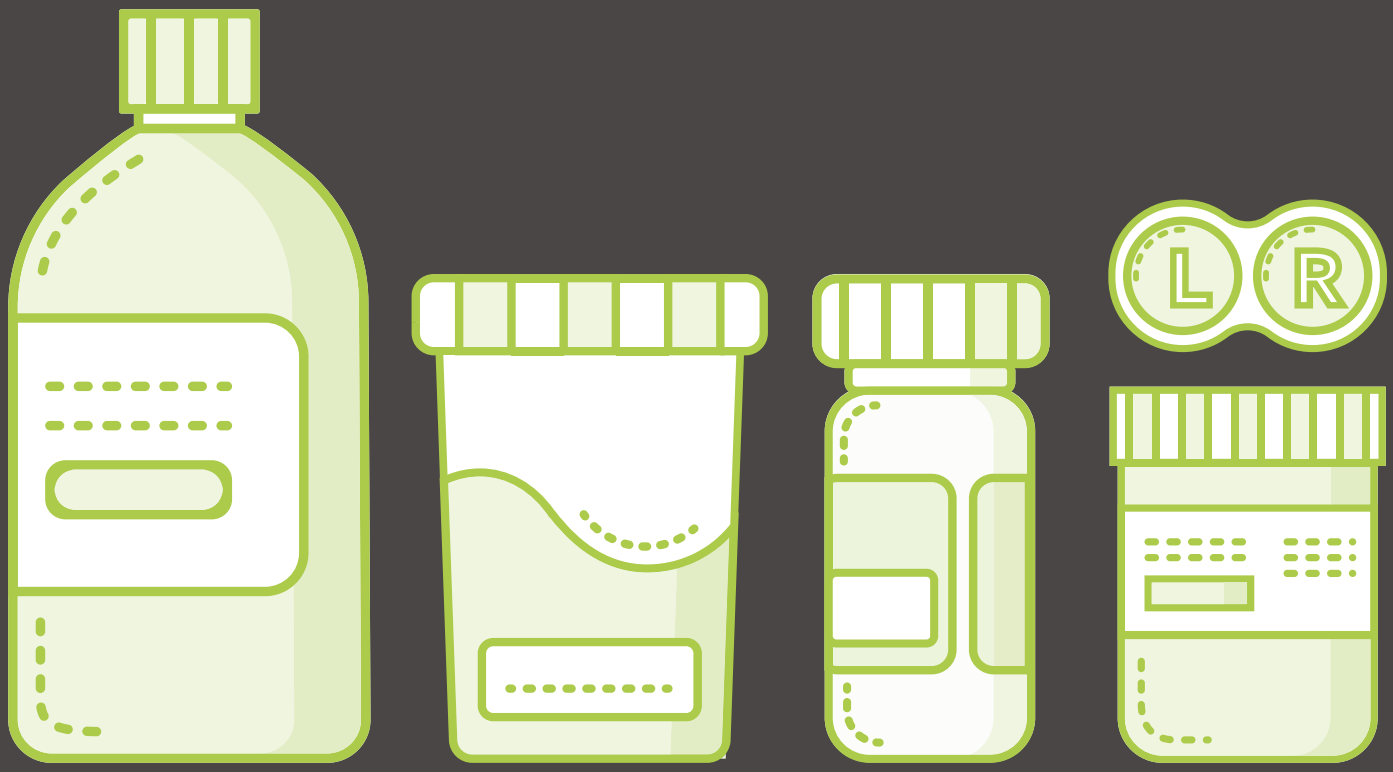
1.15 The appraisal led to an all-Wales learning event and a workshop, where key messages were explored with various stakeholders at the Regional Partnership Board level. Building on the findings of the appraisal, and at the request of Welsh Government, the Directors of Primary and Community Care Group undertook its own evaluation of pacesetters, specifically to support the roll out of the 2019-20 pacesetter programme. The group assessed whether the pacesetters covered all of the themes in the Primary Care Model for Wales and aligned with the three aims of the National Primary Care Fund, namely sustainability, improved access and increasing the availability of care in the community. The evaluation concluded that all components of the model have been covered by the pacesetters although some elements have had greater emphasis, such as multi-disciplinary working.

1.16 The evaluation also reported that health boards are working on how successful schemes can be adapted and adopted across Wales through the integrated medium-term planning process. Further work is now planned to strengthen evaluation and facilitate the roll out of successful programmes into other areas[18].

18 Directors of Primary and Community Care Group, **Review of 2018/19 Pacesetter Programme and Proposals for 2019/2020 Programme**, January 2019

Part 2

Change needs to happen at greater pace and scale to address longstanding challenges and ensure strained primary care services are made fit for the future



There are increased pressures on the traditional model of primary care and continued difficulties in accessing appointments

2.1 There are a number of trends that suggest growing pressure on the traditional GP practice model. Appendix 1 describes these trends in detail and the bullet points below summarise the key points:

- a the number of GP partnerships[19] in Wales has reduced. In 2014 there were 462 partnerships but in 2018 this had reduced to 420. This is partly due to mergers of partnerships to create larger practices but is also due to closures when practice lists are dispersed to other practices.
- b the number of GP practitioners in Wales has fluctuated but in 2018, there were 42 fewer GPs than in 2014. The number of GP locums increased by 144 between September 2015 and September 2018, suggesting a shift of service provision that relies more on temporary staff.
- c the number of GPs per 100,000 population in Wales has fallen slightly from 63.2 in 2014 to 62.6 in 2018. This is higher than England (58) but much lower than Scotland (76)[20].
- d the age profile of GPs has been raised as a concern for the sustainability of services because older GPs are more likely to retire in the near future. The data show that between 2014 and 2018, the proportion of GPs aged over 55 has actually reduced slightly while the proportion of GPs in the 30-44 age group has increased.

2.2 There are limitations in the current data relating to numbers of GPs, for example there is no recording of how many hours each GP works, with many working part-time. Whole time equivalent data has not been available since 2013. The Welsh Government has launched the Wales National Workforce Reporting System to secure better data which should in future create a clearer picture of the GP workforce, and the pressures it is facing.

2.3 The General Practitioners Committee Wales has highlighted some of the increasing pressures on GP workload. The committee says these include changes to the Personal Independence Payment scheme requiring additional letters from GPs; local authorities increasingly requiring a mobility assessment for disabled people to support applications for a Blue Badge; and patients on hospital waiting lists being re-referred back to the GP in order to expedite appointments.

19 Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019
20 Nuffield Trust, **Is the Number of GPs Falling Across the UK?** May 2019

2.4 There are also some financial issues that threaten the sustainability of the traditional GP practice model because they could potentially persuade GPs to retire early. These issues are summarised below:

- **NHS Pension Scheme changes** – the amount of pension that GPs can accrue over their career and the annual amount of pension they can accrue without being taxed have both reduced. This is reported to be contributing to doctors retiring at a younger age and is persuading some doctors to cut back on the number of sessions they work. The UK Government is considering how to respond to these challenges.
- **Last person standing** – GP partnerships share financial liabilities (and any benefits) across all partners. If several partners retire or leave for other reasons, one partner may be left with outstanding liabilities[21] of the practice. If the remaining partner cannot find other doctors to take on the partnership, they may decide to close the practice. The Welsh Government is now considering steps to address this.

2.5 Ongoing changes to national IT systems are also adding to the pressure on some GP practices. Around half of the practices in Wales have had to change the supplier of their practice IT system after the original supplier's contract ended. There have been delays in implementing the new systems and some affected GPs have expressed concerns at the significant disruption involved in these changes

2.6 When a GP practice is at risk of closure, the health board follows a formal process to decide whether or not to maintain that practice's services by taking over the direct management of the practice. The number of directly managed practices in Wales fluctuates but at the time of our fieldwork in 2018, there were 24 practices managed directly by five health boards. While some health boards have used primary care support units for many years to provide short-term support to prevent GP practices from failing, we found that health boards are increasingly using these units to take over the management of practices.

2.7 In many areas in Wales people are experiencing difficulties getting an appointment with a GP. The proportion of people finding it difficult to get an appointment decreased slightly from 42% in 2017-18 to 40% in 2018-19 although this level remains of concern and varies around Wales (Exhibit 13)[22]. Exhibit 14 and Exhibit 15 suggest a small improvement in GP practice opening hours. There has also been an increase in the overall rate of satisfaction with care received at GP appointments, from 86% in 2017-18 to 93% in 2018-19[23].

21 Such liabilities could include leases on rented buildings, outstanding mortgage, negative equity on buildings and redundancy payments.

22 Welsh Government, **National Survey for Wales 2018-19: Hospital and GP Services**, June 2019

23 Welsh Government, **National Survey for Wales 2018-19: Hospital and GP Services**, June 2019

Progress is patchy in delivering a multi-professional primary care model

2.8 The NHS in Wales is working on long-term solutions to sustainability in primary care by increasing the number and range of other professionals working in primary care settings. This is partly about relieving the pressures on the current GP-centric model of care, but it is also about creating a better model of care where patients have improved access to a wider range of professionals. Box 2 summarises some of the new roles that are supporting the move towards implementing the multi-professional model.

Box 2 – Examples of steps taken towards implementing the multi-professional model

Physiotherapists – direct access to physiotherapy aims to reduce the need for GP appointments and provide more timely assessment and treatment for musculoskeletal conditions. The Chartered Society of Physiotherapy has guidance[24] including costings to support clusters considering employing physiotherapists.

Pharmacists – pharmacists are undertaking wider roles in practices, such as providing prescribing advice, undertaking annual reviews of patients' medication and independent prescribing. These pharmacists can be employed by the practice, or the health board and may work in an individual practice or across several practices or clusters.

Advanced nurse practitioners – have had additional training to allow them to diagnose, prescribe medications and treat a wide range of acute illnesses and chronic conditions within their scope of practice.

Physician associates – clinically trained healthcare professionals who work with a dedicated medical supervisor but can work autonomously with appropriate support.

Lifestyle support, social prescribers and community connectors – because health is influenced by social, economic and environmental factors, social prescribing aims to help people access different activities. These professionals go by different names but are being piloted in a number of clusters.

Source: Wales Audit Office

24 Chartered Society of Physiotherapy, **General Practice Physiotherapy Posts: A Guide for Implementation and Evaluation in Wales**, July 2017

2.9 Despite these positive steps, we found that progress in implementing the multi-professional model has been patchy. Our local work found a number of barriers[25] to expanding the model, as summarised below:

- filling vacancies can create gaps elsewhere as professionals are recruited from other parts of the health and care system.
- many of the new roles require supervision, training and mentoring. This can mean the new roles are not immediately autonomous, and there can be a significant time commitment from those providing the oversight, which can make it more difficult to meet patient demand.
- more needs to be done to share and spread good practice to ensure these extended roles are implemented at pace and scale.
- there needs to be more strategic thinking about the development of these new roles. For example, there could be benefits from introducing more standardised training, job descriptions and specific career paths for these professionals.

2.10 The NHS in Wales is now taking steps that attempt to address some of the issues listed above. The Welsh Government recognises that implementation of the Primary Care Model for Wales is inconsistent and expected health boards to respond to this in their integrated medium-term plans[26] covering 2019-20 to 2021-22. In addition, a national compendium of role descriptors has been developed. Clusters considering employing staff can now use the descriptors to prevent unhelpful variation in the roles and remits of these professionals across Wales[27].

2.11 The Strategic Programme for Primary Care workstream on workforce is pulling together learning from the pacesetters to address issues related to pay and employment and to make primary care a more attractive place to work. The workstream is also developing a cluster workforce planning tool and important work is ongoing between Health Education and Improvement Wales and Social Care Wales to develop a workforce strategy to cover all of health and care by November 2019.

25 The August 2018 report by the Primary and Community Care Reference Group entitled Multi-Professional Roles within the Transforming Primary Care Model in Wales, provides more detailed evidence about these barriers and issues.

26 Welsh Government requires all health boards and NHS trusts to submit an integrated medium-term plan setting out how resources will be used over a three-year period. The plan must: address areas of population health need; improve health outcomes and quality of care; and ensure best value from resources.

27 NHS Wales Shared Services Partnership, Workforce, Education and Development Services, **Emerging Roles and Models in Primary Care**

Progress has been slow in shifting resources towards primary care although it is difficult to quantify exactly how much is spent on primary care

2.12 Exhibit 4 provides basic analysis from the NHS accounts of expenditure on contracted primary care services. When inflation is accounted for, the figures suggest a small (0.4%) real terms increase in primary care spending by health boards between 2014-15 and 2018-19[28]. Within this overall figure are large increases in general medical services and ophthalmic services.

Exhibit 4 – the NHS accounts suggest a small increase in primary care spending in Wales but limitations in these data make robust trend analysis difficult

	£ millions				
	2014-15	2015-16	2016-17	2017-18	2018-19
Prescribed drugs and appliances	511.8	522.3	519.6	523.9	507.7
General Medical Services	476.1	486.7	487.2	517.6	550.1
General Dental Services	172.5	173.0	173.9	178.2	185.2
Pharmaceutical Services	151.7	148.7	150.1	150.5	151.4
General Ophthalmic Services	32.0	32.6	39.0	41.6	42.0
Other Primary Health Care expenditure	25.7	31.4	29.6	34.7	36.3
Total	**1,369.7**	**1,394.6**	**1,399.3**	**1,446.4**	**1,472.7**

Source: Wales Audit Office analysis of the health boards' annual accounts.

28 For an explanation of the categories of spending see the Wales Audit Office report, **A picture of primary care in Wales**.

2.13 However, Exhibit 4 does not provide a particularly robust picture of primary care spending because it does not include spending in relation to the National Primary Care Fund (see paragraph 2c), nor does it include spending in relation to other central funds that are indirectly relevant to primary care. These funds include the £100 million transformation fund (see paragraph 4), the Integrated Care Fund and the Efficiency Through Technology Fund.

2.14 A key finding from our work is that it is difficult to quantify exactly how much the NHS in Wales is spending on primary care, and how much this is changing over time. We reached this conclusion because:

a spending on some aspects of primary care is not consistently categorised across health boards, making comparisons difficult across organisations.

b accounting changes over time make trend analysis difficult, and complicate efforts to monitor whether the NHS is achieving its ambition of shifting resources toward primary care.

c primary care services and primary care transformation can be funded from multiple sources, making it difficult to track and compare the totality of investment in primary care.

d some health board primary care activities are not included in the primary care section of their accounts, meaning the accounts do not represent the totality of spending on primary care. Examples include contracts with voluntary organisations and spending on health board staff that support primary care services.

e in some services and specialties, elements of service provision are provided in primary care, whilst other elements are provided in hospital. The cost of the primary care elements is often difficult to define.

2.15 We assessed whether health boards are taking specific actions to achieve a shift in resources towards primary and community care. The bullet points below suggest health boards are taking some actions but faster progress is required:

- all health boards have examples of some secondary care services now being delivered in primary or community settings (ie shifting certain audiology services into GP practices, employment of diabetes nurses in primary care, and shifts in physiotherapy and occupational therapy services). However, these are fairly isolated examples rather than examples of a wholesale shift at pace and scale.
- no health boards have set targets for moving resources towards primary care.
- no health boards have quantified the total amount of resource moved towards primary care since the inception of the national primary care plan in 2014.
- health boards' plans for transforming primary care have limited detail about how changes will be afforded.
- overall financial deficits can complicate efforts to shift funding and silo working within health boards can result in departments protecting their budgets.

2.16 In July 2018, Welsh Government issued a financial framework to help support the shift of secondary acute services to primary and community delivery[29]. The framework provides detailed guidance for health boards on developing a business case approach to service change and financial savings without jeopardising the quality of care. This report includes a recommendation for the Welsh Government to work with health boards to evaluate, and if necessary, improve the effectiveness of the financial framework.

29 Welsh Government, **Improving Value through Allocative & Technical Efficiency: A Financial Framework to Support Secondary Acute Services Shift to Community/Primary Service Delivery, Welsh Health Circular WHC (2018) 025**, July 2018

Monitoring of primary care performance and activity is limited and the available data suggest mixed success

2.17 We found that performance monitoring in health boards was being hampered by difficulties in obtaining and standardising important primary care data. For example, activity data, such as numbers of appointments and time taken during appointments, could be helpful in planning and monitoring the workload of primary care services. However, GPs, community pharmacists, dentists and optometrists are independent contractors, so the NHS does not have automatic rights to their data. There are also difficulties in ensuring the data collected by independent contractors is standardised and comparable.

2.18 We found weaknesses in the national targets, which can have an influence on where health boards invest their time and resources. Current targets[30] for primary care cover things that are easily measurable, such as numbers of immunisations, quantities of prescribed medicines, and opening times of GP surgeries. Appendix 2 sets out the performance achieved by the health boards against these national targets and shows a mixed picture of performance. A report[31] on attainment of quality improvement measures by Primary and Community Care Development and Innovation Hub in December 2018 found similar variation across health boards and at cluster level. However, the current suite of targets does not provide an effective overview of whether patient outcomes are being improved by primary care.

2.19 The Welsh Government reviews the overall performance of health boards through twice-yearly Joint Executive Team meetings with NHS bodies. Primary care is only a small part of these arrangements. The Welsh Government is looking to strengthen the oversight of primary care through the development of delivery milestones for the Primary Care Model for Wales and by increasing the number of primary care measures considered as part of monitoring arrangements. The Welsh Government is also planning to improve scrutiny of primary care performance by publishing an annual, national report on primary care performance.

30 As described in the NHS Wales Delivery Framework and Reporting Guidance 2018-2019.

31 Public Health Wales, Primary Care Division, **Primary Care Measures: National Variation Report**, December 2018

2.20 In addressing a national primary care conference in November 2018, the Minister for Health and Social Services acknowledged weaknesses in how primary care is monitored. He urged consideration about what is measured and proposed an indicator based on the time that people spend at home, as opposed to measuring the time they spend in hospital.

2.21 Work is underway to introduce more meaningful primary care measures. The Primary and Community Care Development and Innovation Hub developed a set of revised measures for which information is readily accessible[32]. These measures were made available to health boards on the Primary Care Information Portal in March 2018 and as a report in December 2018[33]. From 2018-19, the Welsh Government required health boards, through clusters, to use the measures to inform their primary care plans. The data and digital technology workstream of the strategic programme is developing additional measures.

Much work remains to be done to ensure primary care clusters have a clear remit, broad membership and are able to drive change at pace and scale

2.22 Primary care clusters (described in paragraph 2b) were established in 2010 but as shown in Exhibit 5, very few cluster leads considered their clusters to be 'mature'.

32 These measures include GP practice indicators such as measuring alcohol consumption and medication reviews; public health indicators around screening and circulatory disease mortality rates; and dental indicators such as access to dental care for children and adults.

33 Public Health Wales, **Primary Care Division, Primary Care Measures: National Variation Report**, December 2018

34 Welsh Government, **Phase 2 – primary care quality and delivery measures, Welsh Health Circular WHC (2018) 026**, July 2018

Exhibit 5 – only nine cluster leads thought their cluster was at a mature stage of development

The table shows how cluster leads rated the maturity[35] of their cluster.

	Developmental	Stable and starting to deliver	Mature	No response
Abertawe Bro Morgannwg	1	4	2	4
Aneurin Bevan	1	6	0	5
Betsi Cadwaladr	2	5	1	6
Cardiff and Vale	0	5	2	2
Cwm Taf	1	5	2	4
Hywel Dda	0	4	1	2
Powys	1	1	1	2
Wales	**6**	**30**	**9**	**25**

Note: We sent an online survey to leads at all 64 clusters in Wales in April 2018. The overall response rate was 64% (45/70). A total of 70 responses were received reflecting returns from both cluster and GP network leads in Powys, and more than one lead for each cluster replying in Cwm Taf.

Source: Wales Audit Office survey of cluster leads

35 'Developmental' was defined as 'Still at early stages of development with significant support required: not all cluster members fully engaged'. 'Stable and starting to deliver' was defined as 'Starting to deliver some benefits but still early days, ongoing support required and full potential yet to be reached'. 'Mature' was defined as 'All cluster members fully engaged; delivering across a number of areas in line with the cluster plan'.

2.23 Some confusion remains about the role and remit of clusters. During our fieldwork, we heard how the work of some clusters remains too focused on GP practices rather than the wider primary care system. And we heard how the membership of some clusters needs to broaden. Our cluster lead survey revealed that while the majority of clusters had third sector representation, approximately half had local authority representation, and very few had a lay member.

2.24 Our fieldwork also revealed some concerns about the effectiveness of clusters in driving change at pace and scale. Some interviewees told us that clusters can struggle to take timely decisions, particularly around spending and procurement, which can delay service changes. We also heard mixed views about whether or not clusters should have more or less financial autonomy from their health boards.

2.25 In October 2017, the Health, Social Care and Sport Committee reported on its inquiry into primary care clusters. The report concluded that clusters had achieved many positive developments but highlighted issues with the pace and nature of clusters, including the need for a broader membership base. Funding arrangements, ICT, workforce and premises were also highlighted as areas where faster change was required. The committee also suggested work should be undertaken to raise public awareness of the benefits of changes to service models. The committee made 16 recommendations although the Welsh Government rejected five, saying that they did not want to limit the autonomy of clusters to develop based on their local circumstances by being too prescriptive.

2.26 In October 2018, the Primary and Community Care Development and Innovation Hub coordinated production of a governance framework for primary care clusters. The framework was developed with the aim of addressing some of the recommendations from the cluster inquiry and covers key areas such as employing staff, financial arrangements and quality assurance. This is a positive development, although it is too soon to know whether the framework is being used effectively.

2.27 Clusters remain an important aspect of the future of primary care although transformation will require effective joint working between many organisations and groups. A Healthier Wales sets out a vision for seamless health and social care, building on foundations of local innovation, 'including through clusters of primary and community care providers'. A Healthier Wales says that Regional Partnership Boards[36] will 'occupy a strong oversight and coordinating role' and are at the heart of driving change. The Regional Partnership Boards have been allocated monies from the £100 million transformation fund. The National Director & Strategic Programme Lead for Primary Care has a schedule of attendance at Regional Partnership Boards and health boards to provide primary care representation. The NHS in Wales will need to keep in view its engagement with Regional Partnership Boards, to ensure primary care transformation is driven by all relevant stakeholders.

More needs to be done to involve the public in changes to primary care to ensure that people understand how the model will work

2.28 Our local work found variation in the extent to which health boards engaged with the public when developing their plans for primary care. For some health boards we found little or no evidence of public engagement. The approach taken by the rest of the health boards ranged from consulting the public when developing their plan, to engagement on specific projects or service changes.

2.29 The development of the Primary Care Model for Wales has been a gradual evolution that has incorporated good ideas and successful new ways of working as they have arisen. While some elements of the model have been consulted upon with the public at a local level, there has not been formal consultation or public involvement in the overall model at a national level.

2.30 At the national primary care conference in November 2018, the Board of Community Health Councils talked about the importance of public involvement. They stressed that the public care deeply about primary care, although they do not always fully understand what their local services are. The presentation also stated that people fear change they do not understand.

36 In April 2016, seven statutory regional partnerships came into being through the Social Services and Well-being (Wales) Act 2014. Their purpose is to drive the strategic regional delivery of social services in close collaboration with health.

2.31 The findings of our work suggest that given the lack of involvement of the public, there is the potential for confusion and disagreement with the proposed new ways of working in the model. There is also a need to increase awareness, understanding and support for the model amongst NHS staff, who can guide patients to the right service and can act as advocates for the new ways of working.

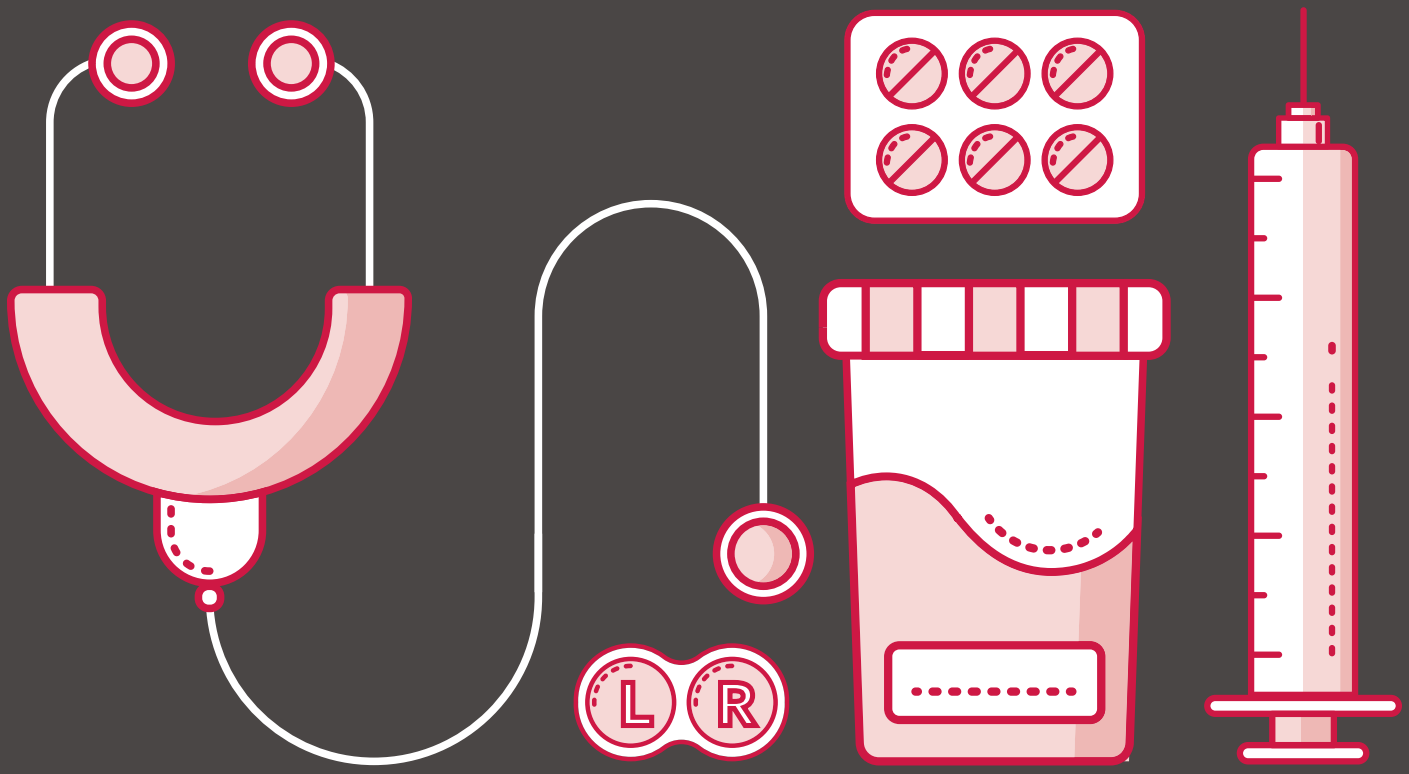
2.32 The Welsh Government has allocated each health board £20,000 a year since 2018-19 to support local activities that improve communication and public messaging about the model. The local activities are based on a national-agreed set of messages. The strategic programme for primary care includes a specific workstream for communication and engagement. This workstream has produced a national communications strategy and a national campaign in 2019.

Appendices

Appendix 1 – Workforce data

Appendix 2 – Performance data

Appendix 3 – Our methods



Appendix 1 – Workforce data

This appendix shows trends in some key data related to the primary care workforce.

There are limitations in the current data relating to numbers of GPs, such as not recording how many hours each GP works, with many working part-time. Whole time equivalent data has not been available since 2013. Welsh Government has launched the Wales National Workforce Reporting System to secure better data which will create a clearer picture of the GP workforce, and the pressures it is facing, in future.

Exhibit 6 – trends in the number of GP partnerships in Wales

There were 420 GP partnerships in 2018, a drop of 42 since 2014. This is an overall decrease of 10% although rates vary from no change in Powys to a fall of 18% in Cwm Taf.

Health Board	2014	2015	2016	2017	2018	Change 2014-2018 (Number)	Change 2014-2018 (%)
Abertawe Bro Morgannwg	76	75	73	71	67	-9	-13%
Aneurin Bevan	88	86	81	79	78	-10	-13%
Betsi Cadwaladr	114	111	109	107	105	-9	-9%
Cardiff and Vale	66	66	66	66	63	-3	-5%
Cwm Taf	46	45	42	42	39	-7	-18%
Hywel Dda	55	54	53	50	51	-4	-8%
Powys	17	17	17	17	17	0	0%
Wales	**462**	**454**	**441**	**432**	**420**	**-42**	**-10%**

Note: The table does not distinguish between resolved partnerships, ie practice lists which have been dispersed to other practices, or practice mergers ie where a new/larger partnership was formed.

Source: Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019

Exhibit 7 – trends in the number of GPs working in Wales

There has been a decrease of 42 GP practitioners since 2014 while there has been an increase in GP locums of 144.

	2014	2015	2016	2017	2018	Change 2014-2018 (Number)
All practitioners (excluding GP Registrars, GP Retainers & locums)	2,006	1,997	2,009	1,926	1,964	-42
GP Registrars (1)	220	231	232	239	230	10
GP Retainers (2)	23	25	19	17	14	-9
GP Locums (3)	---	634	684	754	778	144 (2015-2018)
Other practice staff (4)	7,192	7,379	7,341	7,299	7,505	313
Registered patients (millions)	3.17	3.19	3.2	3.2	3.14	-0.03

Note: Welsh Government obtains this data every 30 September from NHS Digital generated from the Exeter (GP payments) system. Welsh Government has concerns about the quality of the data and has undertaken validation work in 2018. In future, data will be collected through Wales National Workforce Reporting System.

Source: Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019

(1) A practitioner employed for the purpose of training in general practice and in respect of whom a training grant is paid. A GP registrar is either in their second or third year so the GP registrars are not all in the same cohort.

(2) A practitioner who provides service sessions in general practice. They undertake the sessions as an assistant employed by the practice and are allowed to work a maximum of 4 sessions each week.

(3) A GP who deputises temporarily at a GP Practice, usually to cover for an absent GP Practitioner. Such cover should last for no more than 6 months. The GP locums data includes the number of locums registered to work on the Medical Performers List, not the number who were working at that point in time, or who had completed any work during the year.

(4) Includes qualified nurses providing a wide range of services, other staff providing direct patient care who are not nurses, administrators including practice managers and other staff such as cleaners.

Exhibit 8 – trends in the age ranges of general practitioners

The number of GPs aged over 55 has decreased since 2014 but there has been an increase in GPs aged 30-44

	2014	2015	2016	2017	2018	change 2014-18 (Number)
Under 30	22	16	30	17	16	-6
30-44	830	828	879	878	886	56
45-54	686	649	655	595	625	-61
55-64	392	396	381	374	378	-14
65 and over	70	64	64	62	59	-11
Total number	2,006	1,997	2,009	1,926	1,964	-42

Note: This table does not include age data for locums, registrars or retainers listed in **Exhibit 7**.

Source: Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019

Exhibit 9 – trends in the average list size for GP practices

The average list size varies from 1,366 patients for each GP partner in Powys to 1,668 in Betsi Cadwaladr. List sizes have increased slightly on average across Wales since 2014 but there are big differences between areas with large increases in Betsi Cadwaladr and large decreases in Cwm Taf.

	2014	2015	2016	2017	2018	change 2014-18 (Number)
Abertawe Bro Morgannwg	1,563	1,580	1,595	1,665	1,545	-18
Aneurin Bevan	1,570	1,575	1,538	1,605	1,622	52
Betsi Cadwaladr	1,581	1,600	1,595	1,733	1,668	88
Cardiff and Vale	1,620	1,621	1,649	1,651	1,612	-8
Cwm Taf	1,785	1,707	1,730	1,777	1,661	-124
Hywel Dda	1,510	1,606	1,607	1,707	1,548	38
Powys	1,411	1,414	1,330	1,365	1,366	-46
Wales	**1,582**	**1,596**	**1,592**	**1,664**	**1,599**	**17**

Note: Average list size is calculated by dividing the total number of patients on lists by the number of 'All practitioners (excluding GP registrars, GP retainers and locums)'.

Source: Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019

Appendix 2 – Performance data

This appendix summarises some of the key performance data included in the NHS Wales Delivery Framework and Reporting Guidance 2018-2019.

Exhibit 10 – child immunisation rates as at 31 March 2019

The exhibit shows performance in relation to two delivery measures within the guidance:

- Delivery measure 2: Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1. Five health boards met the target of 95%; and
- Delivery measure 3: Percentage of children who received 2 doses of the MMR vaccine by age 5. No health board met the target of 95%.

	% of children who received 3 doses of '6 in 1' vaccine by age 1	% of children who have received 2 doses of MMR by age 5
Abertawe Bro Morgannwg	95.9	91.8
Aneurin Bevan	95.6	92.3
Betsi Cadwaladr	95.4	94.3
Cardiff and Vale	94.3	90.6
Cwm Taf	97.5	93.1
Hywel Dda	93.9	90.3
Powys	96.3	91.3
Wales	**95.4**	**92.2**

Note: 6 in 1' DTaP/IPV/Hib vaccine protects against Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio, Hib infection and Hepatitis B.

Source: Public Health Wales, **Vaccine Preventable Disease Programme. Vaccine uptake in children in Wales; Annual report 2018-19**, June 2019

Exhibit 11 – trends in uptake of flu vaccination 2014-15 to 2018-19: Patients aged 65 years and older

Delivery measure 5i: Uptake of the flu vaccination among: 65 year olds and over. Target 75%. No health board has met the target for this measure.

	Uptake in patients aged 65 and older				
	2014-15	2015-16	2016-17	2017-18	2018-19
Abertawe Bro Morgannwg	65	64.6	65	68.2	68.1
Aneurin Bevan	70.4	70	67.7	68.1	69.7
Betsi Cadwaladr	70.1	68.7	68.7	70.6	71.0
Cardiff and Vale	70	68.9	69	71	69.1
Cwm Taf	67.5	65	64.9	67.7	67.1
Hywel Dda	64.9	63.9	63.4	65	62.9
Powys	66.5	64.3	63.9	66.3	65.5
Wales	**68**	**66.6**	**66.7**	**68.8**	**68.3**

Source: Public Health Wales, **Seasonal influenza in Wales 2018/19**, June 2019

Exhibit 12 – trends in uptake of flu vaccination 2014-15 to 2018-19: Patients younger than 65 who are at risk

Delivery measure 5ii: Uptake of the flu vaccination among: Under 65s in risk groups. Target 75%. No health board has met the target for this measure.

	Uptake in patients younger than 65 at risk				
	2014-15	2015-16	2016-17	2017-18	2018-19
Abertawe Bro Morgannwg	44	43.4	43.7	46.7	43.0
Aneurin Bevan	55.3	52.9	49.4	49.7	46.9
Betsi Cadwaladr	51.4	49.3	49.3	51.6	47.9
Cardiff and Vale	50.4	48.3	48.3	49	44.0
Cwm Taf	49.8	45.9	45.2	46.8	40.0
Hywel Dda	46.2	43.2	42.3	42.9	38.1
Powys	47.8	44.2	46	47.9	43.1
Wales	**49.3**	**46.9**	**46.9**	**48.5**	**44.1**

Source: Public Health Wales, **Seasonal influenza in Wales 2018/19**, June 2019

Exhibit 13 – percentage of people who found it difficult to make a convenient GP appointment

Delivery measure 47: Percentage of people (aged 16+) who found it difficult to make a convenient GP appointment. The target is to achieve an annual reduction. Three health boards achieved this measure in 2018-19.

In 2018-19, on average 40% of respondents across Wales who had seen their GP in the last 12 months found it fairly difficult or very difficult to get an appointment.

	2017-18 %	2018-19 %
Abertawe Bro Morgannwg	48	37
Aneurin Bevan	48	41
Betsi Cadwaladr	37	37
Cardiff and Vale	42	45
Cwm Taf	48	46
Hywel Dda	35	36
Powys	33	37
Wales	**42**	**40**

Source: Welsh Government, **National Survey of Wales. April 2018 to March 2019**, June 2019

Exhibit 14 – daily opening hours - Percentage of GP practices open during daily core hours or within 1 hour of daily core hours

Delivery measure 53: Percentage of GP practices open during daily core hours or within 1 hour of daily core hours.

Opened for daily core hours is defined as:

- practices which were open Monday to Friday from 08:00 to 18:30 each day, with no lunch time closure[37] (as set under the General Medical Services contract).

Opened within one hour of daily core hours is defined as:

- practices which were open Monday to Friday from 08:00 to 18:30 each day, but closed for one hour or less for lunch on one or more days, or
- practices which opened between 08:00 to 08:30 and closed between 18:00 to 18:30 with no lunch time closure.

	2016	2017	2018
Abertawe Bro Morgannwg	85	90	95
Aneurin Bevan	99	99	99
Betsi Cadwaladr	74	78	81
Cardiff and Vale	88	88	87
Cwm Taf	90	90	90
Hywel Dda	74	73	80
Powys	100	100	100
Wales	**85**	**87**	**89**

Note: GP practices returned data collection forms to Welsh Government in January 2019 and refer to December 2018.

Source: Welsh Government, **GP Access 2018**, March 2019 and Welsh Government, **GP Access 2017**, March 2018

37 Where practices close their premises for lunch, they often remain open to respond to phone calls.

Exhibit 15 – weekly opening hours – percentage of GP practices open for 100% of core hours or longer

While Exhibit 14 considers daily opening hours of practices, Exhibit 15 considers the total opening hours across a week. It shows that on average, 53% of GP practices are open for at least 52.5 hours a week which has increased from 51% in 2016.

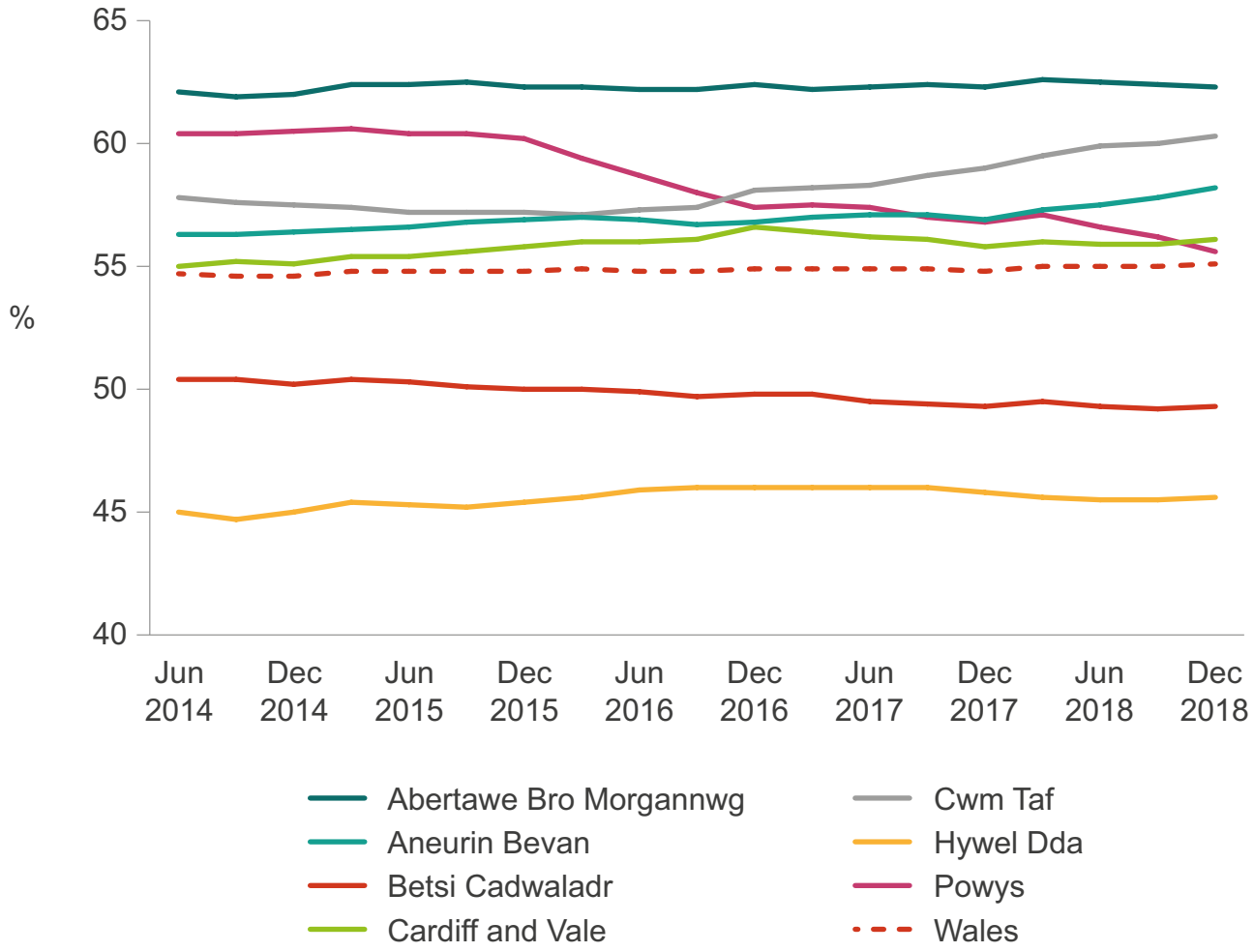
	2016	2017	2018
Abertawe Bro Morgannwg	41	49	51
Aneurin Bevan	83	84	86
Betsi Cadwaladr	34	38	40
Cardiff and Vale	44	44	45
Cwm Taf	67	59	56
Hywel Dda	43	41	41
Powys	53	53	50
Wales	**51**	**52**	**53**

Note: GP practices returned data collection forms to Welsh Government in January 2019 and refer to December 2018.

Source: Welsh Government, **GP Access 2018**, March 2019

Exhibit 16 – percentage of residents treated at an NHS dental practice in the previous 24 months, between 2014 and 2018

Delivery measure 57: Percentage of the health board population regularly accessing NHS primary dental care. Target is for annual improvement but the data shows little improvement in access rates since 2014.



Note: Data are shown for patients seen over 2 years each quarter ending 31 December 2018. The data is derived from dental activity forms submitted for payment and processed by NHS Business Services Authority Dental Services.

Source: Welsh Government, **NHS Patients Treated for Adults and Children by Local Health Board**, December 2018

Appendix 3 – Our methods

We reported on primary care services in each health board during 2018. Our local fieldwork took place between February and May 2018. We carried out our national-level fieldwork in late 2018 and mid 2019. Details of our approach are set out below.

Exhibit 17 – our methods

Method	Detail
Health board self-assessment	We used a self-assessment questionnaire to gather corporate-level data from each health board.
Document review	We reviewed key documents relating to primary care at each health board. We also reviewed documents from the National Primary Care Board and other national groups.
Interviews	We interviewed: • a range of staff at each health board including executives, senior managers, operational managers and clinical leaders; • representatives from community health councils; • representatives from the British Medical Association's General Practitioners Committee and the Royal College of General Practitioners; • staff from Welsh Government; and • a range of other people involved in planning and delivering primary care in Wales.
Cluster lead survey	We sent an online survey to all cluster leads in Wales in April 2018. The overall response rate was 64% (45/70).
Review of health boards' integrated medium-term plans	We reviewed the health boards' medium-term plans to assess the extent to which primary care is included.
Use of existing data	We used existing sources of data wherever possible such as Welsh Government and Public Health Wales statistics.

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Auditor General for Wales

Structured Assessment 2019 – **Betsi Cadwaladr University Health Board**

Audit year: 2019

Date issued: December 2019

Document reference: 1635A2019-20

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The team who delivered the work comprised Andrew Doughton, Fflur Jones, and Mike Whiteley under the direction of Dave Thomas.

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2019 structured assessment work at Betsi Cadwaladr University Health Board (the Health Board). The work has been undertaken to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

2 Our 2019 structured assessment work has included interviews with officers and Independent Members, observations at board and committees and reviews of relevant documents, performance and financial data.

3 The key focus of structured assessment is the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. This year, auditors paid critical attention to the finance and performance of the Health Board in the context of short-term recovery actions and long-term strategic service changes necessary to ensure services become sustainable. The report groups our findings under five themes:

- the Health Board's performance trends;
- vision and planning;
- turnaround and transformation;
- governance and management, and
- workforce efficiency and effectiveness.

Background

4 The Health Board is in a period of sustained difficulty and has been in 'special measures', the highest level of escalation within the Welsh Government's NHS Escalation and Intervention Framework, since June 2015. The escalation to special measures in 2015 was associated with concerns about organisational leadership and governance, mental health services, maternity services, primary care out of hours and broader concerns about connecting and engaging with the local population.

5 Since then there have been improvements in specific areas which have resulted in maternity services and primary care out-of-hours services being taken out of Special Measures. However, these improvements have been tempered by growing concerns about financial management and other specific aspects of performance, which has resulted in these areas being added to the Special Measures oversight arrangements.

6 The ability to contain expenditure within its resource limit has been a particular challenge for the Health Board, since the introduction of the NHS Finance Act (Wales) 2014, and it has never managed to prepare an approvable Integrated

Medium-Term Plan (IMTP). In relation to the performance, the Health Board has long-standing challenges with meeting targets for referral-to-treatment times, aspects of unscheduled care, and follow-up outpatient appointments. More positively, since the imposition of Special Measures in 2015, there have been recognised improvements to mental health services and strengthened leadership structures within the division, noting that there is still more to do to address the concerns identified in the Ockenden and HASCAS reports. Action has also been taken to secure improvements in board effectiveness, overall governance arrangements, and a number of important quality metrics.

7 Wales Audit Office structured assessment reports have provided a commentary on progress and challenges at the Health Board for several years. Last year, we concluded that 'while the Health Board is strengthening its governance and management arrangements, it continues to struggle to develop financially sustainable medium-term plans and improve priority areas of performance'. Given that this year's report provides a commentary on key aspects of progress and issues arising since our last structured assessment, it should be read with consideration given to our 2018 review.

Main conclusions

8 Our overall conclusion from the 2019 structured assessment work is that the Health Board is still grappling with many of the key challenges we identified in last year's structured assessment. There is evidence of improvements in respect of some important quality metrics as well as a commitment and action to address long-standing problems with finance and key aspects of performance. However, much of the latter is geared towards short-term solutions which are not yet securing the scale of improvement needed. The need to develop a vision and strategy that deliver clinical services which are both financially and clinically sustainable is now more pressing than ever. This needs to be taken forward as part of a Health-Board-wide approach that is focused on continuous improvement and service transformation.

9 A summary of our main conclusions can be found below and the findings that support these are described in greater depth in the detailed report:

- **while long-term quality performance trends are positive, the Health Board's financial position remains of significant concern and challenges persist in respect of performance of services.** The Health Board continues to spend beyond its means, which has resulted in a cumulative £109.9 million deficit over the last three years, a £21.2 million year-to-date deficit in 2019-20, and several key performance measures particularly relating to access to services are significantly off target. Nevertheless, the Health Board's commitment to quality is showing improvement in some areas.

- **there remains a pressing need to develop a strategic vision of health services in north Wales that is both clinically and financially sustainable**. The Health Board has set a high-level strategic direction but needs to be ambitious and clear about changes it needs to make. In doing so the Health Board may have to re-assess the location and shape of services to ensure that they are effective and sustainable in the longer term. This will require effective and strong clinical leadership, engagement and decision making and a well thought out approach to public and stakeholder engagement.
- **while there is evidence of actions in respect of turnaround and transformation, these have yet to secure the required improvements. There is a need to balance short-term actions to control costs with longer-term service improvement and modernisation plans.** The Health Board is significantly strengthening its financial turnaround arrangements in in the short term. However, these are not yet securing the required improvement and there is a risk that the annual cycle of 'deficit and recovery' will continue for some time. Approaches for turnaround in performance are developing, but it is not clear that these will result in sustained improvement without additional funding in future. Our work also indicates that the Health Board needs to build its programme management capacity and capability to support an improved pace of transformation.
- **governance arrangements are generally improving but there is a need to strengthen aspects of the senior management structure and ensure that Board working remains cohesive and constructive**. Our work indicates there is an improving rigour and challenge within Board and Committee meetings, although on occasion this could be more constructive. The executive team is working to improve team effectiveness and cohesiveness but there is a need for stronger and formalised leadership for acute services.
  Other notable aspects of governance and internal control include revised performance management arrangements and improving annual plan monitoring, and also developing board assurance arrangements, risk management and clinical audit programme and processes.
- **workforce management arrangements are clearly strengthening, but there remain long-standing challenges in relation to recruitment, productivity and modernisation.** The Health Board is demonstrating a positive direction of travel in workforce planning and there continues to be a proactive approach for workforce management. However, the extent of the challenges faced, particularly in relation to recruitment and retention, means that these issues will take a long time to resolve. This is resulting in a high use of agency and locum staff, and new challenges, such as personal pension related tax liabilities may result in increased agency cost and/or impact on service performance. Efforts also need to be concentrated on

securing improvements in the efficiency and productivity of existing resources.

Recommendations

10 Recommendations arising from this audit are detailed in Exhibit 1. We will place the Health Board's management response to these recommendations on our website along with our report once considered by the relevant committee.

Exhibit 1: 2019 recommendations

Recommendations
Clinical strategy and service planning R1 Ensure that work to develop a clinical services strategy is delivered to planned timescales and includes a fundamental review of the shape and location of clinical services across all three main hospital sites. This work should focus on solving a number of service sustainability issues including: • medical staffing, vacancy gaps and on-call rota management; • service efficiency and affordability; • ability to meet forecasted growth in service demand; • mitigate the impact of unscheduled care on the effectiveness of wider services; and • enabling sub-specialisation of clinical services, where beneficial.
Clinical engagement in service design and transformation R2 Ensure clinical engagement and leadership are integral elements as part of the development of clinical strategy and associated change programmes.
Programme management arrangements supporting service change and transformation R3 To support effective delivery of clinical strategy, introduce a clear programme management structure, change programmes and programme management methodology. This should incorporate both required central and corporate structure as well as resources to enhance division-level change management capacity.
Executive team structure R4 The Health Board should review the form and function of the executive team to: • ensure that there is clear responsibility for acute care services at an Executive level; • ensure that programme leadership for service transformation has clear executive director level responsibility or responsibilities; and • increase focus on strategy, organisational design and the capacity and capability within the organisation to deliver the necessary change.

Recommendations	
Reliance on temporary management staffing	
R5	As part of the Health Board's wider approach to workforce planning, aim to reduce reliance on external interim management by building the required senior manager capacity and capability within the organisation, especially in relation to service transformation and change.
Acute services structure	
R6	Finalise and agree the management structure for acute services.
Audit recommendation tracking and sign-off	
R7	Ensure that senior management processes for reviewing and sign-off are strengthened so that the audit committee is assured that progress is accurately reported and that actions in response to recommendations are delivered in a timely and effective manner.

Detailed report

Performance trends

11 This year's structured assessment work is informed by an analysis of performance. We considered a range of metrics, with a focus on quality, access to services and finances. Our analysis on performance informs our view later in the report on the sustainability of current service models.

12 Our work has identified in 2019 that **while long-term quality performance trends are positive, the Health Board's financial position remains of significant concern and challenges persist in respect of performance of services.**

Quality of services

13 **Quality improvement work is demonstrating the Health Board's commitment to the quality of care with early signs of improvement in some areas.**

14 As part of the Health Board's quality improvement strategy, it has continued to focus on quality arrangements through development of its quality improvement hub[1], particularly in relation to nursing metrics, rollout of the ward quality dashboard and ward accreditation[2]. Electronic ward quality dashboards are actively used as a basis for monitoring and management on an ongoing basis and the supporting intelligence also informs the programme of ward accreditation. As at July 2019, the ward accreditation included 42 unannounced visits. The accreditation applies strict criteria and as a result 23 have been rated silver, 12 bronze and seven white. No wards have been rated gold wards at present, but we understand a number have implemented improvement actions, and hope for a positive re-assessment.

15 In terms of quality indicators, there are examples that the Health Board in setting more challenging stretch targets. Selected performance data shows signs of improvement in some areas:

- long-term trends for C. difficile, an area that we highlighted as a concern in 2012, have significantly and consistently improved over several years;
- in-hospital Staphylococcus Aureus and E. coli infection rates show long-term reduction trends, but both infection types remain a challenge in the community;
- the number of reportable incidents closed within the required timeframe, and the number of Welsh government incidents that remain open shows a continued trend of improvement, both with further opportunity to improve; and
- rates of Healthcare Acquired Pressure Ulcers have improved, but work needs to progress to reduce the occurrence further.

Key aspects of performance

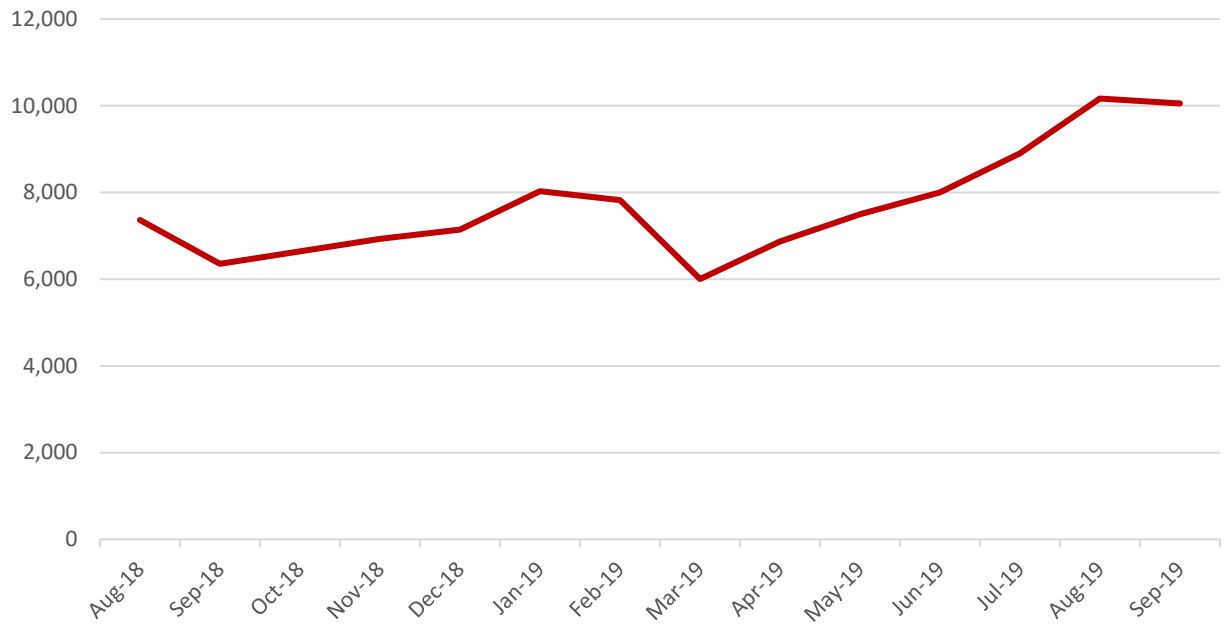
16 **Performance is not improving to the extent that is needed and remains below target in key service areas.**

[1] Betsi Cadwaladr University Health Board – quality improvement hub

[2] Ward accreditation is a process that assesses healthcare practices across North Wales on a range of quality measures and observations

17 Scheduled care remains an ongoing challenge for the Health Board. Based on existing service models, there is a mismatch between supply and demand in some specialties and parts of the referral-to-treatment[3] pathway and follow-up outpatient services. In addition, scheduled care services are negatively impacted upon by unscheduled care demand and a shortage of staff in some key areas. Referral-to-treatment measures (Exhibit 2) show that the Health Board has a high number of patients waiting longer than 36 weeks. The numbers of patients waiting longer than 36 weeks within the Health Board now exceeds the total for the rest of Wales. As in previous years, the Health Board is using outsourcing to provide additional capacity, but this approach adds to cost pressures and while this helps to deal with the waiting list backlog, it does not help balance its own supply and demand. Our recent review of Operating Theatres[4] indicates that there is potential to drive greater productivity and efficiency which will be required to ensure continuous improvement.

Exhibit 2 – the number of patients waiting more than 36 weeks from referral to treatment



Source: Health Board performance report, October 2019

18 The number of patients delayed on the follow-up outpatients waiting list has increased over the 12-month period from around 81,000 patients delayed in August 2018 to around 90,000 delayed as at October 2019. We also understand that there are now 56,000 patients that are 100% delayed (ie waiting at least as twice as long as they should be for a follow-up outpatient appointment). The

[3] https://www.wales.nhs.uk/nhswalesaboutus/nhswaitingtimes

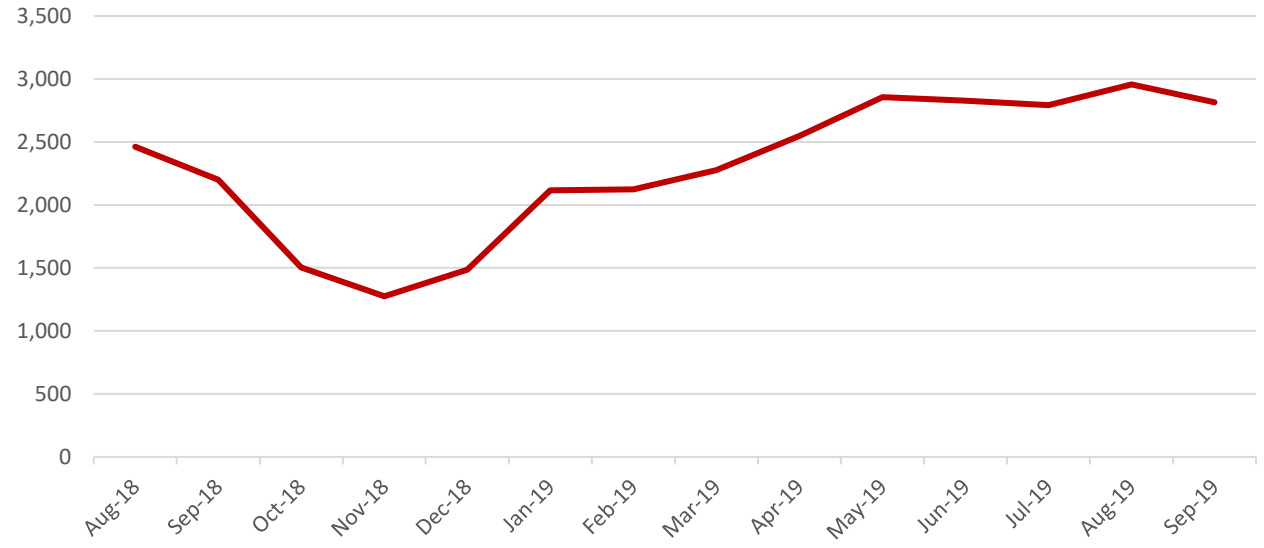
[4] https://www.audit.wales/publication/betsi-cadwaladr-university-health-board-operating-theatres-review

deterioration is concerning given the attention which has fallen on this issue both nationally and locally.

19 The number of patients waiting over eight weeks for diagnostics is also concerning (Exhibit 3). In November 2018, performance started to deteriorate particularly in relation to diagnostic endoscopy. As at September 2019, of the 834 patients waiting over 24 weeks for diagnostic endoscopy across Wales, 830 are from this Health Board. The Health Board has developed several recovery measures, but these have taken several months to implement. In general, these actions have only recently started to lead to improvement, although the Health Board has indicated that there has been greater progress for 'surveillance' patients.

Exhibit 3 – the number of patients waiting over eight weeks for diagnostics

There is a growing number of patients experiencing diagnostic delays



Source: Health Board performance report, October 2019

20 More positively, cancer waiting times compare favourably to the Welsh average. The Health Board has prioritised and protected capacity to ensure that cancer performance is sustained. Throughout the year, the 31-day[5] cancer target of 98% has been achieved in most months and the 62-day[6] cancer target performance has been sustained at around 85% on average, albeit this is below the 95% target.

21 Unscheduled care remains a significant issue for the Health Board. Our analysis shows that demand for unscheduled care at main emergency departments and minor injury units is high and growing

[5] Newly diagnosed cancer patients not included as Urgent Suspected Cancer (USC) referrals to start definitive treatment within one month (31 days) of a decision to treat.

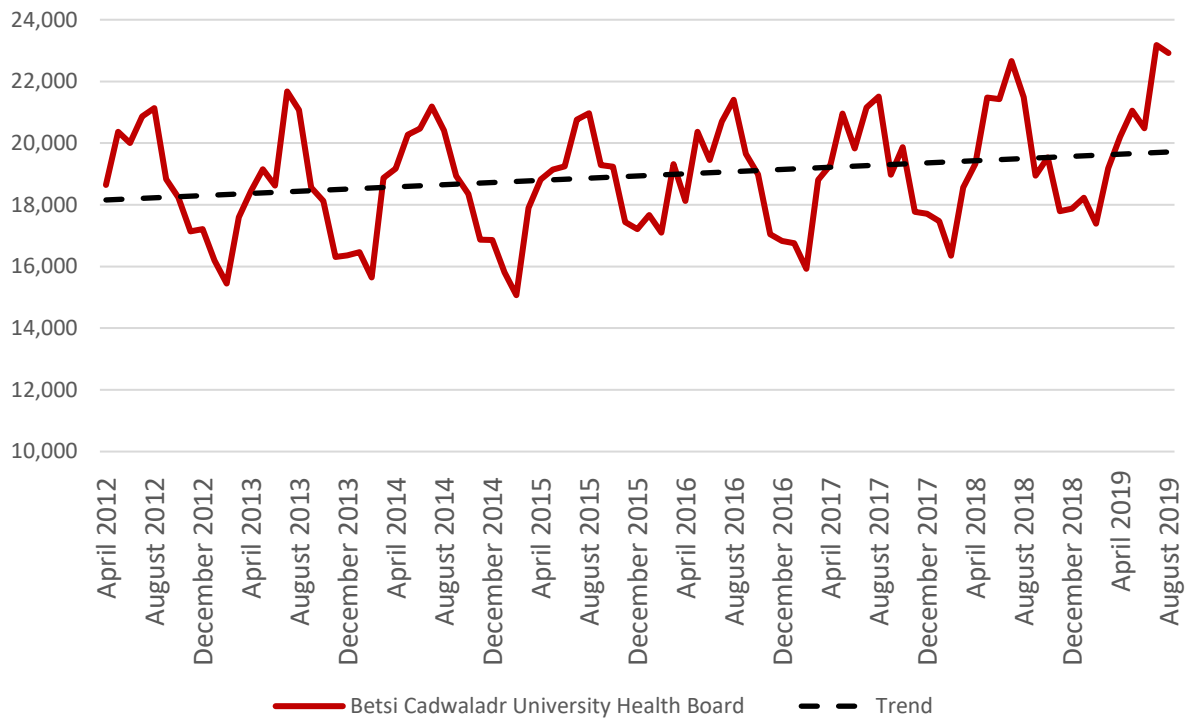
[6] Newly diagnosed cancer patients that have been referred as USC and confirmed as urgent by the specialist to start definitive treatment within two months (62 days) from receipt of referral at the hospital.

(Exhibit 4). Performance against unscheduled care measures indicates current service models are continuing to struggle to adequately meet demand:

- performance against the four-hour target has deteriorated over several years but has improved slightly in the last six months. As at September 2019, 72% patients were seen within four hours against a target of 95%.
- too many patients are waiting over 12 hours in an emergency department setting. In most months there are over 1,500 patients waiting over 12 hours. As at September 2019, 1,977 patients waited longer than 12 hours.
- there were promising signs of improvement for the one-hour ambulance handover target during 2018-19, although there are some signs of deterioration since March 2019, particularly in Ysbyty Glan Clwyd.

Exhibit 4 – the number of attendances at emergency departments and minor injury units

The number of attendances at emergency departments and minor injury units is growing



Source: NHS Wales Informatics Services, accessed via StatsWales, October 2019

Financial position

22 **The Health Board's recurring financial deficit remains a significant challenge.**

23 The Health Board continues to spend beyond its means, which has resulted in an accumulative £156 million deficit over the last five years (Exhibit 5). The Health Board has failed its first financial duty of

the NHS Finance (Wales) Act 2014, and it is concerning that the proportion of deficit is growing and represents an increasing challenge for the Health Board.

Exhibit 5 – financial deficit over the last five financial years

Financial performance against the revenue resource limit shows a significant and recently growing difficulty achieving financial balance.

	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	Cumulative deficit 2016-2019 £m
Financial performance	26.6	19.5	29.8	38.8	41.3	156

Source: Health Board annual report 2018-19

24 Looking to the 2019-20 financial year, the Health Board has set a planned deficit of £35 million, albeit that the Welsh Government has indicated that it expects the Health Board to achieve a 'control total' deficit of £25 million. In July 2019, the Board received, but decided it could not approve, the financial plan as it did not meet the Welsh Government control total.

25 There are a range of saving schemes in place with more in development, but financial performance reported to date shows £3.7 million negative variance against planned expenditure as of month six. This will increase the pressure during the last six months of the year to adopt additional short-term financial recovery measures. The Health Board continues to target a £35 million deficit but if the current financial trend continues for the full-year this could increase to as much as £42.4 million.

Strategic planning

26 Our work considers how the Board sets strategic objectives for the organisation. This includes how it is planning to shape its clinical services and progress with financial planning. We also reviewed the progress made in addressing our recommendations arising from our previous structured assessment reviews.

27 We found that **there remains a pressing need to develop a vision and strategic plan for health services in north Wales that is both clinically and financially sustainable**. Our findings are set out below.

Setting the overall strategic direction

28 **The Health Board has set a high-level strategic direction but needs to be ambitious and clear about changes it needs to make**.

29 In our 2018 structured assessment, we recognised the progress the Board has made agreeing its ten-year **Living Healthier Staying Well** strategy at its Board meeting in March 2018. The three main

elements of this strategy are: more serious health needs (acute services), care closer to home, and health inequalities and health improvement.

30 Over the course of the last year, the Board has approved several plans and it is positive that these generally align to the overall direction of travel set out in the strategy. We also recognise that the Health Board is starting to better align objectives and plans with requirements set out in the Well-being of Future Generations (Wales) Act 2015, albeit those areas most aligned to the Act relate to the 'Healthier Wales' wellbeing goal. We also note a stronger commitment to work with partners and other stakeholders at a strategic and service level and early demonstrations of the 'ways of working'. The transformation fund is providing a positive mechanism to stimulate work with partners, and the Health Board will need to build on this over the next year.

31 While our findings this year continue to reflect those from last year it is increasingly apparent that several existing services are overstretched, and some are fragile. As identified in the previous section, the track record of performance and finance shows the long-term challenge that the Health Board is facing. Alongside these long-term challenges are shorter-term recruitment and rota challenges, set against the context of a healthcare environment which is increasingly sub-specialist and where demand for services is increasing. The growing extent of the challenge means that the Health Board will need to be ambitious and clear about the changes it needs to make.

Developing a clinical strategy

32 **The need to develop a clinical strategy that supports effective, safe and affordable services remains as pressing as ever**.

33 In agreement with Welsh Government, the Health Board was not required to develop an IMTP for 2019-2022. The Health Board prepared an annual operating plan 2019-20 and presented this within a wider three-year outlook plan to the Board in March 2019. There were gaps in the plan at that time and, while a revised version was presented in July 2019, the plan still did not include the required improvement trajectories for finance or performance, therefore the Board were unable to approve it. Notwithstanding the Board's non-approval of the 2019-20 annual plan, it includes clearer lines of accountability and this is creating a stronger focus on delivery. However, there remains a need to better link actions to measures, outcomes, efficiencies and affordability. During 2019, the Health Board has made some progress with elements of service development including opening vascular services and the sub-regional neonatal services in Ysbyty Glan Clwyd, and it has started to progress its orthopaedics plan. The Health Board is also exploring options for stroke care, and robotic assisted surgery in urology. These are positive areas of clinical service progress.

34 Going forward, there appears to be an increasing desire to align health-economy-based and cluster-based planning and clear roles and responsibilities for planning. While not a current Welsh Government planning requirement for the Health Board, the approach for setting out an annual plan in the context of a wider three-year period is also positive and, in the absence of an IMTP, should continue.

35 We first highlighted the urgent need for strategic plans for acute clinical services in our **Joint review with Healthcare Inspectorate Wales in 2013**. Many, but not all, of those we interviewed as part of this year's structured assessment recognise the need for a clinical strategy. The Health Board is in the process of developing a clinical strategy which is expected to be completed during the 2019-20 financial year. Given the recurring challenges in relation to performance and finances and the

challenges recruiting and filling rotas in some high-risk areas, it is vital that the Health Board progresses the work on its clinical services strategy with urgency and pace. This should include a review of the shape and location of existing services, particularly the way services are delivered across the three acute sites. This will require effective and strong clinical leadership and decision making, and a well thought out approach to public and stakeholder engagement (Recommendation 2).

36 The recently issued **NHS planning framework 2020-2023** guidance places a greater onus on commissioning and also decommissioning of services where they are no longer needed, could be better provided elsewhere, or are not providing the expected outcomes or value. As part of engaging stakeholders during planning, there will be a need to engage and explain to the public the extent of issues in relation to timeliness of access to services, quality risks and affordability of services to ensure that there is appropriate context as to why some services may need to change or potentially be de-commissioned.

Enabling plans

37 **The Health Board is starting to develop enabling plans to support improvement.**

38 We have considered the Health Board's estate, workforce and IT/digital plans and, in each case, there is a positive direction of travel. The strategies for estates and workforce were approved in March 2019, and while both will need to align to longer-term plans as they are developed, they are both providing a better framework for shaping the direction of travel for these 'enabling' services. The Health Board's estate is in some areas not fit for purpose with a high level of backlog maintenance and some key risks particularly in Wrexham Maelor Hospital. The Health Board is starting to shape its estates strategy to address some of these risks and provide a bridging position until future estates requirements become clearer. While a digital strategy is not yet agreed, it is in development and there is a clear desire to digitally enable health services.

Financial planning

39 **Financial planning is starting to improve but does not set out a financially sustainable future.**

40 The Health Board continues to face significant challenges with financial planning. For several years, the Health Board has not been able to meet its statutory duties to break even and to prepare a financially balanced three-year integrated medium-term plan. Several factors are resulting in overspends, including, but not limited to:

- growth in staff costs;
- outsourcing and waiting-list initiatives, in services where capacity does not match demand;
- high use of locum and agency;
- growth in continuing healthcare costs; and
- not identifying and achieving opportunities to improve the productivity and efficiency of services.

41 The Health Board is taking positive steps to strengthen its arrangements. With the support of the Welsh Government, it has engaged management consultants to carry out a financial baseline review to support the Health Board in understanding the underlying financial position and the risks to the financial plan for 2019-20. In relation to financial planning, the Health Board has made good progress and is working to:

- move from the current annual planning approach to a multi-year financial recovery plan;
- better link finances to demand and capacity planning; and
- set clear priorities around performance and finance.

42 In previous years' structured assessments, we have commented on the Health Board's short-term approach to securing savings and we remain concerned about the short-term nature of financial planning which often leads to performance and finance being managed as conflicting priorities, ie that to improve performance, the Health Board needs to spend additional financial resource.

43 There is limited evidence to show that the Health Board is moving towards a more transformational approach that aligns clinical, workforce and financial planning and which seeks to exploit the benefits of prudent and value-based healthcare. The Health Board's approach to turnaround and transformation is considered further in the following section.

Turnaround and transformation

44 We have considered the arrangements that the Health Board has put in place to support turnaround and transformation. We found that **While there is evidence of actions in respect of turnaround and transformation, these have yet to secure the required improvements. There is a need to balance short-term actions to control costs with longer-term service improvement and modernisation plans.** Our findings are set out below.

Turnaround

45 **The Health Board is taking steps to improve the financial position and performance in the short-term, but there remain significant risks to the achievement of the planned £35 million deficit.**

46 Overall there is a stronger financial recovery approach than in previous years, but at present there remains a significant risk to achieving the £35 million deficit planned by the Health Board. Our work has found clear financial leadership for turnaround, with delegated responsibility of financial recovery and the identification and achievement of savings. The focus by the organisation on financial recovery, grip and control is clearly stronger than in previous years:

- the Health Board commissioned management consultants to undertake reviews and support savings delivery. Of 330 improvement actions identified through both this work and NHSi[7] grip and control best practice, 177 are complete as at September 2019.
- the Financial Recovery Group is providing better grip and control of finances. This group is supported by a financially oriented programme management office.
- the Interim Financial Recovery Director is providing strong and regular challenge to senior management.
- there is a clear programme of efficiency savings which are risk assessed against likelihood of delivery. The Health Board is supported by external consultants to identify savings.
- vacancy and procurement controls are now in place.

[7] https://improvement.nhs.uk/home/

- executive-led improvement groups are supporting savings programmes, albeit these groups are at differing stages of maturity. We consider the role of these groups on the following page.

47 Nevertheless, there is slippage against delivery of savings and aspects of in-year cost growth which creates a need to identify additional savings. Several other factors continue to present challenges which if unaddressed create a risk that the annual financial cycle of 'deficit and attempted recovery' will continue to repeat. These include the need to:

- embed financial grip and control throughout the organisation and build financial capacity and capability within divisions and reduce reliance on external expertise;
- rationalise estate that is not fit for purpose, and disinvest or decommission activity that provides limited evidence of value;
- align savings priorities across the organisation's structure to ensure that financial efficiency in one division does not result in greater costs or poor performance in another; and
- adopt a more transformational approach to service planning and design.

48 Turning to performance turnaround, work is developing to address key aspects of performance, but the impact of these is not yet leading to continuous improvement in key areas:

- scheduled care – recovery plans now have greater focus on pathway efficiency and productivity than past approaches. These include recovery plans for endoscopy, orthopaedics, ophthalmology and urology. Additional funding to improve aspects of performance is likely to have some positive impact. However, there remain risks to scheduled care performance improvement which include the:
  - frequent management changes in acute services;
  - reliance on interim management staffing;
  - impact of unscheduled care on scheduled care efficiency;
  - extent that outsourcing has a positive impact on those waiting the longest; and
  - pension related taxation that is affecting availability of medical staff.
- unscheduled care – there are a clear range of actions specifically tailored to the needs of each health economy (sub-region of North Wales) The Health Board is adopting a whole-system approach and actions link to improvement metrics, with an improved focus on prevention and diversion (in instances where patients should be seen in alternative settings). While these plans look promising, the impact of these in the short or longer term is yet to be realised.

Transformation

49 **The Health Board's improvement groups are developing though there is a risk they become too short term and financially focussed. There is also a need to build change and programme management capacity and capability in the organisation.**

50 During summer 2019, the Health Board began introducing an improvement group structure. We understand that the early intention for these 11 groups was to drive continuous improvement and support longer-term transformation. However, groups are at different states of maturity and the nature of the groups has evolved, becoming more focussed on shorter-term financial recovery than was originally intended. While there is a clear need for this focus, there must also be a focus on designing and modelling financially sustainable services that also deliver the required performance. The Health

Board is utilising external 'interim managers' to enhance existing capacity to provide improved grip and control on performance as well as supporting the development of wider improvement plans.

51 Our structured assessment work has considered progress relating to the delivery of the Health Board's annual operating plans. The Health Board's year-end report for 2018-19 on delivery of the annual operating plan identified 640 actions delivered against a plan with 766 actions. While more positive in terms of percentage than in previous years, it illustrates a focus which is more on detailed actions than on outcomes. For 2019-20, the Health Board is reporting that it is on track to deliver key aspects of the annual plan, although our review indicates that:

- progress is slower in areas that relate to clinical service change; and
- it is not easy to predict the extent that delivery of the plan at the year-end will result in a marked difference in terms of transforming the organisation into a more financially sustainable and better performing organisation.

52 As in previous years, our work indicates gaps in change management capacity and capability within the organisation. Given the extent of the need for service change, there needs to be a clear programme management structure, change programmes, programme management methodology and some thought given to the extent of central vs decentralised change capacity (Recommendation 3).

Previous recommendations

53 In our previous structured assessment reviews, we made the following recommendations in relation to change management and transformation. Exhibit 6 describes the progress made.

Exhibit 6: progress on previous structured assessment recommendations

Previous recommendation	Description of progress
R1 2017 Embed a savings approach based on targeting savings at areas where benchmarking demonstrates inefficiencies, to deliver longer-term sustainability.	With the assistance of external consultants, savings schemes are better focussed across a range of areas, linked to benchmarking areas of opportunity. **Recommendation closed.**
R2 2017 Identify where longer-term and sustainable efficiencies can be achieved through service modernisation and application of approaches such as value-based healthcare, productivity improvements and invest to save.	There is insufficient evidence that value-based healthcare, productivity improvements, invest to save and service modernisation are having a sustained positive impact on the finances. **This recommendation is open and has been amalgamated to recommendation 1 of the 2019 review.**
R3 2017 Ensure that budget holders receive the necessary specialist support from enablers such as the Programme Management Office, workforce, procurement and informatics teams.	There is a significant package of work in place co-ordinated through the financial recovery group. Several interim management appointments are supporting and driving improvement. Shared Service Procurement services are actively engaged in the Health Board's financial recovery programme. **Recommendation closed.**

Previous recommendation	Description of progress
R4 2017 Ensure that financial savings assumptions are fully integrated into annual and medium-term plans so that savings efficiencies form part of service modernisation.	Financial savings assumptions are clearly built into service plans and trajectories for annual planning, but this is less clear for the longer-term financial position. **Recommendation closed.**
R6 2017 Further strengthen the corporate monitoring approach to ensure it supports and enables savings plans which are slipping and encourages longer-term savings and efficiency programmes.	Robust corporate monitoring is taking place which clearly identifies risks to achievement of savings, monthly trajectories and early identification on slippage. There are regular challenge meetings on each savings programme. **Recommendation closed.**
R10a 2017 Ensure financial savings are embedded into change programmes and plans.	Financial recovery both in the short term and longer term is increasingly becoming the dominant agenda item for the improvement groups and their developing programmes. **Recommendation closed.**
R10b 2017 Strengthen capacity and capability within centrally managed change programmes.	The Health Board was in the process of strengthening the capacity and capability of the centrally managed change programmes, earlier in the year, but the attention has more recently been given to short-term financial recovery. There remains a need to build stronger change and programme management arrangements. **This recommendation is open and has been amalgamated to recommendation 3 of the 2019 review.**
R10c 2017 Strengthen change enabling capability and capacity in divisions.	There has been some improvement to change enabling capacity, particularly in the acute setting with interim management. The organisation needs to build its own capacity and reduce the reliance on interim management. **This recommendation is open and has been amalgamated to recommendations 3 and 5 of the 2019 review.**
R10d 2017 Ensure workforce, informatics and other enabling resources are integral to change delivery arrangements.	There are clear, approved and realistic workforce, informatics and estates plans that support and enable clinical and operational service improvements. **Recommendation closed.**

Previous recommendation	Description of progress
R10e 2917 Ensure clinical engagement and leadership are integral elements within change programmes.	Clinical engagement in service change, improvement and modernisation remains key to effective service modelling, and long-term sustainability of services. This is demonstrated in pockets. **This recommendation is open and has been amalgamated to recommendation 2 of the 2019 review.**
R10f 2017 Strengthen accountability for progress against plans, including the annual operating plan and, when developed, the IMTP.	There is stronger accountability for delivery of plans and better oversight of progress. **Recommendation closed.**
R13 2017 Increase investment in technology where this clearly will result in a greater level of returned cashable efficiencies or transformational economies.	Plans are starting to better incorporate digital investments to create efficiencies. Nevertheless, there remains significant opportunity for digitally enabled care services to drive service efficiency and productivity across care pathways. **Recommendation closed.**

Governance

54 As in previous years, our structured assessment work has examined the Health Board's governance arrangements. We looked at the way in which the Board and its sub-committees conduct their business, and the extent to which organisational structures are supporting good governance and clear accountabilities and internal controls. We also reviewed the progress made in addressing our recommendations arising during previous structured assessment reviews.

55 In 2019, we found **Governance arrangements are generally improving but there is a need to strengthen aspects of the senior management structure and ensure that Board working remains cohesive and constructive**. Our findings are set out below.

Conducting business effectively

56 Scrutiny and challenge – **Improving scrutiny at Board and Committee meetings is resulting in better challenge although on occasion there is opportunity to make this more constructive.**

57 In general, governance processes supporting the Board and committees work well as do the processes followed during meetings. Since last year's structured assessment review, a new Digital and Information Governance Committee has formed and is now progressing its agenda well.

58 Our observations indicated that the conduct of Board and committee meetings has evolved, with a greater degree of scrutiny than in previous years. We have seen greater positive challenge from independent members which helps unpick issues and press for improvement where this is an issue. We also note that there is a better degree of transparency and in general a fair and balanced perspective on aspects of progress and challenges and risks demonstrated by both executive and independent members at Board and committee meetings. But, the length of some committee meetings

has increased as has growth in the volume of committee papers. The Health Board needs to keep this under review.

59 We have also observed committee discussions where on occasion there are concerns about the quality of papers and where the level of challenge by independent members is extensive. This sometimes requires executive directors to respond to issues of detail and does not always appear to move the organisation forward.

60 Executive leadership – **There is a need to ensure that the Executive team creates greater capacity to lead change, and stronger leadership of acute services.**

61 Over the past year, there have been changes to the Executive team with the appointment of a new Medical Director, and Acting Executive Director of Finance. There have been some minor changes in portfolios over this period, and those changes have generally had a positive effect.

62 While we did not observe executive management team meetings as part of this year's fieldwork, we found that the balance of existing executive portfolios combined with some significant pressures on capacity is not providing the important and necessary space for them to shape organisational intent. During interviews, concerns were raised around the capacity of the Executive team and the resulting impact on developing a collective and cohesive strategic vision for the organisation.

63 We have also identified concerns relating to the continuity of leadership of acute care services. This has been an issue for several years and in our view has impacted on the ability of the organisation to deliver both short-term performance improvement and longer-term sustainable models of service. We have also commented in previous structured assessment reports on the ability of the organisation to deliver change and transformation. There is clearly a need to more formally recognise transformation/programme roles within the senior management structure. As such, the Health Board should review the form and function of the executive team in regards of the points above (Recommendation 4, 2019). We are aware that the King's Fund is currently supporting Board and Executive development and, as their work progresses, may encompass aspects highlighted above.

Ensuring organisational design supports effective governance

64 **There has been investment to strengthen operational capacity, but the current approach is reliant on interims and there is a need to ensure a strong and formally agreed management structure for acute care.**

65 Since our last structured assessment, the Health Board has utilised additional Welsh Government funding to strengthen operational capacity through use of interim management. Our work indicates that this is both supporting operational improvements and development of service improvement plans. However, use of interims presents a risk particularly if those capabilities are lost if and when interim managers leave the organisation. The Health Board recognises the need to develop its own capacity and capability alongside that provided through interim management, but this remains a risk that needs to be mitigated (Recommendation 5).

66 Our work this year has considered the acute service structure. This has been problematic for many years with recurrent turnover, vacancies and changes that destabilise the continuity of management and limit the pace of improvement and the extent that improvements are embedded into organisational practice. As such, our work finds that there is a need to formalise the acute services management structure (Recommendation 6).

Monitoring delivery of the strategic plan

67 **There is notable improvement in the way the Health Board is monitoring its delivery of the annual plan**.

68 In previous years, we noted that Board-level oversight of delivery of its annual operational plan was insufficient. We have reviewed the current arrangements and found that the monitoring of the plan as part of the Health Board's governance arrangements has improved substantially. Reports to the Board on annual operating plan delivery have improved, more clearly identifying accountability for delivery as well as milestones of progress against expectation. Whilst the narrative within the document provides a high-level overview on progress of delivery of actions, the Health Board will need to continue to develop its reporting approach to demonstrate whether the actions have had the desired impact.

69 Below the Board, annual plan monitoring reports are provided to each Finance and Performance Committee, Strategy Partnerships and Population Health Committee and Quality, Safety and Experience Committee meeting.

Embedding a sound system of assurance

70 Assurance and risk – **The Health Board has continued to adapt its assurance and risk arrangements and recognises the need to refine this to help shape the required assurance**. Over the last 12 months, the Health Board has prepared a Board Assurance Framework narrative document that describes governance arrangements and how assurances are managed. The Health Board regularly updates and develops its assurance mapping approach as part of its Board Assurance Framework. However, this is challenging when there continues to be a large number of organisation objectives. This would be easier if there were a smaller number of clear outcome-focussed objectives. The Health Board continues to demonstrate good practice in relation to its Legislation Assurance Framework. This work has assessed all relevant legislation and the aspects of the organisation it relates to. There remains work to do in some departments, such as Estates, to provide assurance of compliance with a range of legislation.

71 In terms of corporate risk arrangements, the Health Board is in the process of reviewing the corporate risk strategy and is likely to make several fundamental changes. These include:

- improving consistency of scoring and risk escalation processes;
- reducing the number of layers of escalation between ward and board;
- ensuring risk ownership to encourage management to resolve risks locally; and
- greater clarity on committee and Board level risk oversight.

We understand the revised risk strategy will be in place by April 2020.

72 Internal controls – **work to improve internal controls is ongoing and appropriate**.

73 We considered the work of Internal Audit, and the Post-Payment Verification team[8]. We found a well-focussed and structured programme of work for both, with enough resources for delivery, and effective approaches for reporting assurances or concerns. However, audit recommendation tracking requires some improvement. An electronic system currently tracks recommendations from internal and external

[8] Link to more information on post-payment verification

audit reviews. However, Audit Committee members frequently raise concerns about the timeliness and accuracy of progress updates and recommendation sign-off. This issue needs resolving (Recommendation 7).

74 We reviewed progress made against our previous recommendation on the effectiveness of clinical audit. From a weak position, clinical audit arrangements are now developing at pace. There is clear senior management ownership, and this is helping to drive improvements to clinical audit policy and procedure development. This includes formality around clinical audit planning, reporting and the necessary assurance links into committees. The arrangements will take some time to fully put into place, but the level of progress is promising.

75 The Health Board has reviewed Standing Orders and the Scheme of Reservation and Delegation in line with the national approach with relevant local tailoring and these were presented to the full Board in November 2019 for approval.

76 The Health Board has continued its good work on its Register of Interests and Declaration of Gifts and Hospitality. The former has seen strengthening of management controls following an internal audit review. As part of its focus on compliance, the Audit Committee reviews the Register of Interests and Declarations of Gifts and Hospitality policy and reports. It also regularly scrutinises single tender waivers and single quotation wavers as part of its in-committee agenda.

77 We have not undertaken a review of the Health Board's quality governance arrangements as part of this structured assessment. A more detailed examination of these arrangements will be undertaken during 2020.

78 Performance management arrangements – **There is continued work to improve performance management arrangements and reporting**.

79 Since our last structured assessment, the Health Board has continued to adapt its performance accountability arrangements. The most notable change is the move to health economy (ie sub-regional) accountability meetings. The purpose of the move is to align aims, accountability and challenge across primary, community and acute care. Feedback from interviews on the effectiveness of these meetings is mixed, with some positive about the new arrangement and some expressing concerns about being held accountable for performance in a division despite not having any control over it. We also heard that there may be a need to strengthen the level of challenge at meetings.

80 Wider performance reporting to Board and committees is reasonably detailed, honest and transparent, albeit improvement actions highlighted in the reports are not consistently having a positive impact. We have noted that the structure of the integrated quality and performance report has continued to evolve positively with increasing detail in some areas.

81 Arrangements to prevent, detect and respond to fraud – **The Health Board has made good progress in addressing the matches identified through the National Fraud Initiative.**

82 The National Fraud Initiative[9] is a biennial data-matching exercise that helps to detect fraud and overpayments. Participating bodies submitted data in October 2018. In January 2019, the Health Board received 8,896 data-matches, of which 843 were higher risk and recommended for review. As at 15 October 2019, the Health Board had reviewed most of the high-risk payroll matches with enquiries ongoing in a small number of cases. The Auditor General is undertaking further work to

[9] Link to National Fraud Initiative specifications

examine the effectiveness of counter fraud arrangements across the public sector in Wales, with a view to publishing his findings in summer 2020.

83 Health and safety – **Health and Safety arrangements are improving at pace**. From a weak position in previous years, there is now clear delegated responsibility, a management oversight structure, a new Occupational Health, Safety and Wellbeing Strategy and associated programme of health and safety improvement work. This has included analysis of 31 items of Occupational Health and Safety legislation and 117 site specific inspections across acute, mental health and community services, GP practices and HMP Berwyn in Wrexham. The results of this work have now been analysed by theme and risk-rated, leading to recommendations for future improvement work and required priority actions. While there remains a large amount to do, the new arrangements provide assurance on progress.

Previous recommendations

84 In our previous structured assessment reviews, we made the following recommendations in relation to assurance arrangements, and the extent the financial information supports Board decision making. Exhibit 7 describes the progress made.

Exhibit 7: progress on previous structured assessment recommendations

Previous recommendation	Description of progress
R2 2016 The Health Board should build upon its assurance mapping work and work towards a board assurance map to complement the corporate risk register, and ultimately the IMTP.	The Health Board has continued to make with its board assurance mapping. **Recommendation closed.**
R4b 2016 The Health Board should strengthen its processes for systematically reporting, cascading and implementing lessons learnt (in relation to quality of services).	We will consider progress as part of our quality governance review during 2020.
R7 2017 Ensure that plans presented to the Board include costed options where applicable and contain sufficient information to indicate to the Board that they are affordable in the short, medium and long term.	Plans presented to the Board and committees now include costings, which is helping decision-makers to understand affordability of proposals within the current budget. **Recommendation closed.**

Previous recommendation	Description of progress
R9 2017 Build on the Health Board's programme of clinical audit to ensure it: • aligns with quality strategy priorities and risks; • sets out patient/quality outcomes or impact as a requirement of audit planning to help it understand the value that clinical audit is contributing; and • informs the Quality, Safety and Experience Committee with clear and focussed assurance reports.	The Health Board has improved its clinical audit planning and accountability and started to consider reporting and assurance approaches. While there remains more to do, progress is positive and regularly overseen by the Audit Committee. **Recommendation closed.**

Managing workforce productivity and efficiency

85 We considered the action that the Health Board is taking to manage its workforce. In doing so, we have reviewed the progress made in addressing our recommendations arising from our previous structured assessment reviews.

86 We found that **workforce management arrangements are clearly strengthening, but there remain long-standing challenges in relation to recruitment, productivity and modernisation.** Our findings are set out below.

Managing the workforce

87 Recruitment and retention – **The Health Board is being proactive in workforce management, but the extent of the challenges faced, particularly in relation to recruitment and retention, are significant and are likely to take several years to resolve**.

88 Retention remains one of the key challenges of the Health Board. The Health Board recognises the importance of appropriate staffing levels and has developed a range of priority actions to retain existing staff. The areas include targeting retention in hotspot areas, refreshing and improving the exit interview process, improving staff engagement, retirement and succession planning.

89 Recruitment resources have improved, and the Health Board is focussing on unique selling points for some key hard-to-fill roles, which is starting to have a positive effect. The extent of the recruitment challenge cuts across the organisation, but for some specific roles and in specialist areas, vacancies present a greater risk to service continuity and result in fragile and higher-risk services. This is an ongoing challenge and is a key reason why the Health Board needs to make urgent progress with the development of a strategy and plan clinical services.

90 The Health Board is developing a good working relationship with Health Education and Improvement Wales and with universities, which is helping to support local workforce development and training opportunities. While positive, this needs to expand to ensure the Health Board can continue to influence the workforce marketplace and education providers to meet its long-term workforce needs. Workforce shortages have been an issue for the Health Board for many years and will likely take several years to resolve.

91 Use of a temporary workforce – **The Health Board has a historically high use of agency and locum workforce, and there are specific risks going forward**.

92 The Health Board has a clear plan to reduce its agency costs and build its own temporary staff capacity. The Health Board has a historically high locum and agency usage. Demand for medical and nursing agency staffing has reduced from its peak in 2016-17 of £39 million to £26.9 million in 2018-19. Over this time nursing agency costs rose, but medical agency staff costs halved from £29.9 million to £14 million. Current national staff shortages in some areas, along with income tax pension liabilities for higher income staff, may limit the extent that staff wish to work over their contract hours, which could again result in increased agency staff or outsourcing costs.

93 Sickness absence can increase locum and agency usage. As of September 2019, the Health Board's sickness absence performance is slightly better than the NHS Wales average at 5.22%. The Health Board set out an ambitious target to reduce sickness absence to 4.2% by March 2020. The workforce team has developed a range of improvement actions but despite these efforts, sickness absence rates have continued to rise, albeit slowly.

94 Selected workforce statistics provide indicators of workforce trends (Exhibit 8). While some indicators compare favourably with the all-Wales average, those areas that affect the use of a temporary workforce, including vacancies and sickness absence, remain a concern.

Exhibit 8: performance against key workforce measures, July 2018 and July 2019

	Health Board July 2018	Health Board July 2019	Health Board July 2018 compared to 2019	Wales average July 2019
Sickness absence rates	4.9%	5.2%	↑	5.4%
Staff turnover rates	8.7%	8.5%	↓	7.1%
Advertised vacancies*	2.7%	3.0%	↑	2.9%
Staff undertaking appraisal	66.0%	79.0%	↑	70.0%
Statutory and mandatory training	85.0%	85.0%	↔	80.0%

*Advertised vacancies are only a proxy measure for overall vacancies and actual vacancies are likely to be higher.

Source: NHS Wales Workforce Dashboard, Health Education and Improvement Wales, July 2018 and 2019

Workforce design and engagement

95 Workforce design **– workforce planning is improving and recognises the need to support improvements in workforce efficiency**.

The current workforce strategy approved in March 2019 takes a broad approach to shape the workforce for current and future needs. The Health Board clearly recognises the challenges that it faces, including:

- recruiting and retaining clinical staff can be impacted by outdated or traditional service models;
- sustainability of several services and rotas is high-risk due to the level of vacancies within existing models;
- the level of vacancies at consultant, middle grade and trainee doctor levels as well as staff nurse vacancies and staffing challenges in GP practices;
- a significant level of 'unfunded' capacity eg escalation beds is 'stretching' the workforce; and
- high pay expenditure.

96 The Health Board recognises that it needs to improve workforce productivity and there are some examples of prudent healthcare approaches, such us the use of extended scope practitioners. The direction of travel is positive and will need to strongly support the shaping of service models and clinical pathways. There also remains significantly more to do to improve surgical and medical productivity to maximise the efficiency of existing resources. The central workforce team is in the process of consolidating with the medical workforce team and this should then support a whole system approach to organisational development.

97 Workforce engagement **– The Health Board is demonstrating a positive direction of travel in relation to staff engagement, but challenges remain**.

98 The Health Board continues its work to build staff engagement. In previous years, we have mentioned the aspects such as the annual staff awards ceremony, and the monthly Seren Betsi nomination and award. This work has continued to provide positive recognition for staff going above and beyond.

99 The Health Board received the result of the all-Wales staff survey in November 2018. From a low base in 2013, the staff survey results indicated that levels of engagement had improved in 2016 and again in 2018. The scores are now more in line with the Wales average. The Health Board's own analysis of the results presents a fair picture of both the areas of progress and the challenges. The Health Board has developed an organisation-wide improvement plan and good divisional analysis and improvement plans to respond to specific issues in different areas, and to devolve ownership. As part of the intent to obtain more regular 'temperature' of the organisation, the Health Board is now undertaking quarterly staff pulse surveys.

100 Another important aspect of workforce engagement is the process supporting appraisals and staff development. The Health Board has shown that it is taking action to improve take-up of staff Performance Appraisal and Development Reviews. It has set an ambitious target which it is not currently on track to deliver, but the month-on-month appraisal rates are far improved compared to previous years (Exhibit 8).

Previous recommendations

101 In our previous structured assessment reviews, we made the following recommendations in relation to targeted approaches for recruitment. Exhibit 9 describes the progress made.

Exhibit 9: progress on previous structured assessment recommendations

Previous recommendations	Description of progress
R11a 2017 Work with educational partners, research partners and internal stakeholders to shape new job roles to increase the attractiveness of the job offer as part of clinical staff recruitment.	There is now a clear commitment to work with education partners to shape job roles to improve the attractiveness of the role, particularly for some hard-to-fill vacancies. **Recommendation closed.**
R11b 2017 Increase tactical recruitment capacity to support delivery of R11a.	The new workforce management structure now has stronger recruitment support capacity. **Recommendation closed.**

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Cyfarfod a dyddiad: Meeting and date:	Audit Committee 12th Dec 2019
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Corporate Risk Register and Assurance Framework Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris – Deputy Chief Executive/Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Mrs Justine Parry, Assistant Director of Information Governance and Assurance Mr David Tita, Head of Risk Management
Craffu blaenorol: Prior Scrutiny:	The full Corporate Risk and Assurance Framework (CRAF) is scrutinised by the Health Board twice per year and is published on the Board's external facing website. Individual risks are allocated to one of the Board's Committees for regular consideration and review. This report has been approved for submission to the Committee by the Deputy Chief Executive / Executive Director of Nursing and Midwifery.
Atodiadau Appendices:	1

Argymhelliad / Recommendation:

The Audit Committee (AC) is asked to:

1) Note, approve and recommend the Corporate Risk Register (CRR) to the Board and to gain assurance that the risks are managed in line with the Health Board`s risk management strategy.
2) To recommend two new risks which were approved by the QSE to the Board for inclusion onto the CRR.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

This paper presents risks on the Health Board`s CRR and seeks to demonstrate and highlight the controls and further actions being implemented to mitigate the risks as well as the progress and any changes that have been made since the risks were last presented to the Board on the 7th November 2019.

Whilst this coversheet presents the key highlights/progress and changes to the risks, Appendix 1 presents details of each of the risks captured.

Cefndir / Background:

The Health Board has undertaken a complete review of its risk management strategy which is underpinned by a risk management vision statement clearly setting the Board's vision and direction of travel regarding risk management. The new strategy underlines the powerful intention and firm commitment of the Health Board to embark on the implementation and embedding of an Enterprise Risk Management (ERM) Model across the entire organisation from `Ward to Board` in 2020/21 and

will be presented to the Board at the end of January 2020 for ratification and implementation from 1st April 2020.

The renewed energy for the management of risk across the Health Board has created a positive culture of risk awareness and momentum across the Health Board that is providing focus for ongoing debates and conversations around how best to capture, strengthen and monitor the effective management of the Health Board's principal risks. This will over the next few months enable us:-

- To appropriately identify, assess and capture the Health Board`s principal risks which are aligned to the achievement of its objectives as defined in its 3 Year Plan and emergent clinical strategy.
- To align this to an assurance framework and widening our understanding of our key principal strategic risks as well as providing assurance that there are systems, processes and governance arrangements in place to robustly identify, assess, monitor and manage them, fostering a better understanding of the Health Board's strategic and extreme operational risks.

Defining the principal risks will enable the Health Board to appropriately frame and inform agendas. It will enable a timely response to any gaps in controls and assurance in a more dynamic way.

The results of the recent Risk Management Gap and Training Needs Analysis undertaken by the risk management team across the Health Board also indicate a commitment by colleagues to regularly review and update their risks. In response, whilst the new risk management strategy and policy robustly clarifies the governance and escalation process for risks from `Ward to Board`, a training pack has been developed as well as targeted support being provided to ensure that staff are sufficiently empowered and confident in raising, capturing and discussing risks at their local Governance and Quality and Safety meetings.

Asesiad / Assessment & Analysis

The Quality, Safety and Experience Committee (QSE) which held on 19th November 2019 noted that CRR issues will be picked up at the Audit Committee Workshop due to hold on 2nd December 2019 and that risks identified as a result of the Health and Safety (H&S) Gap Analysis will be themed, assessed, mitigated and managed appropriately. Following some discussion, approval and recommendation for the two H&S risks (CRR20 and CRR21) to be included onto the CRR, members requested for their target dates to be adjusted to 1st November 2020 as the current dates were unachievable. Members also noted that the current score of the Mental Health risk has been reverted to what it was previously following some concerns around how it had been reduced.

The Digital and Information Governance (D&IG) Committee which held on 21st November 2019 reviewed their risks and noted that their risks could not be reviewed prior to presentation at the Board on 7th November 2019 due to timing issues and that any updates from the Board will be reflected in the subsequent version. The committee then considered the accuracy of the scores as well as the effectiveness of the controls and actions as captured in each of their risks.

Due to timing challenges, updates from the Finance and Performance Committee (F&P) and the Strategy, Partnerships and Population Health Committee (SPPH) have not been incorporated into this report.

In summary, following review, scrutiny and monitoring from the relevant committees, the following changes have been made to CRR since the last report was received by the Audit Committee:-

- **CRR01 Population Health.**
  Key progress: This risk was reviewed at the Public Health Senior Leadership team meeting where the need for continuous engagement of the Live Lab work with Office of Future Generations Commissioner and Public Health Wales was noted as a key factor. Focus on Healthy Weight in Pregnancy and Children was also underlined. There has been no change to the current risk score since it was last presented to the Audit Committee. This risk will be presented and reviewed at the Strategy, Partnership and Population Health Committee on the 3rd December 2019.
- **CRR02 Infection Prevention and Control.**
  Key progress: This risk was reviewed at the QSE and members noted that it remains largely the same with no change in score as was in the previous submission. Infection Prevention quality visits have commenced to replace the previous "audit programme". These visits encompass observation of clinical practices, support and advice, micro teaching, safe clean care updates, hand hygiene observations, screening and any other relevant support needed by the ward staff. Scrutiny of every avoidable infection and lessons learnt are regularly shared.
- **CRR03 Continuing Health Care.**
  Key progress: As part of the review process, members at QSE were also informed that this risk will be split into two distinct risks i.e. CHC and the Care Home strand to ensure both components are appropriately assessed, developed and presented at the QSE for review, scrutiny, approval and recommendation either for inclusion onto the CRR in replacement of CRR03 or de-escalation from the CRR and continuous mitigation and management at the appropriate level.
- **CRR05 Learning from Patient Experience.**
  Key progress: This risk was reviewed at the QSE and members noted that it remains the same as in previous CRR report. Performance and accountability reviews include concerns monitoring as Patient Advice and Support Service has been initially established in YGC. There has been no change to the current risk scoring.
- **CRR06 Financial Stability.**
  Key progress: Risk controls have been refreshed, strengthened and a related risk from Secondary Care in the East has now been linked to this risk to ensure a greater understanding of the impact of this risk at a local level. There has been no change to the current risk scoring. The risk will be reviewed, scrutinised and updated following meeting of the F&P scheduled for 4th December 2019.
- **CRR09 Primary Care Sustainability.**
  Key progress: There have been no further updates since the previous submission and review by the SPPH Committee which agreed to move the target risk date to the 31st March 2021. This risk will be updated in the subsequent report following discussions at the SPPH meeting planned for 3rd December 2019.
- **CRR10a National Infrastructure and Products**.
  Key progress: This risk was reviewed at the D&IG Committee on the 21st November 2019 as members noted that there was no further update since previous submission to the Committee. A discussion ensued with regards to the Service Level Agreement in place with the National Team and the possibility of escalation, in order to achieve target risk scoring. It was noted that the issue was ongoing but progress was ongoing in order to resolve this.
- **CRR10b Informatics - Acute Health Records.**
  Key progress: There has been no further updates since the previous submission to the

Committee. However, members recommended a change in title to incorporate `community` so as to reflect its original. Members requested an update in the scoring of this risk and advised the risk handler and manager to liaise with the Head of Risk Management to ensure the risk is appropriately scored. A meeting is being arranged for the weeks ahead to sort this.

- **CRR10c Informatics infrastructure capacity, resource and demand.**
  Key progress: There has been no further updates since the previous submission to the Committee. It was agreed that there was no further action to be taken at present to change the aligned targets.
- **CRR11a Unscheduled Care Access.**
  Key progress: Seasonal Plan added as a control and additional notes added to further actions to clarify progress to date. There has been no change to the current risk scoring. This risk will be presented and reviewed at the F&P Committee on the 4th December 2019.
- **CRR11b Planned Care Access.**
  Key progress: The risk description has been updated to include national standards and further involvement with partner organisations. Seasonal Plan has been added as a control and additional notes added to further actions to clarify progress to date. There has been no change to the current risk scoring. This risk will be presented and reviewed at the F&P Committee on 4th December 2019.
- **CRR12 Estates and Environment.**
  Key progress: Estates rationalisation and disposal programme in place for 2019/20. Further actions updated to reflect new actions for this financial year. There has been no change to the current risk scoring. This risk will be presented and reviewed at the F&P Committee on the 4th December 2019.
- **CRR13 Mental Health Services.**
  Key progress: The current risk score of this risk has been reverted at the request of QSE members. Members also clarified that risk handlers should not modify the scores of risks on the CRR without approval and recommendation from the relevant committee as well as ratification from the Board.
- **CRR14 Staff Engagement.**
  Key progress: This risk has now achieved its target score with further emphasis currently being placed on sustaining and embedding its controls. The current and target risk scores have been decreased since the last presentation to the Board. This risk will be presented and reviewed at the SPPH Committee on the 3rd December 2019.
- **CRR15 Recruitment and Retention.**
  Key progress: Key controls have been strengthened and updated with further actions identified to support achieving the target risk score. There has been no change to the current risk scoring. This risk will be presented and reviewed at the SPPH Committee on the 3rd December 2019.
- **CRR16 Safeguarding.**
  Key progress: This risk was reviewed at the QSE and it was noted that its controls have been strengthened to include business planning, a refreshed reporting framework and the introduction of a senior management Tier in the safeguarding structure. Further actions have also been updated to support achieving the target risk score and linked to operational risks, however the target risk date must be re-considered. There has been no change to the current risk scoring.
- **CRR17 Development of Integrated Medium Term Plan.**
  Key progress: This risk remains unchanged as per previous report as it will be reviewed at the SPPH meeting planned for the 3rd December 2019. Updates will be reflected in the next report.

- **CRR18 EU Exit - Transition Arrangements.**
  Key progress: This risk remains unchanged from the previous report as controls have been strengthened especially in the light of government hightened preparation for `no deal` exit. This risk will be reviewed at the Strategy, Partnership and Population Health Committee on planned for today 3rd December 2019.

De-escalated Risks:
No risks are being presented for de-escalation during this meeting.

However:
- CRR04 was de-escalated in July following review by the Maternity SMT.
- CRR08 was de-escalated in July 2018 by the Board.
- CRR19 was de-escalated in June 2019 by the F&P Committee.

Closed Risk:
The following risk has been closed since the last CRR report was presented to the Board:
- CRR07 - Capital Systems on the 25the June 2019 by the F&P Committee.

New risks
The following three risks which were generated from the old Informatics Risk – CRR10 as per the recommendations of the Information Governance and Informatics Committee have now been added onto the CRR:
- CRR10a - National Infrastructure and Products
- CRR10b - Informatics - Acute Health Records
- CRR10c - Informatics infrastructure capacity, resource and demand

A further two new risks which were presented to the QSE Committee on the 19th November 2019 were approved and are hereby recommended for inclusion onto the CRR.

- **CRR20 Security Risk** - A comprehensive review of security management identified shortfalls in the systems including CCTV, lone working, lock down procedure, security contract, violence and aggression, key holding and alarm systems. Work is also progressing to identify the assurance mechanisms in place for this risk.
- **CRR21 Health & Safety Risk** - Through a gap analysis of 31 pieces of legislation, Occupational Health and Safety identified areas of concern in the safety management system and compliance with the law. Work is also progressing to identify the assurance mechanisms in place for this risk.

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5			CRR03	CRR10a CRR11a CRR11b CRR17 CRR20	
	Likely - 4			CRR05	CRR01 CRR06	

					CRR09 CRR10b CRR10c CRR15 CRR16	
	Possible - 3				CRR12 CRR13 CRR18	CRR02 CRR21
	Unlikely - 2				CRR14	
	Rare - 1					

Strategy Implications
This CRR report is strategically important as it evidences, confirms and provides assurance to the Audit Committee that the Health Board is effectively and efficiently identifying, assessing, mitigating and managing high/extreme risk risks to the achievement of its Priority Areas and Objectives as defined in its 3 Year Plan in line with best practice and its risk management strategy.

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

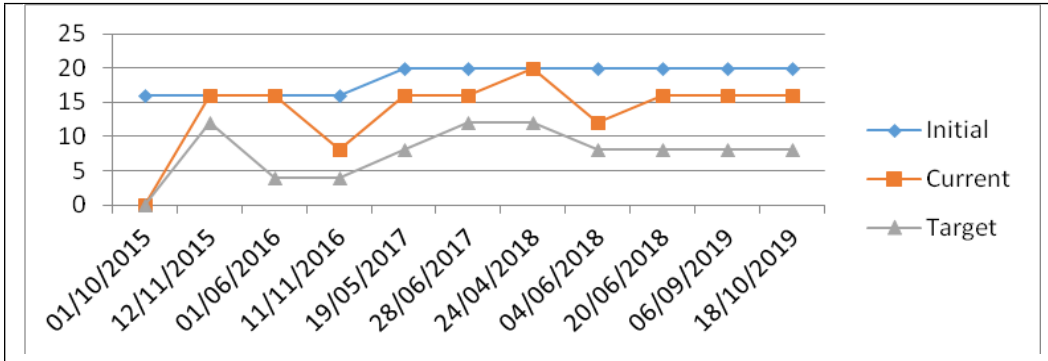
Risk Analysis
No risks have been identified from crafting this report as the risk of inaction is far greater than that of positive engagement with its content.

Legal and Compliance
This CRR report which will be periodically shared with the Board is intended to provide assurance.

Impact Assessment
Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Appendix 1: Details of the Corporate Risk Register

CRR01	**Director Lead:** Executive Director of Public Health	**Date Opened:** 1 October 2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 18 October 2019
	Risk: Population Health	**Target Risk Date:** 31 March 2021
There is a risk that the Health Board fails to deliver improvements in population Health in North Wales. This is due to a failure to focus on prevention and early intervention. This will lead to higher levels of non communicable diseases such as obesity, hypertension, coronary heart disease, stroke, diabetes, and some cancers. This will lead to an increase in demand on primary and secondary care, and increase levels of health inequalities between our most and least deprived communities.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Population health intelligence updated on a continuing basis ensuring that information is available to support planning for and monitoring of health status. 2. Approved Population assessment to inform Social Services and Wellbeing Act developed in partnership, and now informing implementation of North Wales Regional Plan for 2018-2023. 3. Review of Board cycle of business completed to enable focus on population health issues.	1. Further exploration and identification of new opportunities for Health Board to secure population health improvement through leadership role in strategic partnerships utilising new structures - Regional Partnership Board and Public Service Boards. 2. Health Improvement and Inequalities Transformation (HIIT) Group lead the development of relevant section of 2019/22 IMTP submission, and ensure co-ordination with

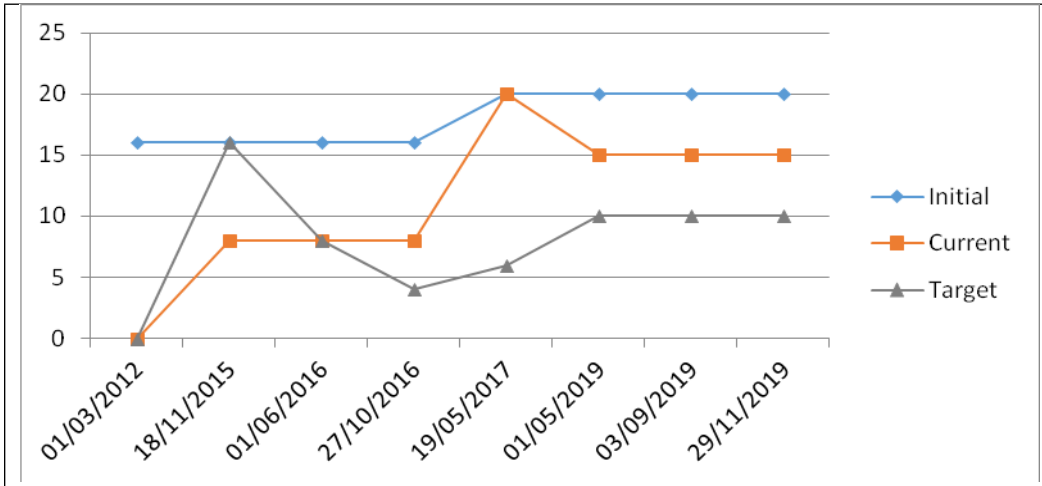
4. Wellbeing Assessments completed and approved. 5. Wellbeing Objectives and Plans approved / to be approved in the 4 PSBs. 6. Strategic Partnerships in place providing opportunities for advocacy for improving population health with partners. 7. Approved HB Strategy Living Healthier, Staying Well confirms emphasis on improving population health through more focus on prevention. 8. Baseline Assessment informing LHSW completed, underpinned by WG Public Health Outcomes Framework. 9. Improved data on Primary care available to Area Teams and Contractors via PH Directorate website. 10. Organisational objectives have now been revised and redefined as our Wellbeing Objectives. 11. 2018/19 BCUHB Operational Plan aligned with key actions for improving health identified in Public Health Wales IMTP. 12. DPH / Public Health Consultants attend all PSBs and Part 9 Board to advise and influence on prevention / early intervention agenda. 13. Delivery of Public Health Team workplan is aligned with operational Area Teams. 14. Public Service Boards Wellbeing Plans developed. 15. Health Improvement and Inequalities Transformation Group now fully established and has led the development of the relevant section of the 2019/20 IMTP submission, to ensure co-ordination of the Plan which are interdependent. 16. Continued engagement with the Live Lab work with Office of Future Generations Commissioner and Public Health Wales. Focusing on Healthy Weight in Pregnancy and Children.	other aspects of the Plan which are interdependent. 3. Identify substantive PMO support for this programme. 4. Participate in Live Lab work with Office of Future Generations Commissioner and Public Health Wales to provide a new focus for prevention within the delivery of community services, and generate learning which can be shared across Wales. 5. Review of all other public health risks underway which will inform the existing risk mitigation measures for this overarching risk.

Assurances	**Links to**		
1. Oversight by Public Service Boards and Local Authority Scrutiny Committees. 2. WG Review Meetings (JET). 3. Public Health	**Strategic Goals**	**Principal Risks**	**Special Measures**

Observatory reports and reviews. 4. WG Review and feedback on needs assessment.			**Theme**
	1 2 5 6 7	PR8	Strategic and Service Planning

CRR02	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 29 November 2019
	Risk: Infection Prevention & Control	**Target Risk Date:** 31 March 2020

There is a risk that patients will suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.



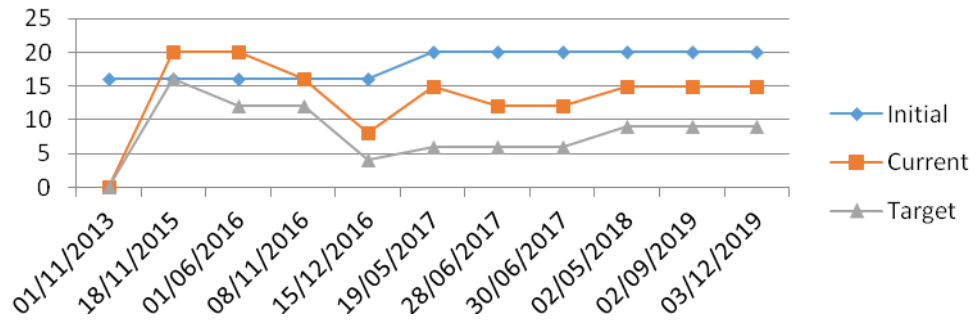
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Infection Prevention Sub-Group scrutinise trajactories and performance through the regular cycle of business, quarterly and annual reports to Quality and Safety Group. 2. Surveillance systems and policies/SOPs in place for key infections, with data presented through the governance route to Board. 3. Areas and Secondary Care sites governance arrangements. 4. Monthly Executive-led scrutiny meetings to review infections and learning from each site in place. 5. Continued progress on ANTT staff training, with key trainers in place, increased focus on medical staff supported by MDs, competencies held by individuals managers. 6. External review performed August 2017; report on further actions	1. Continue the implementation of SCC and IP via annual work programmes. 2. Implement the other actions identified in the 2019-20 annual infection prevention programme. 3. Implement actions in response to Welsh Government Antimicrobial Delivery Plan, relevant Welsh Health Circulars and in response to multi-drug resistant organisms. Part of the ARK study. 4. Continue to progress key actions from Duerden report 2016 in relation to Consultant Microbiologist staffing and capacity, Antimicrobial Stewardship, Estates and Facilities, policies and procedures.

presented to Board. Second review report recieved in August 2019 shows improvement, as does the internal audit on SCC assurance in June 2019. 7. Safe Clean Care Programme (SCC) launched 29-01-18, consideration to align SCC with IP annual work programme. 8. CAUTI snapshot carried out in September 2019. 9. Deep dive considers every 6 organisms under WG scrutiny.	5. Scrutinise every avoidable infection and lessons learnt from these are shared formally. 6. Progress work on influenza preparedness in preparation for winter 19-20. 7. 12 Key action points carried out HB wide in November 2019. 8. Educational event and Link practitioners in place December 2019. 9. Canula devices and documents approved for distribution. 10. Collaberative work with Continence, Tissue Viability and pharmacy to address unwarrented variation. 11. Improved visability across the HB from IP service. 12. Review of all IP policies and SOPs

Assurances	**Links to**		
1. Professor Duerden report 2016. 2. WG review of decontamination. 3. Demonstrable improvement in line with National Benchmarks. 4. CHC Bug watch visits. 5. HSE reviews. 6. Internal Audits of Governance Arrangements.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Leadership

CRR03	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 1 November 2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 03 December 2019
	Risk: Continuing Health Care	**Target Risk Date:** 31 December 2019
There is a risk that the CHC Framework and process will not be fully adhered to. This is due to inconsistent application and service pressures including availability of suitable provision. This could lead to poor patient experience and outcomes and associated complaints and retrospective claims.		



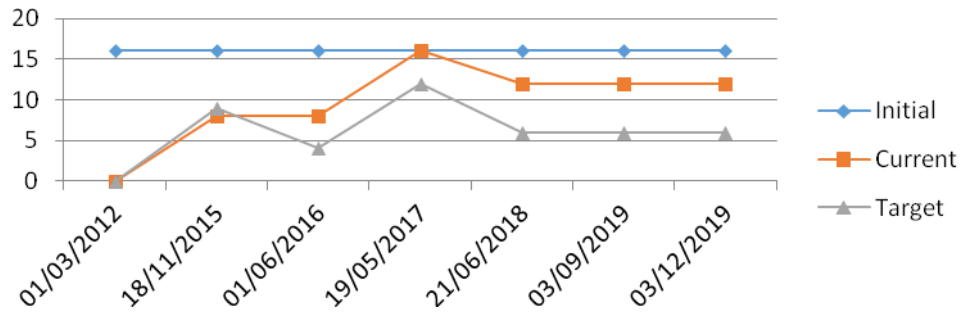
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. 2014 national CHC Framework. 2. Revised CHC structure in place including Practice Development Team. 3. All Wales Retrospective Claims process (Powys). 4. Joint LA & BCU CHC Regional Implementation Group. 5. Revised BCUHB CHC Governance Framework agreed. 6. PMO Scheme for CHC with associated project management and reporting in place. 7. Annual WG self assessment. 8. North Wales care home market place community project. 9. Contracts and contract monitoring team in place. 10. Implemented Scheme of Delegation Process within Areas. 11. Implemented Skills and Knowledge Framework.	1. Implement revised CHC Governance and Strategic Commissioning Team. 2. Finalise and implement regional SOP. 3. Development of dashboard KPI's for CHC with Broadcare. 4. Monthly exception reporting. 5. Develop CHC commissioning strategy. 6. Implement the Older persons Commissioner and Operation Jasmine action plans. 7. Roll out Bevan Exemplar care home support team. 8. Finalise and implement joint quality monitoring tool across north Wales. 9. Implement patient and family feedback process.

12. Recruited to Retrospective Team. 13. Implemented revised national retrospective claims procedure. 14. CHC Contracts in place for all placements. 15. Care Home QAF in place. 16. Care Home Market position statement developed.	10. Increase partnership working with the sector to include shared services. 11. Develop training and workforce strategy for Care Homes. 125. Development of training and workforce strategy for CHC process.

Assurances	**Links to**		
1. Regular meetings with Regulators (CSSIW). 2.Inter-agency processes in place to review escalated concerns. 3. FNC Judicial Reviews of NHS Wales fee setting methodology implemented. 4. National reporting on CHC placements.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 6 7	PR1	Strategic and Service Planning

CRR05	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 03 December 2019
	Risk: Learning From Patient Experiences	**Target Risk Date:** 31 January 2020
There is a risk that the Health Board does not listen and learn from patient experience due to the untimely management and investigation of concerns. This could lead to repeated failures in quality and safety of care.		



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	3	4	12
Target Risk Score	2	3	6
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Corporate concerns team embedded in operational management structures. 2. Performance and accountability reviews include concerns monitoring. 3. Weekly divisional PTR meetings being held. 4. Monthly reporting and monitoring of performance and learning to QSG. 5. Enhanced monitoring of claims with Welsh Risk Pool. 6. Ongoing programme of work in place as part of the IMTP to deliver improvement. 7. Patient Advice and Support Service established in YGC initially. 8. Minimum data sets provided monthly to all divisions regarding Concerns.	1. Concerns management and investigation processes being reviewed with support of new ADQA with a particular emphasis on incident management. 2. Review and revision of corporate concerns management to enhance learning in the divisions and create capacity to support training and development for the divisions. 3. Manage performance in line with revised trajectories. 4. PALs service introduced into East and West. 5. Learning from complaints now added into QSE reports. 6. Peer review of complaints redress reimbursement commenced on an All Wales basis to share learning across Wales. 7. Development of newsletter to include learning.

9. Initial review (72hr) of serious incidents implemented. 10. Revised trajectories agreed as part of IMTP. 11. Significant reduction in total numbers of complaints open - focus on resolving complaints as OTS where possible. 12. Harm dashboard launched and being informed by Datix. 13. Weekly teleconference with corporate and divisions to monitor complaints. 14. Associate Director Quality Assurance in post. 15. Process commenced to manage historic incidents to closure and learning. 16. Additional support identified to manage overdue complaints and allow divisions to focus on new complaints raised. 17. Weekly Incident review meeting established to review all serious incidents and complaints over 3 month overdue.	8. Focus on training and development of human factors training programme. 9. Implementation of new "Once for Wales" RLDatix concerns management system to aid learning across Wales.

Assurances	**Links to**		
1. Welsh Risk Pool Reports. 2. Monthly review by Delivery Unit. 3. Public Service Ombudsman Annual Report, Section 16 and feedback from cases. 4. Regulation 28 Reports from the Coroner.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 4 5 6	PR7	Leadership

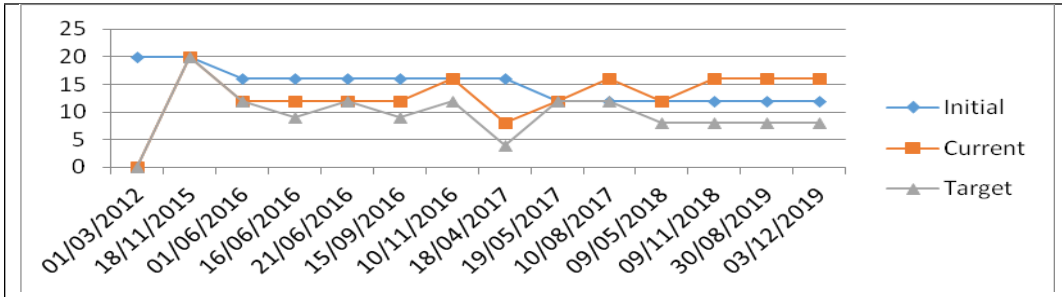
CRR06	**Director Lead:** Executive Director of Finance	**Date Opened:** 1 March 2012
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 03 December 2019
	Risk: Financial Stability - Health Board Financial achievement of the control total agreed with Welsh Government	**Target Risk Date:** 31 March 2020

There is a risk that the Health Board will fail to achieve the deficit that meets the control total set by Welsh Government.

This is due to:
1. Savings plans that are not fully identified and may not be fully delivered.
2. Expenditure exceeding plan in both pay and non-pay areas.
3. The use of non-recurrent measures to support the in-year position risking the Health Board's longer term sustainability and continued failure to achive its financial duty.
4. Failure to identify and progress transformational schemes that will position the Health Board for the longer-term.

The impact of this could increase the in-year deficit to 31 March 2020 and fail to progress towards the Control Total of £25m, and impact on the ability of the Health Board to improve its financial position in out-years.

The Health Board will remain in Special Measures until the financial position improves and will fail to attract necessary investment.



	Impact	Likelihood	Score
Initial Risk Rating	4	3	12
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

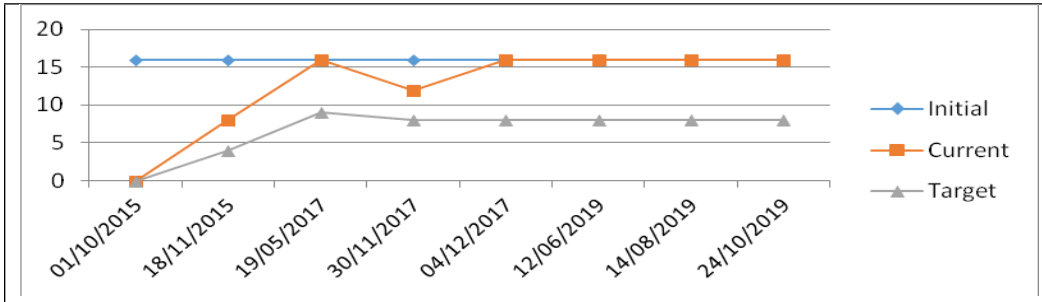
Controls in place	**Further action to achieve target risk score**
1. Appointment of Recovery Director and establishment of a multi-faceted Recovery Programme, including recovery challenge meetings across all business areas and improvement themes, deployment of	1. Further work to identify and convert recovery opportunities, including ongoing review by Improvement Groups of the All Wales Efficiency Framework for further

detailed grip and control, and active management if savings opportunity pipeline. 2. Scheme of Financial Delegation and Accountability Agreements in place covering all devolved budgets. 3. Additional stretch targets issued across all business areas. 4. Dedicated Chief Finance Officer embedded in the management team of each Division (and hospital/area team). 5. Focused additional recovery support provided by PwC and Finance in key areas of budgetary pressure. 6. Programme Management software used to track and monitor the delivery of savings. 7. Reporting through Financial Recovery Group and Finance and Performance Committee.	opportunities. 2. Ongoing communications to continuously embed financial goals across the organisation and all devolved budget areas including Better Care, Spending Well initiative. 3. Potential F&P Committee requesting attendance of divisions with recovery shortfalls to seek assurances regarding further progress. 4. Improved Financial Recovery Reporting to support oversight and decision-making.

Assurances	**Links to**		
1. Monthly financial position reported to the F&P Committee and Board. 2. Finance Delivery Unit (FDU) view at the WG Special Measures meeting.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	7	PR2	SM4 SM1

CRR09	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 1 October 2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 24 October 2019
	Risk: Primary Care Sustainability	**Target Risk Date:** 31 March 2021

There is a risk that the Health Board may be unable to meet its statutory responsibilities to provide a primary care service to the population of North Wales. This may be due to the significant number of GPs who are able to retire within the next 5 years and the supply of GPs in training may not meet the demand created by the turnover. This could lead to delayed access for some patients to the appropriate primary care service.



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. 5 Domain Sustainability risk assessment metric developed by PCUS used pan-BCUHB and by Areas to RAG rate and identify highest risk requiring support. Last assessment undertaken July 2019. 2. Each Area has developed a regular practice review process to prioritise support. 3. Area Teams have developed support infrastructure to those practices experiencing significant challenges/pressures in terms of sustainability. 4. National Sustainability assessment process allows practices to request support from the Health Board. 5. Clinical advice available from Area Medical Directors and Cluster leads to provide support and development advice to practices. 6. Salaried GPs employed by Areas, working in managed practices and also GMS practices in difficulty. Further GPs employed since April 2019.	1. Evaluation and integration of new service models into primary care to ascertain their success. 2. New governance models of primary care need to be assessed to identify their reliability and assurance. 3. Care closer to home strategy to be evaluated. 4. Establish primary care academy and further develop primary care training, including mentorship. 5. Recruit to GP schemes being adopted by Clusters and supported by new project manager for recruitment and retention. 6. Primary care workforce plan to be developed and fully implemented. 7. Further engagement with primary care and partner

7. Agreement to employ clinical leads in managed practices to provide leadership and oversight. Clinical lead appointed for Blaenau Ffestiniog, other practices progressing recruitment at present.. 8. Recruitment and retention plan to recruit new GPs into North Wales under development. Project Management for recruitment and retention appointed. Attendance at recruitment fairs and other conferences being co-ordinated to promote careers and share current vacancies in North Wales. 9. Schemes for retaining and recruiting staff e.g. Outstanding GP scheme and the GP with experience scheme in place. 10. Developed Multi-Disciplinary Teams within GP practices eg physiotherapists, ANPs, audiologist, pharmacists and this team takes on patients that were previously seen by the PG. 11. Developing new models of delivery of care within GP practices. 12. Primary care funding is supporting the way that services are delivered within community and primary care setting to take pressure off GPs. 13. Emerging schemes that will further support the way that services are delivered from Primary care eg Occupational therapy, advanced practice paramedics and GP sustainability and innovation unit have been allocated funding from Primary Care Investment funds in 2018/19. 14. Cluster plans and funded schemes are focusing on areas such as pathways and supporting the way that care is delivered at local level. 15. ANPs focusing activity within Care/Nursing homes to improve patient care and reduce demand on GP visits. 16. Running 24/7 DN service to reduce out of hours call out and unnecessary ED admissions. 17. Navigators working within GP practices signposting patients to the right healthcare. 18. Workflow optimisation training available to practices. 19. Intermediate care funded schemes supporting primary care. 20. 16 BCUHB managed practices in place that are providing opportunities to trial new models of working and develop new areas of clinical care.	organisations. 8. Demand management scheme – establishing ways to release GP capacity and shift services out of hospital settings – new roles, new models, and new services. 9. Work with Deanery to increase the number of GP training places in N Wales. 10. Lobby WG for review of national DDRB pay scales and recommendations to increase the rates to better reflect the different roles of salaried GPs. 11. Accelerated role out of advanced practice training. 12. Promote practice mergers and federating. 13. Project to establish a Primary & Community Care Academy in place to deliver a sustainable, fit for purpose workforce within primary and community services through the allocation resources and development of new models. 14. Further development of clusters/localities with partners to strengthen primary/community/social care. 15. Accelerate estates improvements to ensure fit for purpose buildings for care in community settings.

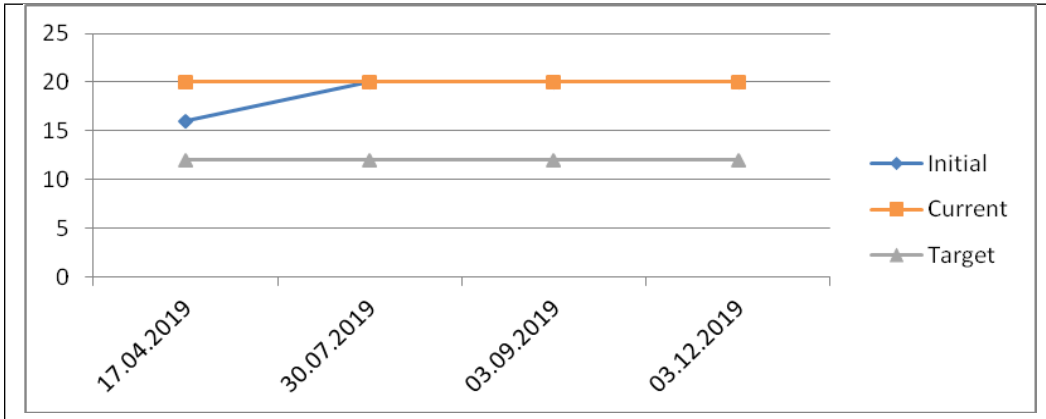
21. BCUHB has approved a 'Care Closer to Home' strategy that provides a vision of the way that care will be provided within community and primary care setting in the future. A CCtH transformation board has been established to oversee progress, with the first meeting held on 20 July 2018. 22. Care closer to home themes set out in annual operational plan. Priority for cluster development, service model, workforce development, digital healthcare and technology and estates. 23. Governance and accountability of managed practices group in place; performance indicators established, project management work books published, governance framework for nurses and pharmacists agreed. 24. Premises issues being addressed with a number of practices, including approval to assign some premises head leases from partners to BCUHB. 25. Programme for recruiting and training practice nurses funded by PC funds in place with 6 nurses being recruited per annum. 26. Director of Primary and Community Health Services appointed and in post. 27. Plans to progress CCtH built into IMTP 2019-20, identified leads for progressing 4 themes (CRTS, Clusters, Health and Worksforce/service model) Centres. 28. Project to establish a Primary & Community Care Academy in place to deliver a sustainable, fit for purpose workforce within primary and community services through the allocation resources and drvelopment of new models. Project Manager appointed August 2019 and additional pacesetter proposal being submitted in same month to further develop the Academy. 29. Changes to GP contract inlcude parntership premium to support and encourage GPs becoming partners going forward.	

Assurances	**Links to**		
1. Oversight by Board and WG as part of Special Measures. 2. CHC visits to Primary Care. 3. GP council Wales Reviews. 4. Progress	**Strategic Goals**	**Principal Risks**	**Special Measures**

reporting to Community Health Council Joint Services Planning Committee.			**Theme**
	1 2 3 4 5 6 7	PR6	Primary Care

CRR10A	**Director Lead:** Executive Medical Director	**Date Opened:** 28 March 2019
	Assuring Committee: Information Governance & Informatics Committee	**Date Last Reviewed:** 03 December 2019
	Risk: National Infrastructure and Products	**Target Risk Date:** 28 December 2020

There is a risk that the national infrastructure, technical architecture and products are not fit for purpose and do not allow the organisation to deliver benefits when planned. This may be caused by
a) a one size fits all approach.
b) products which are not delivered as specified (e.g. time, functionality and quality).
c) the approach of the National Programme to mandate/design systems rather than standards.
d) poor resilience and a "lack of focus on routine maintenance".
e) Supplier capacity leading to commitment or delivery delays.
f) Historic pricing models that are difficult to influence / may not be equitable.
This could result in negative impacts in several key areas including:- Patient outcomes. An inability to support the strategic direction of the Health Board. Delays to delivery of transformational change. Inefficient work flows, poor system usage. Increased costs as we maintain multiple systems / pay inequitable prices. Delays with the delivery of cost saving schemes.



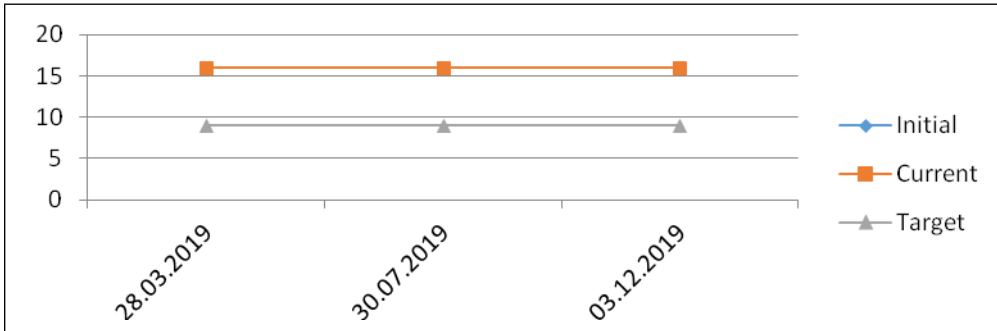
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**

1. Scrutiny of NWIS by DIGC. 2. Project Governance.	1. Viable SLA. 2. Development and approval of local Digital Record. 3. Implementation of recommendation's from Architecture and Governance Reviews (due in May 19).

Assurances	**Links to**		
1. Public Accounts Committee Review of NWIS. 2. Reports from the Digital Transformation Group to IGIC / EMG. 3. WAO – review. 4. National Architecture and Informatics Governance Reviews.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	7	PR6	Not Applicable

CRR10b	**Director Lead:** Executive Medical Director	**Date Opened:** 28 March 2019
	Assuring Committee: Information Governance & Informatics Committee	**Date Last Reviewed:** 03 December 2019
	Risk: Informatics - Acute and Community Health Records	**Target Risk Date:** 31 December 2019
There is a risk that patient information is not available when and where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This could result in substandard care, patient harm and an inability to meet our legislative duties.		



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

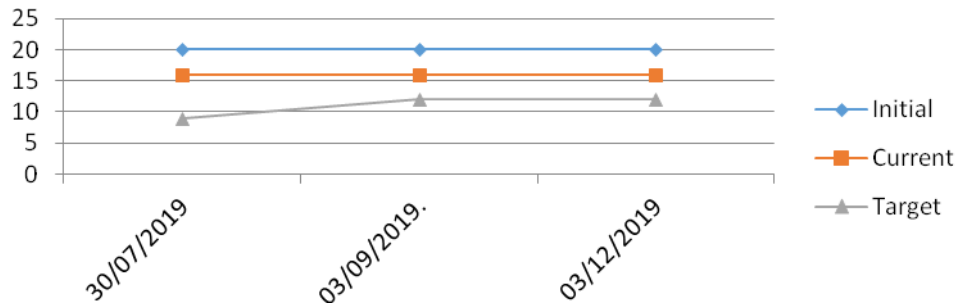
Controls in place	**Further action to achieve target risk score**
1. Corporate and Health Records Management policies and procedures are in place pan-BCUHB. 2. iFIT RFID casenote tracking software and asset register in place to govern the management and movement of patient records. 3. Escalation via appropriate committee reporting. 4. Key performance indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group).	1. Enable actions to meet the regulatory recommendations from the ICO, HASCAS/Ockenden and Internal Audit reports. 2. (Project) Development of a local Digital Health Records system to digitise the 'acute general' patient record. 3. (Project) Improve the assurance of Results Management (stop printing results). 4. (Project) Digitise the clinic letters for outpatients through implementation of Digital Dictation, and as appropriate Speech Recognition software.

	5. (Project) Digitise nursing documentation through the implementation of CHAI Paediatrics, and Adults National Nursing systems. 6. (Project) Baseline the; storage, processes, management arrangements and standards compliance, and present the recommendations and funding requirements to work towards PAN-BCUHB Patient Records Compliance with legislation and standards in patient records management across all casenote types. 7. Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.

Assurances	**Links to**		
1.Chairs reports from Patient Record Group. 2.ICO Audit. 3.HASCAS Audit.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	7	PR1	Not Applicable

CRR10C	**Director Lead:** Executive Medical Director	**Date Opened:** 28 March 2019
	Assuring Committee: Information Governance & Informatics Committee	**Date Last Reviewed:** 03 December 2019
	Risk: Informatics infrastructure capacity, resource and demand.	**Target Risk Date:** 31 December 2019

There is a risk that digital services within the Health Board are not fit for purpose. This may be due to:
(a) A lack of capacity and resource to deliver services / guide the organisation.
(b) Increasing demand (internally from users e.g. for devices/ training and externally from the public, government and regulators e.g. growing need for digital services).
(c) the moving pace of technology.
This could lead to failures in clinical and management systems, and a failure to support the delivery of the Health boards strategy / plans impacting negatively on patient safety/outcomes. It may also pose a greater risk to the Health board of infrastructure failures and cyber attack.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

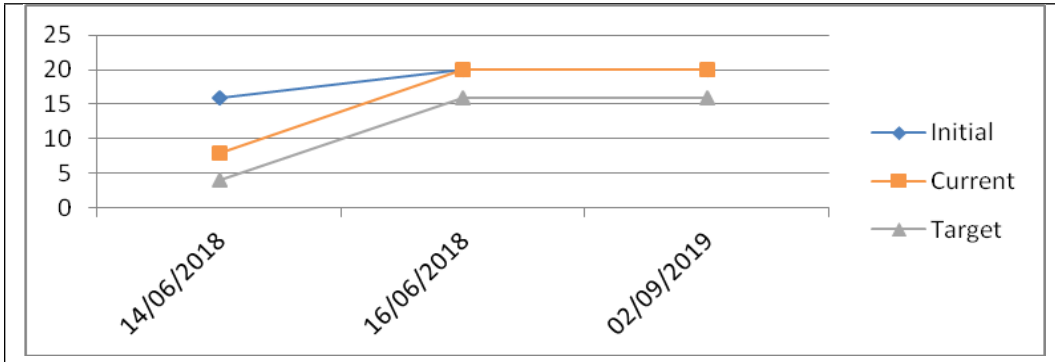
Controls in place	**Further action to achieve target risk score**
1. Governance structures in place to approve and monitor plans. Monitoring of approved plans for 2019 2020 (Capital, IMTP and Operational. Approved and established process for reviewing requests for services. 2. Integrated planning process and agreed timescales with BCU and	1. Develop associated business cases for resource required based upon risks and opportunities e.g. Digital Health Record. 2. Review workforce plans and establish future proof informatics/digital capability and capacity.

third party suppliers. 3. Key performance metrics to monitor service delivery and increasing demand. 4. Risk based approach to decision making e.g. Local hosting v's National hosting for WPAS etc. 5. DTG - whose remit includes review of resource conflicts.	

Assurances	**Links to**		
1. Annual Internal Audit Plan. 2. WAO reviews and reports e.g. structured assessments and data quality. 3. Scrutiny of Clinical Data Quality by CHKS. 4. Auditor General Report - Informatics Systems in NHS Wales. 5. Regular reporting to IGIC (for Governance).	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 6 7	PR6 PR5 PR2	Not Applicable

CRR11a	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 June 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 02 September 2019
	Risk: Unscheduled Care Access	**Target Risk Date:** 25 September 2020

There is a risk that systematic harm may be caused to patients needing access to unscheduled care services due to failures to be able to respond to demand in accordance with expected national targets.
This may be caused by mismatches between resources available across the unscheduled care system to demands placed on the system for prolonged periods of time or inappropriate allocation of resources available to meet the demand.
This could lead to an impact/effect on patient experience and outcomes, organisational reputation, delivery of national targets and recognised standards of care.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	4	16
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Multi-agency Unscheduled Care (USC) Transformation Board refereshed to USC improvement group, now chaired by the interim Executive Director of Nursing. 2. Continued cycles of improvement with 3 specific work streams: Demand, Flow and Discharge. 3. Program project manager appointed to oversee production and implementation of action plans.	1. 3 EC managers substantively recruited and engaged with building better care plans (was previously 90 day improvement plan). 2. Building better care plan consisting of 3 streams of work: a. Demand - SICAT established and demonstrating reduction in transfers to ED (~30% of calls - assumption

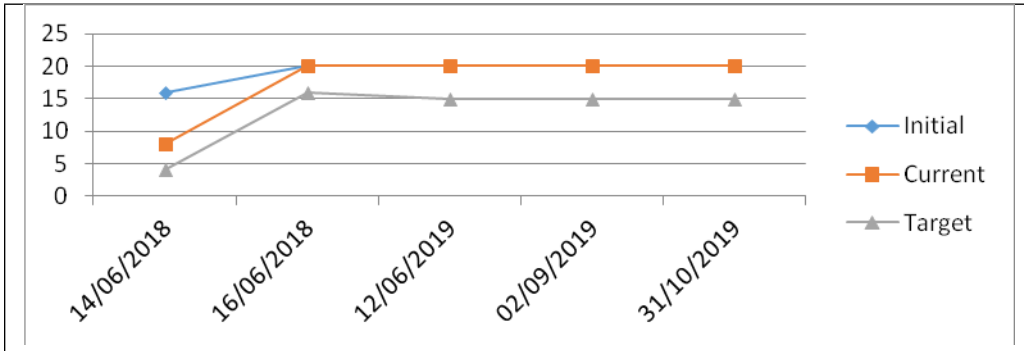
4. Daily National Conference Calls with WG to address daily position. 5. Daily Safety Huddles in place on 3 acute sites. 6. Daily BCU system calls to support flow between divisions. 7. Daily Board rounds on acute sites to support continuity of care and early discharge planning. 8. Weekly MDT stranded patient review meetings to identify reasons for lack of progress to facilitate more complex discharges. 9. Development of USC dashboard with live and daily performance information to support decision making. 10. Weekly teleconference with DU to report performance and concerns and track improvement plans. 11. Sitrep reporting 3 times a day including SAPhTE for ED risk assessment. 12. Mental Health support located within site Police Control. 13. Frequent attenders WEDFANs group regularly review vulnerable patients who frequently access services to support implementation of care plans. 14. Escalation process and structure in place to provide 24/7 escalation from site management through bronze, silver and gold. 15. Development of internal clinical standards to highlight best practice and support teams to consider ways of working to achieve standards. 16. Escalation plan being developed to support clinical standards and staff to maintain site safety. 17. Discharge information provided to patients on admission via new discharge leaflet.	that ALL calls previously would have resulted in transfer). b. Flow - Multiple substreams including: -ambulance handover - WMH lost improved with consistent reduction in time taken for handover. -proactive triage - promoting use of alternative resources and early decision-making to reduce time in ED (Overall average time in ED is reducing). -early senior decision-making - recognition of senior medical staffing issues esp. at WMH - requiring workforce and roster review. -escalation and capacity management review - test of 'grip and control' at YGC site de-escalated from sitrep 4 to 2 without associated reduction in overall time in ED - further work on-going to review process and pilot at other sites. -implementation of SAFER - ongoing - small increase in numbers of earlier discharges. -stranded & super-stranded patient review - to launch across sites. -review of acute assessment/ambulatory models with pilots to be launched later this month at YGC & WMH. -review of specialty reviews for inpatients - to enable earlier discharge. -review of imaging pathways to support early outpatient scans and avoid longer inpatient stay. c. discharge planning - work continues to reduce delays in transfers of care and decision-making. Letter shared re. patient choice and working with staff to encourage proactive discussions with families and patients. 3. Review of site escalation and management to support site responsibility during normal working hours. 4. Associate director for unscheduled care replaced with

	programme manager with additional interim support at area level to oversee progress against building better care plan. 5. Engagement with National ED Quality & delivery framework. 6. Workforce review - supported by Kendall Bluck.

Assurances	**Links to**		
1. Seasonal Plan. 2. RTT Plan. 3. Twice Yearly JET meetings with WG. 4. Monthly meetings with Delivery Unit. 5. National Patient Flow Collaborative. 6. OOHs review (both National and Internal Audit). 7. Subject specific internal audit reviews. 8. Orthopaedic Plan development. 9.Transformation groups reporting. 10. WPAS implementation group reporting and daily tracking.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 6 7	PR3	Leadership

CRR11b	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 June 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 31 October 2019
	Risk: Planned Care Access	**Target Risk Date:** 31 December 2019

There is a risk that the BCUHB is not able to provide access to planned care in accordance with the national standards. This may result in not being able to meet the timely clinical needs and expectations of patients. BCUHB will need to provide assurance to partner organisations on the management of clinical safety and treatment of the backlog.
This is caused by capacity shortfalls or mismatch between allocation of available capacity and demand including booking of patients in chronological order following clinical urgency, a lack of effective utilisation of resources, conflicting pressures (management of Unscheduled Care pressures and elective delivery), equipment failure and availability of suitable facilities, workforce issues.
This could lead to adverse outcomes for patients, prolonged waiting periods, an inability to meet national targets (RTT, diagnostics, cancer, clinically due review time, and impact on the financial stability and the reputation of the Health Board.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	5	15
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

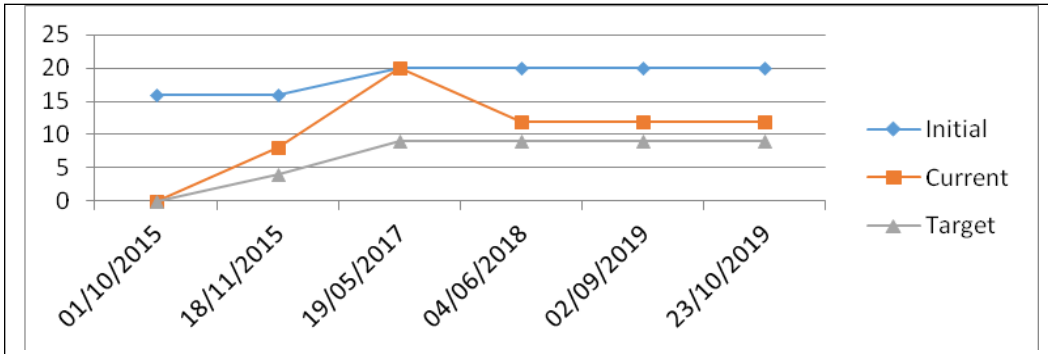
Controls in place	**Further action to achieve target risk score**
1. Weekly PTL and Daily waiting times information in place for RTT, diagnostics and Cancer. 2. Performance team and trackers in Cancer utilising escalation processes with operational teams. 3. Demand and Capacity plan agreed per specialty and site confirming extent of sustainable service gap.	1. Resourced planned care operational plan signed off. 2. Resource for RTT and Diagnostics 2019-20 nearly confirmed. Orthopaedics to be confirmed by the WG colleagues. 3. Pan BCU service line management to be implemented with initial recruitment to the specialties of: Orthopaedics,

4. Weekly Access meeting extended to include RTT, Diagnostics and Cancer. 5. Interim Planned Care leadership in place responsible for leadership across the HB providing oversight of RTT, Cancer, Endoscopy and Diagnostics remedial action plans. 6. Performance management at Hospital and Area Level. 7. Weekly PTL meeting at health economy level in place led by the Associate Director of Planned Care. 8. Weekly outsourcing meeting in place. 9. Elective patient pathway and outpatient improvement cells in place with clear targets for efficiency improvement. 10. Engaged with National Planned Care, National Outpatient and Cancer Implementation Groups. 11. Single Cancer Pathway demand and capacity submission completed and shadow reporting to WG monthly. Capacity gap for diagnostics reported via monthly EMG report and to be considered as part of IMTP preparation 2019-2022. 12. Elective and Seasonal plan assumes only daycase and urgent/cancer surgery is scheduled for winter 2019/20 to support unscheduled care capacity (except at Abergele). 13. Eye care measure reporting commenced 30.9.18 and successful WG fund made for resource to assist with implementation. 14. DU supporting with endoscopy capacity review for diagnostic waits as part of an all Wales programme of work Nov/Dec 2018. 15. Additional contracts in place for non-obstetric Ultrasound aims to recover 8 week waits for this service by end of Dec 2018. 16. Risk for follow up management increased in Central area due to WPAS serious incident, operational oversight group in place. 17. Outpatient Programme Group established and clarity re: governance obtained.	Ophthalmology and Urology. 4. Sustainable service plans for these 3 specialties to be further developed and implemented. 5. Learning from Single Cancer Pathway shadow working to be shared and used to inform Cabinet Secretary decision making - this will impact on diagnostic capacity and demands on cancer tracking. 6. Learning and application of change management in respect of the Eye Care measures to inform sustainable plan. 7. Follow up efficiency measures for the 4 specialties from the national planned care programme to be implemented. 8. Sustainable endoscopy capacity plan to be developed and key appointments made. 9. Outcome awaited on Single Cancer Pathway WCN investment proposal. 10. Matrix working and responsibilities of clinical and operational leaders to be confirmed to strengthen governance. 11. Enhanced governance structure in place and developing.

Assurances	**Links to**		
1. Seasonal Plan. 2. RTT Plan. 3. Twice Yearly JET meetings with WG. 4. Monthly meetings with Delivery Unit. 5. National Patient	**Strategic Goals**	**Principal Risks**	**Special Measures**

Flow Collaborative. 6. OOHs review (both National and Internal Audit). 7. Subject specific internal audit reviews. 8. Orthopaedic Plan development. 9.Transformation groups reporting. 10. WPAS implementation group reporting and daily tracking.			**Theme**
	1 2 3 6 7	PR3	Leadership

CRR12	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 1 October 2015
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 23 October 2019
	Risk: Estates and Environment	**Target Risk Date:** 1 April 2022
There is a risk that the Health Board fails to provide a safe and compliant built environment. This may be due to insufficient financial investment and estates rationalisation. This could result in avoidable harm to patient, staff, public, reputational damage and litigation.		



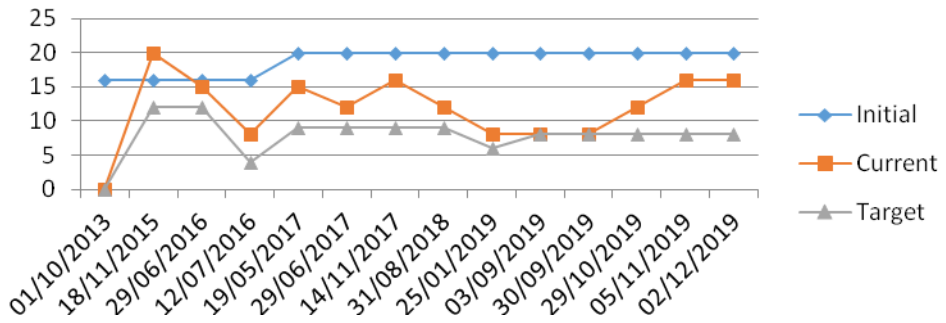
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	Further action to achieve target risk score
1. Clear Board direction on future clinical service model through Living Healthier/Staying Well(2019/20). 2. Operational Risk Registers in place defining high risk priorities for capital and revenue investment. 3. Risk assessed schedules for implementation of agreed priorities. 4. Estates Strategy in place for the delivery of capital and investment objectives. 5. Input data into All Wales Estates Facilities Performance Management System (EFPMS) Portal to assess overall estate performance. 6. Risk based estates rationalisation and disposal programme in place. 7. Project Director appointed for development of Ysbyty Wrexham	1. Approved Health Board Estates Strategy 2019/20 to deliver mitigation and reduce risk. 2. Ongoing programme of estates rationalisation and selective demolition (2019/20). 3. Develop Full Business Cases for Residential Accommodation and submit to Board for approval (December 2019). 4. Estates Strategy to reflect current assessment of backlog maintenance the annual data gathering for the All Wales Estates and Facilities Performance Management System has now been submitted and an

Maelor and Business Continuity Programme Business Case submitted to Welsh Government for essential infastructure investment. 8. Stock Condition Survey of Primary Care Estate premises completed. 9. Operational Estates and Facilities Management annually agreed Discretionary capital funding. 10. Strategic capital investment (2019/20) - (updated and reviewed annual in line with the Health Board's Discretionary Capital Programme and All Wales Capital Projects). 12. New service models for non strategic estate developed. 13. Options Appraisals for both Residential and Laundry Services have been developed and work taking place to complete Business Cases .	All Wales Report will be published in December 2019). 5. Phased Stock Condition Survey of Acute and Community premises to inform capital investment plans (2019/20) - Revenue funding bids are currently being considered within the 2019/20 Health Boards budget setting process. 6. Estates rationalisation and disposal programme in place for 2019/20.

Assurances	**Links to**		
1. Independent authorising engineer appointments. 2. Internal Audit Programme. 3. HSE Statutory Reviews and Reports. 4. EFPMS Portal Data used by WG for Annual All Wales Report. 5. Local Authority Trading Standing. 6. Food Safety Assessment. 7. Annual Reports (HSE, Fire, V&A and sustainability).	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 7	PR5	Strategic and Service Planning

CRR13	**Director Lead:** Director of Mental Health and Learning Disabilities	**Date Opened:** 1 October 2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 02 December 2019
	Risk: Mental Health Services	**Target Risk Date:** 31 March 2020
There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which could result in poor quality outcomes for patients.		

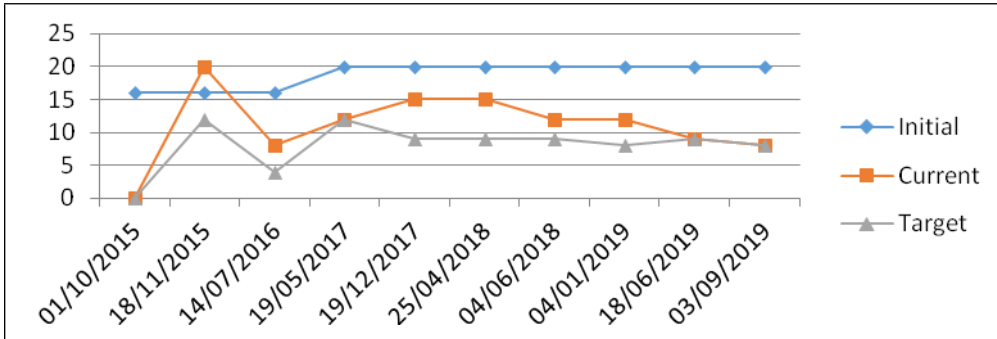


	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	Further action to achieve target risk score
1. Improvement plan in place and subject to ongoing review. 2. Enhanced monitoring in progress at Board level. 3. Renewed focus and escalation arrangements for dealing with operational issues. 4. Governance Framework developed and implemented within mental health. 5. Mental Health Strategy approved by the Board. 6. Senior Management and Clinical Leadership holding structure in place. 7. Older Person's Mental Health action plans in place. 8. Weekly PTR meeting in place. 9. Revised interim leadership, management and governance arrangements in place November 2017.	1. Ongoing implementation of performance and accountability reviews across the division. 2. Continue to improve internal divisional communication systems. 3. Contribute to HASCAS investigation and wider governance review. 4. Undertake review of demand, capacity and skill mix. 5. Ongoing review of staffing levels. 6. Consultation on permanent structure to be completed. 7. Embed revised arrangements for safeguarding, and dynamic risk assessment. 8. Standardise operational procedures for acute inpatient care.

Assurances	Links to		
1. Board and WG oversight as part of Special Measures. 2. External reviews and investigations commissioned (Ockenden and HASCAS). 3. HIW Reviews. 4. External Accreditation (AIMS). 5. Delivery Unit oversight of CTP.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Mental Health

CRR14	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 1 October 2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 03 September 2019
	Risk: Staff Engagement	**Target Risk Date:** 31 March 2020
There is a risk that the Health Board does not maintain a culture which promotes excellence and engagement of staff in order to transform services. This may be caused by a disconnect between stated values and actual behaviours. This could lead to poor quality services, damage to the organisations reputation, long term sustainability and low levels of workforce satisfaction and well being.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	2	8
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Implemented Proud to Lead - Leadership Behaviours Framework. 2. Implemented a range of engagement processes including: -3D Model-Discover, Debate, Deliver; Listening Leads; Staff Engagement Ambassadors; "Proud Of" Groups established in each DGH and some Community Hospitals. -Implemented Staff Reward and Recognition Schemes such as Seren Betsi Star, Staff Achievement Awards and Long Service Awards. 3. Implemented range of public engagement opportunities. 4. Trade Union partnership arrangements: Local Partnership	1. Monitoring progress of the 2018 Staff Survey Organisational Improvement Plan and Divisional Improvement Plans to be through the Workforce Improvement group. 2. Development of an organisational Retention Improvement Plan Q1 2019/20. 3. Development of an Attraction Improvement Plan Q2 2019/20. 4. Development of a Succession Planning Framework at

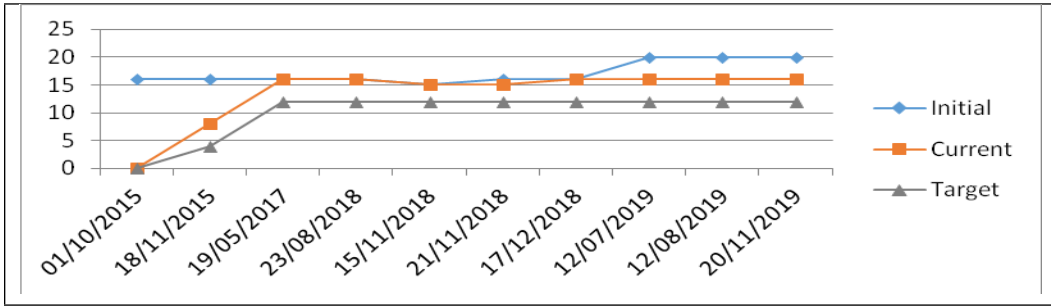
Forum/Local Negotiating Committee in place. 5. Defined purpose and values. 6. Implemented "Hello my name is" / “Helo fy enw I ydy”. 7. Raising Concerns Procedure and Safe Haven Scheme in place with task and finish group oversight. 8. Workforce, clinical and operational policies and procedures in place including Dignity at Work. 9. BCU and Professional Codes of conduct in place. 10. Leadership Development Programmes in place including the newly refreshed Ward Manager Development Programme (previously known as Generation 2015 programme). 11. Implemented Speak out safely campaign. 12. Staff Engagement Strategy and delivery plans have been superseded by the Workforce Strategy 2019-22 and associated Annual Objectives. 13. Simplified PADR documentation currently under consultation. 14. 3D Listening Methodology in place and "You Said - We Did" are collated for each project area. Model has been amended following staff feedback, the 3D Lite has been launched. Teams are using this method widely now to gather staff feedback and ideas to improve patient care, staff working environment and practices and generally raise ideas to improved morale. 15. Leading for Transformation Senior Leadership development programme focussing on leadership behaviours for Bands 8a and above and Medical & Dental staff launched in Q1 2019/20. 16. 2018 Staff Survey Improvement Plans in place for the Organisation, Divisions and Corporate Divisions. 17. BCUHB Best, Facebook and Twitter in place. 18. BCUHB are part of the All Wales Public Services Coaching Network. In-house coaching programmes have been established and are currently available. 19. Partnerships established with Local Further Education Providers to deliver a programme of Essential Skills for Staff. 20. Senior Leadership Master Classes have been established for	Tiers 1-3 Q3 2019/20.

2019/20. 21. Staff Engagement resource tool kit developed and available on the Intranet. 22. Workforce Metrics dashboard implemented. 23. First staff engagement organisational survey ByddwchYnFalch/BeProud is currently live and will close at the end of June 2019. This provides a process for continuous engagement and feedback from staff. A survey will be launched on a quarterly basis. 24. The first ByddwchYnFalch/BeProud Pioneer Teams, 10 in total have commenced their engagement journey. The next cohort of 10 teams commence their journey on 19th June 2019, with Cohort 3 commencing in September 2019. This is a 26 week programme to support teams to build staff engagement at team/local level. 25. PADR Improvement plan in place, PADR compliance gradually improving. 26. Seren Betsi Aur/Gold Award developed - to recognise achievement, selected from all Seren Betsi winners annually,through nomination process and awarded at staff achievement awards - implemented Q3 18/19. 27. Proud of initiative - developed further in Q4 18/19 to amalgamate a range of engagement tools/methods to support staff engagement across the organisation. 28. An advanced Coaching Skills training programme for Medical Staff and Senior Leaders has been developed and delivered with good engagement and outcomes. 29. Proud of Groups - Tested new approach in Area East with positive feedback from staff and senior managers. Outcomes include: •Local groups being established within Community Hospitals to build on and improve staff engagement. •Improved accessibility to Area Director through regular and rotating meetings with staff. •Various engagement methods such as recognition tools and 3D used to celebrate successes and exploring further engagement	

methods within teams.	

Assurances	Links to		
1. Board and WG monitoring as part special measures. 2. Staff survey benchmarked across Wales. 3.Corporate Health Award. 4. Implmentation of I Want Great Care.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR9	Engagement

CRR15	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 1 October 2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 20 November 2019
	Risk: Recruitment and Retention	**Target Risk Date:** 27 March 2020
There is a risk that the Health Board will have difficulty recruiting and retaining high quality staff in certain areas. This may be due to UK shortages for certain staff groups and the rurality of certain areas of the health board. This could lead to poor patient experience and outcomes, low morale and well being and attendance of staff.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Promotion of the employment brand train work live North Wales through digital media and marketing through key publications such as RCN careers brochures, BMJ on line and hard copy. Attendance at two national job fairs for nurses in Birmingham and Manchseter resulted in eight applocations and 150 interested nurses who BCU is direct marketing jobs to. 2. Local atttendance during 2019 at public high proifile engagement events such a national Eisteddfod, Denbighshire shows and food festivals. A new BCU Recruitment Support Team is in place (from september 2019). The Recruitment Team have co-ordinated staff from BCU HB to attend events.	1. Improved digital media marketing via social media the train work live north wales brand now has its own facebook. 2. Identification of recruitment co-ordinators in each secondary care high vacancy areas. 3. Continue with student recruitment and promotion of nurse vacancies to Manchester, Chester and Staffordshire Universities. 4. Contribution to Medical Training Initiatives (MTI) Bapio Scheme. 5. BCU HB needs recruitment marketing funding to

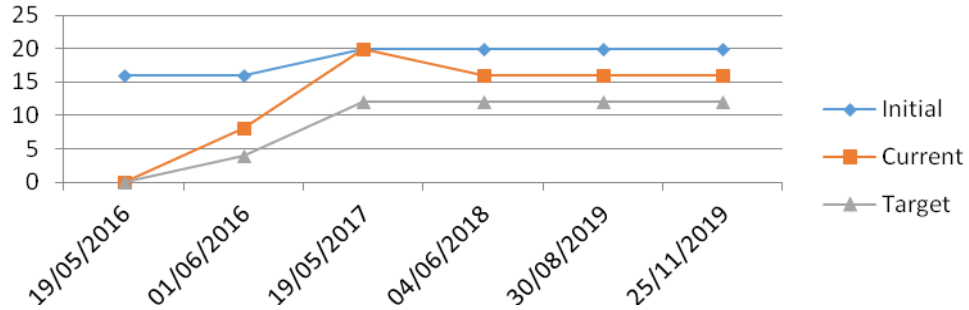
3. Identification of top 10 priority areas for nurse recruitment is in place, the new team are focusing on adverts out versus vacancies and then using enabling techniques to improve the time to hire, pushing through nurses intense focus is placed on these although this creates further challenges as there is no marketing budget agreed. Executives need to support and provide the necessary funding. 4. Recruitment lead for BCU HB working with Corporate Nursing on a number of recruitment pipelines such as fast track of HCA band 4 to adult nurse course at Bangor University (2 year course will provide 12 nurses in 2020). A return to practice campaign will be further promoted later in 2019 - although challenges raised in November 2018 to Bangor University on lack of places for BCU RTP nurses. Corporate Nursing taking forward. Positive changes to bursary system on degree nursing courses at Welsh Universities will commit graduates to 2 years working in the Welsh NHS. A focus on retention with appraisal compliance and mandatory training monitored. National KPI's Time to Hire focus on recruitment timescales monitoring both within BCUHB and NWSSP. 5. TRAC system in place which ensures standardised processes. 6. HR are supporting with the promotion of flexible working: part time working, job share, compressed hours, annualised hours, flexi, career breaks etc. 7. Staff benefits such as cycle to work schemes and other non-pay benefits in place. 8. HR and Recruitment Team continue to promote best practice through times of organisational change, redeployment and secondments and through flexible working arrangements. 9. An Agency cap for medical and dental staff in place, with tight controls in place to reduce agency expenditure. National reporting is conducted monthly, which will be reviewed regularly. 10. BCU HB contributes to the All-Wales Recruitment campaigns - 'train, work, live' brand. BCU Recruitment Team now has the SPOC which is promoted nationally and locally. Student nurse recruitment is the most successful pipeline and BCU have worked with WG/SSP to introduce a more robust method of recruiting our nurse graduates	support further digital marketing. Further work on recruitment pipelines such as trainees, graduates return to practice, cadet scheme and overseas candidates. 6. BCU Recruitment support team following more robust consultant recruitment pathways.improvement of the candidate experience through support by the BCU REcruitment support team in enabling faster time to hire processes.

resulting in 130 nurses joining in September 2019 and a further 75 planned to join in March 2020.	

Assurances	**Links to**		
1. Staff surveys. 2. WG reporting (e.g. sickness absence and long term disciplinary cases). 3. NMC Royal College and Deanery Reviews and Reports. 4. Review of NWSSP recruitment timescales	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR4	Leadership

CRR16	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 19 May 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 25 November 2019
	Risk: A major safeguarding failure occurs	**Target Risk Date:** 31 March 2020

There is a risk that the Health Board does not discharge its statutory and moral duties in respect of Safeguarding. This may be caused by a failure to develop and implement suitable and sufficient safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resources to manage the undertaking. This could impact on those persons at risk of harm to whom the BCUHB has a duty of care.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

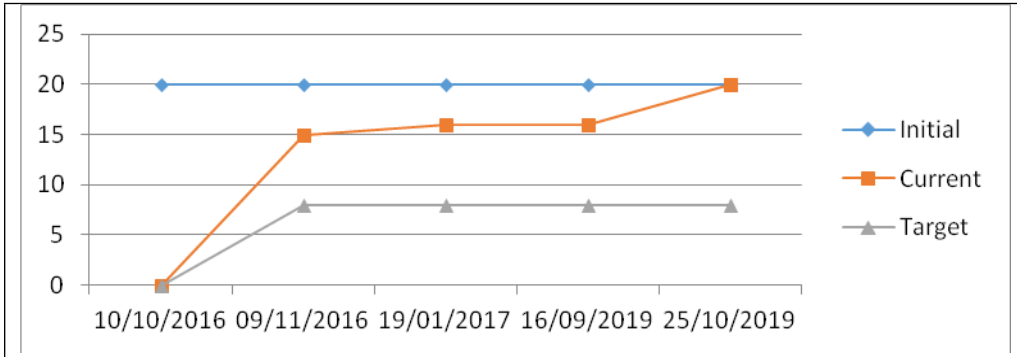
Controls in place	**Further action to achieve target risk score**
1. A cycle of Business Planning meetings have been implemented within the Nursing and Midwifery Directorate which scrutinises and reviews Level 1 and 2 Risks and is attended by the Associate Director of Safeguarding. 2. A refreshed Safeguarding Reporting Framework has been implemented within safeguarding which sets out clear lines of accountability and is underpinned by a Business Cycle. 3. A standardised data report on key areas including Adult at Risk, Child at Risk and DoLS is submitted to Area Forums in order that data	1. A further service reconfiguration is ongoing. The second phase of safeguarding JDs are in the process of being reviewed and will be completed by December 2019. 2. Further structural activity is planned to ensure business continuity and stability within the Corporate Safeguarding Team. This includes the provision of a 7 day on call, flexible working service. This will be incorporated into the Structure Report at QSE in December 2019. 3. HASCAS Recommendation 8 / DO Recommendation

is scrutinised and risks identified. 4.Risk Management has been embedded into the processes of the Reporting Framework by being included as a standing item on the Safeguarding Governance and Performance and Area Forum Agendas. Issues of Significance reports require risks to be identified and reported on in terms of mitigating action. 5. The new Senior Management tier has been appointed to within the Safeguarding Structure. This will strengthen strategic oversight in key areas.	6;A Safeguarding Structure evaluation Report reviewing the effectiveness of the new Structure will be presented to QSG December 2019. This paper will be overseen by Welsh Government. 4. The programme of works relating to the governance and accountability of Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act is under review and implementation of key tasks including signatory training has been implemented. See Risk 2548. 5. A review of the DoLS structure and service provision is a priority activity for 2019-20 and a key requirement from HASCAS. An options paper which sets out options for the DoLS Team will be presented to QSG in Dec 2019. See Risk 2548. 6. The appointment of a Named Doctor, Adult at Risk remains outstanding however positive discussions have taken place with the Office of the Executive Medical Director. A business case will be completed and presented to QSG in Dec 2019 . The post holder when appointed will hold a position on the NWSAB. 7. Continue recruitment activities to maintain a full Team establishment. 8. Fully engage with the Corporate Safeguarding Governance Audit and Deprivation of Liberty Safeguarding [DoLS] Audit, conducted by the NHS Wales Shared Services Partnership Audit and Assurance Service.

Assurances	**Links to**		
1. Strengthened Governance and Reporting arrangements. 2. Enhanced engagement with partner agencies. 3. Safe and effective data collection and triangulation of organisational data to identify risk. 4. Improved compliance against recognised omissions relating to the review and development of Safeguarding policies and Training	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 7	PR9	Governance

materials. 5. Regional Safeguarding Boards.			

CRR17	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 10 October 2016
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 25 October 2019
	Risk: Development of IMTP (Integrated Medium Term Plan)	**Target Risk Date:** 31 March 2020
There is a risk that the Health Board cannot deliver safe and sustainable services to the population of North Wales which may be because there is not an agreed plan for the next 3 years. This could lead to an inability to address and improve health and healthcare services.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	Further action to achieve target risk score
1. The timetable to develop the 2019/22 IMTP was discussed and agreed by SPPH Committee on 9th August 2018. 2. The Health Board approved approach for developing the 2019/22 IMTP on 6th September 2018. 3. Unscheduled Care - 90 day plan launched and measures and trajectories agreed for inclusion in the AOP for 2018/19. 4. Transformation fund proposals developed with RPB partners	1. 2019/22 plan refresh paper to Board in November 2019. 2. Draft health economy plans for 2020/23 due by 5th November for initial review by Improvement Groups. 3. SPPH Committee to review draft 2020/23 plan in December. 4. Draft 2020/23 plan to Board in January 2020 and for submission to WG.

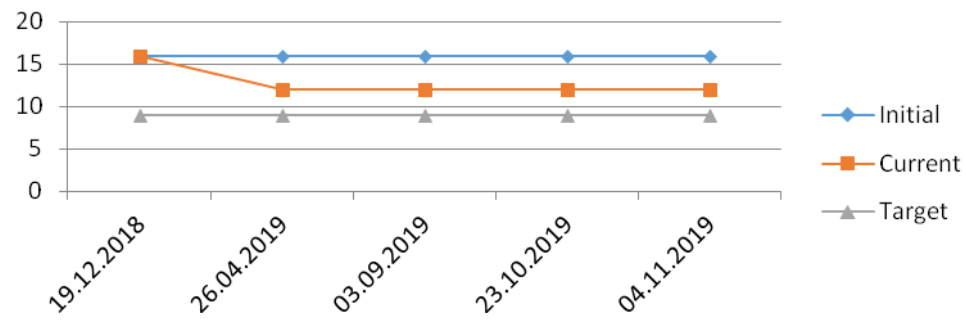
Proposals for Community Services, children, mental health and learning disabilities submitted to Welsh Government. 5. Workplan established to develop 2019/22 IMTP with 3 CEO sponsored workshops held on 4th October, 8th November and 13th December 2018. 6. Care closer to home service transformation plan and approach reviewed and re-profiled under the leadership of the Director of Primary and Community Services. 7. Board resolved to develop a 3 year plan for 2019/22 and WG notified. 8. Board received draft 2019/22 3 year plan in January 2019. 9. Planned care delivery group established in January 2019. Work programme under development including; RTT, diagnostics, cancer and outpatient plans, infrastructure/support, Strategic/tactical change - Acute hospital care programme schemes, Policy/national programmes - National delivery plans, Enablers - PMO turnaround schemes with a focus short term productivity and efficiency improvements and processes i.e. transactional rather than transformational. 10. Feedback from WG received around ensuring a clear work programme for 2019/20 to deliver improvements in RTT and Unscheduled care. 11. Three Year outlook and 2019/20 Annual plan presented to Board in March 2019. Plan approved with further work identified and agreed around elective care in the specialties set out on page 40 of the paper. 12. The Board received an updated plan in July and recommended that further work be undertaken led by F&P committee to scrutinise underpinning planning profiles, specifically RTT, (including diagnostics), unscheduled care alongside the financial plan for 2019/20. 13. Completed profiles at BCU level completed and submitted to F&P committee on 22nd August. 14. Site and speciality core activity profiles developed.	

15. Draft 2020/23 Cluster plans developed to feed into health economy plans. 16. Key deliverables for 2020/23 developed in September 2019. 17. Health economy planning arrangements established to support development of 2020/23 plan with linked support from corporate planning team. 18. 2020/23 Planning principles and timetable prepared and presented to EMG, F&P and SPPH Committees. Identified plan development actions to be implemented September - December to ensure plan developed for submission to WG by end January 2020.	

Assurances	**Links to**		
1. Board and WG oversight as part of Special Measures. 2. Oversight of plan development through the SPPH Committee. 3. All Wales peer review system in place. 4. Joint Services Planning Committee of Community Health Council.5. Regular links to advisory for a - LPF, SRG, HPF.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7 8	PR5	Strategic and Service Planning

CRR18	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 19 December 2018
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 04 November 2019
	Risk: EU Exit - Transition Arrangements	**Target Risk Date:** 31 December 2019

There is a risk that the Health Board (HB) will fail to maintain a safe and effective healthcare service. This may be caused by a lack of clarity and understanding at UK level in respect of the impact of withdrawal from the European Union (EU), and a subsequent failure by the HB to develop robust withdrawal contingency plans. This could lead to a disruption of service delivery and thereby adversely impact on outcomes for patients in terms of safety and access to services.



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

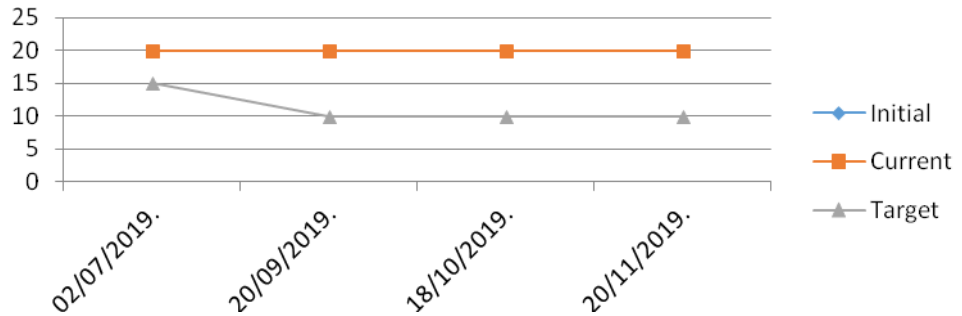
Controls in place	**Further action to achieve target risk score**
1. BCUHB Task & Finish Group established. 2. Initial scoping of potential risks and issues. 3. Involvement with regional co-ordinating groups established under the Local Resilience Forum. 4. Involvement with national forums addressing potential risks from	1. Following extension to date of exit to 31 Jan 2020, planning and preparations to be maintained at current state of readiness; however, response and reporting arrangements stood down until further advice.

EU withdrawal. 5. Support from WG, Welsh NHS Confederation, NWSSP. 6. Engagement with nationally commissioned work streams providing advice and support in respect of supplies and procurement. 7. Engagement with LRF Strategic Co-ordinating Group (meeting monthly). 8. Engagement with Executive Team to ensure cascade of actions (briefing 09/01/19). 9. Update briefing to staff via Bulletin, and webpage established (February). 10. Internal and external communication plans in line with national guidance by end February, linking with LRF Warning & Informing Group. 11. Exercise undertaken 15/02/19 on business continuity. 12. Local tactical response and management arrangements post-exit agreed by Executive Team, briefed to EMG March. 13. Situation reporting and response arrangements paused in light of the extension to article 50. 14. BCUHB Task & Finish Group re-commenced in August 2019. 15. LRF SCG and national NHS Wales SROs' Group re-commenced September 2019 (meeting weekly from October). 16. Risk and impact assessments reviewed in light of updated evidence and revised anticipated date of exit. 17. Lower level risks entered onto Datix and linked to CRR18. 18. Staff briefings circulated by Comms team. 19. National medicines information for patients circulated via pharmacies. 20. Daily SitReps commenced 21/10/19.	2. EU SS scheme advice and support to be made available to staff as part of national programme.

Assurances	**Links to**		
1. Reporting to Executive Team and SPPH Committee 2. WAO audit of preparedness 3. WG oversight through national work streams	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Not Applicable

CRR20	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 2 July 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 20 November 2019
	Risk: Security Risk	**Target Risk Date:** 1 November 2020

There is a risk the Health Board fails to ensure that a suitable systems are in place to protect staff, patients and stakeholders from security, violence and aggression incidents arising out of our work activity. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed.



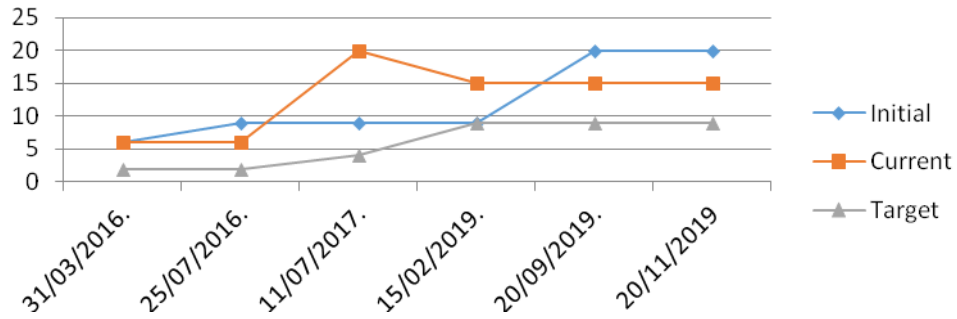
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	2	5	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1) There is a system in place for a contractor (Samsun) to manage the physical/people aspects of Security for the organisation. 2) A V&A Case manager is in place to support individuals who have been exposed to violence and aggression incidents.	A systematic approach is required to both physical and people aspects of the risks identified. This includes: 1. A complete review of CCTV and recording systems. 2. Clear lines of communication with the contractor, review

3) CCTV Policy is being developed. 4) An external contractor is supporting the Head of H&S to review all aspects of Security across the Board. 5) An external Police Support Officer is in place part time to support the organisation and staff.	of the contract in relation to key holding responsibilities and reporting on activities. 3. Responsibilities of Security roles within BCUHB clearly defined. 4. Lone worker procedures and risk assessments further established. 5. Reducing numbers of violence incidents to staff through clear markers and systems for monitoring violent patients. 6. Comprehensive review of Security on gaps in system which was provided to the Strategic OHS group. It was agreed that risk remains at 20 with a target outcome of of 10. A comprehensive action plan is being developed by 1st October to look at mitigating the risk. It is likely that significant investment is required in personnel and structure to support the recommendations identified in the review.

Assurances	**Links to**		
n/a	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	8		Not Applicable

CRR21	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 31 March 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 20 November 2019
	Risk: Health & Safety Leadership and Management	**Target Risk Date:** 1 November 2020
There is a risk that the Health Board fails to achieve compliance with Health and Safety Legislation due to insufficient leadership and general management. This could have a negative impact on patient and staff safety, including organisational reputation and prosecution.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	5	3	15
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Health and Safety Policy requires updating. 2. Health and Safety Management arrangements further developed. 3. Strategic Health and Safety Group in place meeting regularly (3 times in 3 months). 4. Risk Assessments and safe systems of work. 5. Mandatory Training. 6. Clinical and Corporate Health and Safety Teams. 7. Corporate Health and Safety Team.	1. Undertaken gap analysis of 31 pieces of legislation. Completed within specified time frame (117 inspections in 7 weeks). 2. Action plan developed based on non compliance with legislation. 3. Develop a programme of intervention and training through TNA Review. 4. Identified RIDDOR reports and scrutiny of process,

8. Programme of Annual Self-Assessment Audits. 9. Gap analysis in place. 10. Health and Safety Walkabouts. 11. Health and Safety Report to QSE and Board. 12. Health and Safety Improvement Project Plan.	looking at improved RCA system. 5. 12 Month action plan developed and 3 year strategy, that is owned by Divisions and Senior Leaders. 6. Further develop individual risk register for items of none. compliance identified through gap analysis 8-10 specific items. 7. Review Divisional governance arrangements so that they marry with H&S governance system and reporting to Strategic OHS Group. 8. Implement findings of internal audit review of process of inspection and governance. It was agreed that the evidence from the gap analysis required the scoring to remain at 20 as there is significant risk of prosecution and the desired outcome should be 10.

Assurances	**Links to**		
Not Applicable	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	8		Not Applicable

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 12th December 2019**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Draft Clinical Audit Policy & Procedure v1.13
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr David Fearnley Executive Medical Director
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell Senior Associate Medical Director/Improvement Cymru Clinical Lead
Craffu blaenorol: Prior Scrutiny:	Previous drafts have been shared with the participants in a BCU wide development workshop, Divisional Quality & Safety Groups, Corporate Quality and Safety Group, the Audit Committee, Audit Workshop and The Joint Audit and Quality Sub Committee.
Atodiadau Appendices:	Appendix a: Draft Policy

Argymhelliad / Recommendation:

The Committee is asked to approve the amended policy and procedure document.

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

Sefyllfa / Situation:

There has not been a specific audit policy & procedure in place that describes the expectations of the Board with regards to delivering audit that supports planning for improvement in service quality and provides robust assurance that the implemented changes are improving patient care

Cefndir / Background:

This policy aims to support a culture of best practice in the management and delivery of clinical audit. The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures.

This policy has been developed from a workshop with representation from services across BCUHB, enhanced by discussion from the groups listed above.

Asesiad / Assessment

Strategy Implications
The policy describes the prioritization of audits encompassing the Welsh Government mandated audits (Tier 1), local priority audits based on BCUHB priorities and risks (Tier 2). It supports the delivery of best practice and high quality services – prudent healthcare.

Financial Implications
There is shortfall in the corporate Clinical Audit department - a business case will be developed
There needs to be adequate time within job plans to undertake audit and improvement work – this is inconsistent at present for all professional groups and has not yet been quantified.
There is a paucity of electronic support - data capture or action plan monitoring. Options will need to be explored and a business case made

Risk Analysis
The policy will require an implementation plan to ensure ownership and leadership at all levels

Legal and Compliance
The expectation is to develop a quarterly monitoring report that builds to an annual report on activity providing evidence of a robust process and changes in practice to improve patients care
Implementation will deliver the mandatory requirements as set out by the Welsh Government
annually

Impact Assessment
A full equality impact assessment has been reviewed at previous meetings. This policy once implemented will have a positive impact on all BCUHB patients.

Version & Reference Number

Clinical Audit Policy & Procedure (DRAFT)

Author & Title	Clinical Audit Policy. Trevor Smith (Head of Clinical Audit and Effectiveness). Dr Melanie Maxwell Senior Associate Medical Director
Responsible dept / director:	Office of the Medical Director. Dr David Fearnley Executive Medical Director
Approved by:	Audit Committee
Date approved:	
Date activated (live):	
Documents to be read alongside this document:	BCUHB Quality Improvement Strategy (2017-2020).
Date of next review:	
Date EqIA completed:	28 October 2019

First operational:					
Previously reviewed:					
Changes made yes/no:					

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

)

1.0 Introduction / Overview:

1.1 Clinical Audit:

Clinical audit is a multi-professional, multidisciplinary activity.

"Audit is not concerned primarily with fault or discrepancy finding, but with the examination of working practice to improve effectiveness". Dickens (1994)

Figure 1 The Clinical Audit Cycle

"*Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.*"

New Principles of Best Practice in Clinical Audit (HQIP, January 2011).

Within the Health Board clinical audit is embedded within the future direction of improvement activity. Audit is a tool within the quality framework, identifying and prioritising improvement activities (Quality Planning) and providing assurance about service quality (Quality Control):

Figure 2: Quality Cycle: based on Juran and Godfrey (1999).

2.0 Policy Statement

This policy is applicable across all services participating in clinical audit within the Health Board. It sets out the expectations of the Health Board with respect to audit planning, multidisciplinary participation, and acting on the audit findings to maximize its effectiveness.

Clinical audit planning prioritises externally mandated requirements (as documented in the annual *National Clinical Audit and Outcome Review Plan* from Welsh Government), as well as local priorities in line with the Health Board's strategic objectives and risks.
Services should consider audits that provide information and/or assurance relating to key risks and strategies, such as the quality improvement strategy, and other service improvement activity relevant to the Health Board's priorities using the agreed tier structure (see section 8.1).

3.0 Aims / Purpose

This policy aims to support a culture of best practice in the management and delivery of clinical audit.
The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures.

4.0 Objectives

This policy outlines processes in relation to clinical audit activity within BCUHB. It will reinforce its role within the quality framework in delivering quality improvement and quality control.

This includes:

- Topic selection based upon priorities (national and local).
- Local governance arrangements
- Clinical audit and effectiveness training
- Patient and carer involvement
- Roles and responsibilities
- Assurance about the effectiveness of services in relation to best practice

5.0 Scope.

This policy relates to all BCUHB staff and partner organisations participating in clinical audit activity within BCUHB; either by professional requirement, individual interest or relevance to a specific pathway / care group related to their role. Where BCUHB commissions activity externally, quality assurance including participation in audit is included within the contractual arrangements.

6.0 Roles and Responsibilities

6.1 Chief Executive Officer (CEO).

The Chief Executive Officer has overall responsibility in relation to the statutory duty for quality within the organisation and for participation in the mandatory requirements for clinical audit participation, as set out within the Welsh Government's *National Clinical Audit and Outcome Review Plan (NCAORP).*

6.2 Executive Medical Director.

The Executive Medical Director is the Executive lead for clinical audit and effectiveness activity; ensuring that the BCUHB audit plan aligns with mandatory requirements, organisational priorities and is supported across all clinical services including primary, community and secondary care. The Clinical Audit and Effectiveness Department is located within the Office of the Medical Director.

6.3 Professional Leadership Roles.

This group includes other clinical executives, medical directors, nursing directors and other clinical leaders, including clinical audit leads where they exist. Staff in these roles will support the implementation of this policy for services that fall within their remit and sphere of influence.

6.4 Lead Auditors.

Lead auditors are responsible for individual audits. They will ensure the clinical audit cycle is completed in line with their service's clinical audit annual plan. This will include data collection, discussion of the findings and development and delivery of the action plan to improve care. It is their responsibility to escalate any delays or concerns through the service's governance framework.

6.6 Other Staff.

All staff have a duty to ensure they are providing effective care to deliver best outcomes for patients. Participation in relevant clinical audit to enable benchmarking against key standards, supporting the development of subsequent action plans and undertaking quality improvement activity is expected.

6.7 Clinical Audit and Effectiveness Department.

The department's role is managing the audit process. This includes working with services to develop the annual clinical audit plan, maintaining a central repository of audit activity, monitoring the timely implementation of the plan and delivering assurance reports to relevant governance groups culminating in an annual clinical audit report.

The department will provide proportionate support to BCUHB staff for all stages of the clinical audit cycle; priority is given to the mandatory audits (national or local).

The department delivers ad hoc audit and effectiveness training (see section 11).

7.0 Groups / Committees

The following Groups / Committees have a role in ensuring that clinical audit activity within their remit is optimised in terms of improvement potential and assurance. This will include

approval, reporting and monitoring as relevant to each group's terms of reference. (See Appendix 1 – governance structure)

7.1 Audit Committee

The Audit Committee is the approving committee for the annual plan (national and locally prioritised audits). It will seek assurance on the overall plan, its fitness for purpose and its delivery. The role of the Audit Committee includes seeking assurance on:

- Does the organisation have a plan - and is it fit for purpose?
- Is it completed on time?
- Does it cover all relevant issues?
- Is it making a difference and leading to demonstrable change?
- Is change supported by recognised improvement methodologies?
- Does the organisation support clinical audit effectively?

7.2 Quality, Safety and Experience Committee (QSE)

The Quality, Safety and Experience Committee requires more detailed assurance that clinical audit is supporting the delivery of effective health care. It requires assurance that clinical audit is used to identify areas for improvement and subsequent actions deliver better outcomes for patients.

QSE will receive the clinical audit annual plan and recommend its adoption to the Audit Committee. It will be the approving committee for the Clinical Audit Policy and Procedure.

7.3 Joint Audit & Quality Committee

This committee meets annually. It includes all members of the Quality, Safety and Experience Committee and Audit Committee. Its purpose is to jointly review the effectiveness of clinical audit and receive the annual audit report.

7.4 Quality and Safety Groups

At each level of service e.g. Corporate/Divisional/ Site there are quality and safety groups robust audit that supports quality planning and assurance, leading to safe high quality services. Risks identified through the clinical audit process and outcome will be considered, mitigated and/or escalated from sites and divisions to the corporate group as appropriate.

7.6 Clinical Effectiveness and Audit sub Group (CEAsG).

CEAsG provides a forum where clinical audit and service evaluation is discussed as a standard agenda item. In relation to clinical audit, CEAsG receives exception reporting from a number of effectiveness-related groups including the Clinical Improvement and Audit Groups or equivalent Quality and Safety Groups.
This group will reports to the corporate Quality & Safety Group.

8.0 Registration of audits:

All clinical audit activity within the Health Board should be prioritised to ensure it aligns with strategic or operational priorities as outlined in the service or corporate annual clinical audit plan.

All local clinical audit projects conducted within the Health Board must be approved prior to registration, either by the relevant Quality & Safety Group or Clinical Lead, in advance of registration with the CA&E department.

There is a clearly defined application procedure for registration, which involves the following steps:

8.1 Registration Tiers within BCUHB.

Tier 1: National "must do" audits. These clinical audits are mandated by Welsh Government or other regulatory bodies such as *Medicines & Healthcare products Regulatory Agency* (MHRA). Local available resources are prioritized to support these audits. Nationally mandated audits require the completion of the assurance proforma to be returned to Welsh Government within 4 weeks. This documents the actions being taken to address the audit report findings.
NB: All National Clinical Audit and Outcome Review Plan (NCAORP) projects must be incorporated within relevant Divisional/Directorate annual clinical audit plans.

Tier 2: Local priority audits: These 'local must do' audits support delivery of the Quality Improvement Strategy goals and priorities, including accreditation requirements specific to the service, NICE guidance compliance, safety audits, audit related to high risk activity and corporately agreed service improvement priorities. These audits will take priority over completing tier 3 audits.
NB: All Corporate projects agreed at BCUHB Quality & Safety Group as priorities must be incorporated within relevant Division/Directorate annual clinical audit plans.

Tier 3: Local audits. This activity relates to those audits that have been agreed by the Division/Directorate to be included within their local, annual forward plan for clinical audit activity (see section 8.3 below). These should be risk based. All Tier 3 projects must:

- be approved by their Divisional/Directorate or Primary Care Lead.
  NB: These should not be approved unless there is local capacity and completion will not detract from completing Tier 1& 2 audits, including the associated improvement work.
- be registered with the Clinical Audit & Effectiveness Department (registration form accessed through intranet site via link: http://howis.wales.nhs.uk/sitesplus/861/page/45363
- provide a blank copy of the data collection pro-forma / spreadsheet.
- have a registration form signed by the clinical lead or their clinical supervisor and the Divisional/Directorate Clinical Audit Lead or Primary Care Lead.

NB: It is recognised that tier 3 audits may be undertaken as part of education and/or training, to learn the methodology. However, they should still be subject to completion of the audit cycle.

Quality improvement projects may use audit as a tool for measurement; however, they fall outside the scope of this policy. Quality improvement projects should be registered on the quality improvement hub (https://www.bcuqi.cymru)

8.2 Clinical Audit and Effectiveness Department Registration Database

All approved projects are allocated a unique ID number. A database is held within the Clinical Audit and Effectiveness Department, storing all Health Board registered clinical audits/ service evaluations. This facilitates audit activity reporting, identifies potential re-audits and provides evidence to support reviews and Health Board-wide comparison of findings. It enables quality planning and identification of quality improvement projects to support reliable care.

8.3 Annual Divisional / Directorate Clinical Audit Plan

An annual clinical audit plan will be agreed within each Division/Directorate including Primary Care and Community Services by the end of January. Early allocation of suitable lead auditors and the resources including clinicians' time required to complete the audit will optimise completion of the plan.

A systematic approach which enables the multidisciplinary team to prioritise and agree upon topics for inclusion is recommended with domains including:

- ***Frequency*** ('how often' or 'how many'?)
- ***Degree of risk*** (likelihood of something going wrong or not being done).
- ***Level of concern*** (how important is the question?)
- ***Outcome*** (what is the impact in relation to potential for improvement/harm?)

(Welsh Assembly Government, 2003)

8.4 Corporate Clinical Audit Annual Plan

The corporate clinical audit annual plan will be agreed by the end of February each year.
This will include all identified tier 1 and tier 2 audits.
Tier 1 audits will capture in-year data collection and/ or review of report and action planning. Some audit reports will be an analysis of historic data, usually from the previous year.
Tier 2 audits will be based on audits identified by the Clinical Executive Leads as well as Divisional Management teams in line with section 8.1 above.

8.5 Clinical Audit and Effectiveness Department Support

The Clinical Audit and Effectiveness Department is resourced to support Tier 1 and Tier 2 activity. Tier 1 activity will be prioritised.
Clinical Audit and Effectiveness (CA&E) staff will meet with lead auditor(s) to assess the level of support they require and to:

- Identify potential for patient participation/involvement.
- Identify potential for multidisciplinary participation/involvement.
- Agree the proposed methodology.
- Assist/advise with identification of evidence-base/critical appraisal.
- Assist with construction of clear and measurable audit standards.
- Agree data collection pro-forma/questionnaire format.
- Confirm local management support.
- Confirm the appropriate Divisional/Directorate clinical lead is aware of the project.
- Agree project timescales (including planned presentation date).
- Ensure Welsh Government assurance proformas are completed in a timely manner.

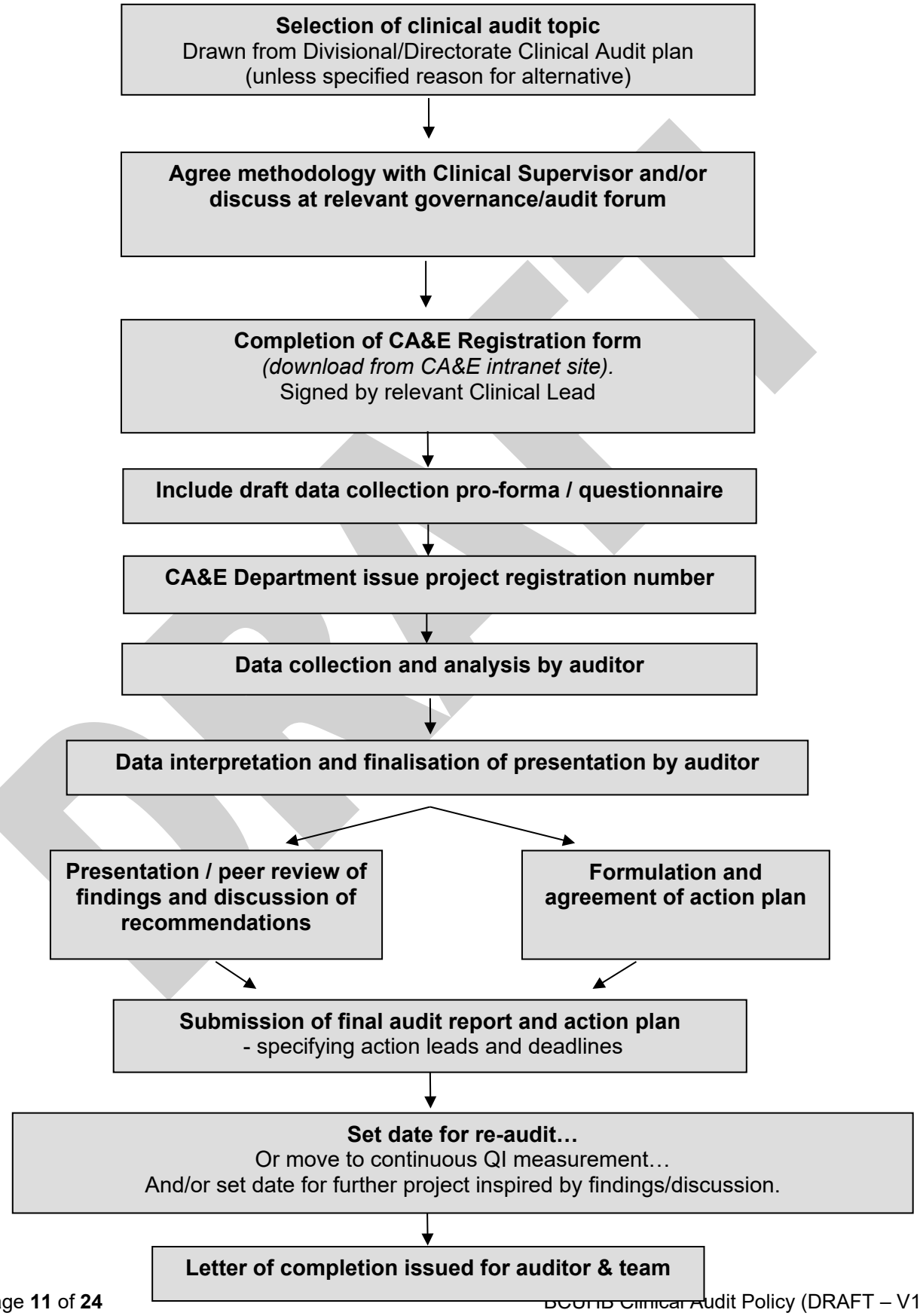
8.6 Assurance Reporting

The Clinical Audit and Effectiveness department will produce quarterly annual plan monitoring reports to the Quality, Safety & Experience Committee. These reports will be cumulative, building to an annual report that will be received by the Joint Audit & Quality Committee in

November each year. The report will document progress against the plan and highlight key service improvements related to clinical audit activity.

PROCEDURE

Figure 1: **Algorithm displaying clinical audit registration and progression.**



9.0 Developing a Clinical Audit Project

The process for clinical audit project development, registration and progression are displayed in algorithm format above.

9.1 Selection of topic

The Divisional / Directorate Annual Clinical Audit plan identifies the topics for Supervisors advising their trainees, juniors and other colleagues. Staff contacting Clinical Audit and Effectiveness department for advice will also be directed to these plans and the relevant Clinical Lead for their clinical area.

9.2 Multidisciplinary audit

Clinical Leads and lead auditors will assess all audits in relation to their potential for multidisciplinary and multi-professional involvement. Consultation with all relevant staff groups will occur. Where applicable, the lead auditor will be advised to invite participation from colleagues representing other professionals appropriate to the topic and also consider Managed Clinical Services colleagues such as Radiology and Pathology.

Multidisciplinary audit refers to a clinical audit team composed of representatives from at least two different disciplines (ideally those associated with the episode of care being audited).

9.3 Patient and Public Involvement

In planning each audit the potential for service user, carer and/or public involvement should be assessed and promoted. This may involve communication with appropriate forums relevant to the topic and/or the service to achieve this. This would range from gaining feedback regarding the proposed audit pro-forma/questionnaire to direct involvement where possible with other stages of the audit, guided by the relevant Information Governance considerations.

9.4 Presentation / dissemination / feedback

All lead auditors will feedback their findings to the relevant service forum, where peer review will confirm that the findings are clinically robust. In addition, findings will be shared as widely amongst the Health Board as appropriate to the topic.
Auditors will agree, in discussion with their Clinical Lead, the appropriate venue for PowerPoint style presentation (see Appendix 2 - template) and efficacy of utilising other media options (poster, circulation of brief written report, intranet, etc.).

9.5 Action planning

Where recommendations are made as a result of the audit, an action plan must be developed following consultation with the relevant staff (ideally at a service forum). Peer review will ensure that findings are disseminated and ascertain whether the recommendations are robust. The action plan must be specific, objective, set within measurable timescales and accountable in relation to who is responsible for each action. (See appendix 3 - action plan template). Tier 1 audits require the completion of the assurance proforma (Part A&B) within 4 weeks of the report release; this documents the actions being taken in response to the audit findings nationally and locally.

9.6 Submission of Clinical Audit Report

On completion of the audit, the lead auditor is required to provide the Clinical Audit and Effectiveness department with a copy of the final report and action plan (see Appendix 4 – report template).

9.7 Re-audit

Re-audit is not always necessary. For example, if no improvement needs have been identified or there is an alternative methodology to ensure improvement. In the latter case, it is important that all recommendations are tracked and monitored through the appropriate committee. Where assurance is required through audit, this needs to be included within a future clinical audit annual plan.

9.8 Letter of Completion for Project Lead

On receipt of the final report, the lead auditor/team (who demonstrate direct contribution) will be issued with a letter confirming their participation by the Clinical Audit and Effectiveness department. This letter will include additional bullet points as evidence is provided, such as:

- Presentation/dissemination/Peer Review of findings.
- Agreement of recommendations/action plan.
- Implementation of intervention.
- Re-audit (or clearly scheduled date and allocation of new lead).
- Clear link to another related project topic (audit, service evaluation, research).

9.9 Assurance

The Clinical Audit and Effectiveness department will be responsible for:

- Collating the annual corporate clinical audit plan each new financial year,
- Providing the Quality, Safety and Experience Committee with cumulative quarterly reports leading to an annual report that monitors progress against the plan.
- Providing JAQS with an annual report against plan.

10.0 Equality, including Welsh Language

An Equality Impact Assessment (EqIA) has been completed and a positive impact anticipated for all patients.

11.0 Training

All staff participating in clinical audit activity should have a good understanding of this methodology.
There is an 'e' learning '*Introduction to Clinical Audit'* training session which is accessible through the BCUHB intranet site:
http://howis.wales.nhs.uk/sitesplus/861/page/59825

In addition, the Clinical Audit & Effectiveness department will respond to requests to provide face to face sessions for teams where this can be delivered within capacity.

12.0 Review

The Clinical Audit Policy, as a new policy will be reviewed in one year's time and then on a three year cycle.

13.0 References

DICKENS, P. (1994). In: Welsh Assembly Government. (2003). *An introduction to clinical audit.* Wales

Healthcare Quality Improvement Partnership (HQIP). (2011). *New Principles of Best Practice in Clinical Audit.*

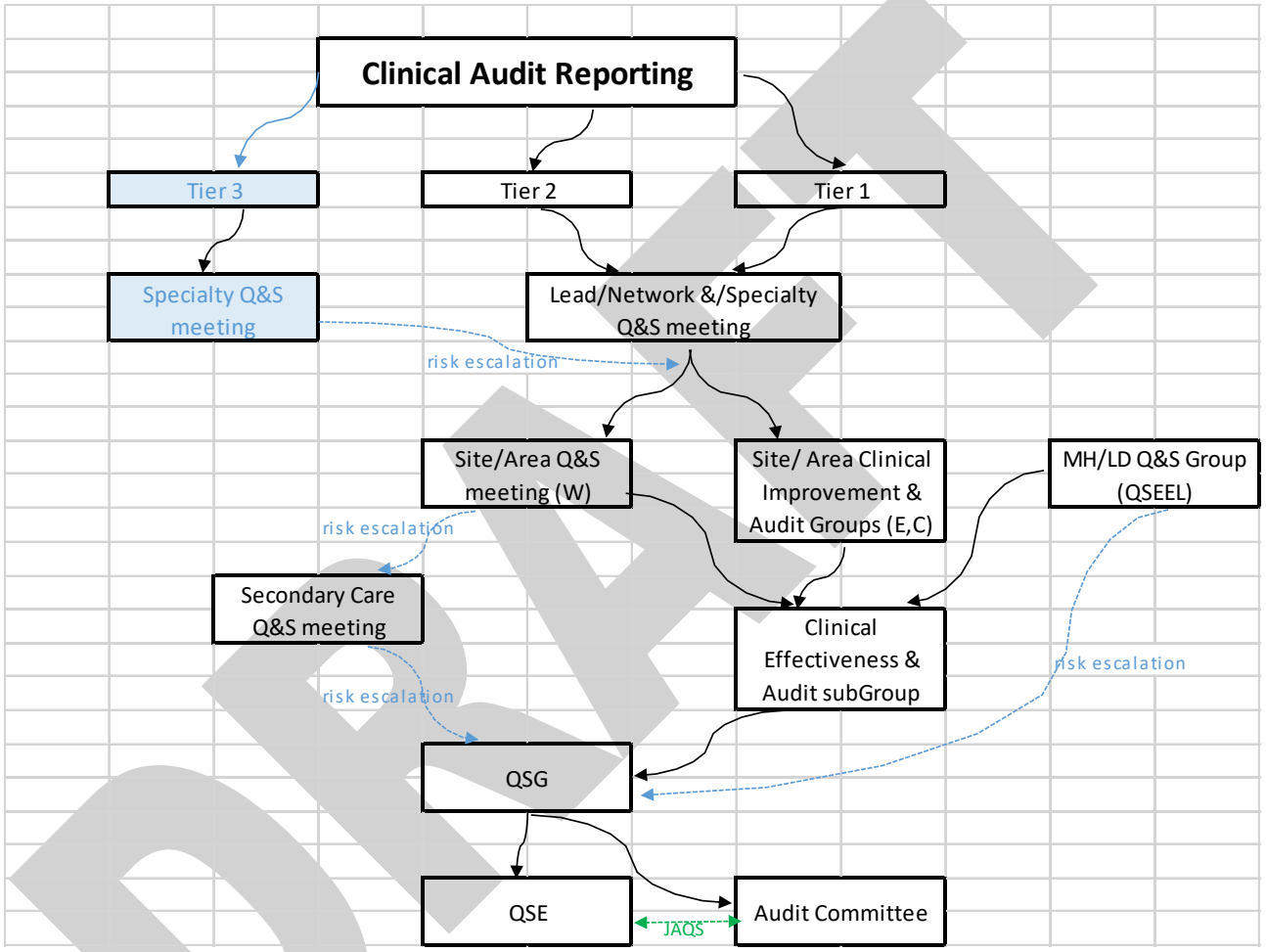
JURAN, J.M., GODFREY, A.B. (eds). (1999). *Juran's Quality Handbook.* 5th Edition. New York: McGraw Hill.

Welsh Assembly Government. (2003). *An Introduction to Clinical Audit*. Wales.

14.0 Appendices

Appendix 1: Governance

NB: Quality governance structures are currently under review and this will be amended once agreed.



Appendix 2: Template for PowerPoint presentation slides.
Here you will see suggested slide headings which contain guidance notes to advise on what to include within each section.

Using PowerPoint to present your findings

Title of Audit……

Project lead / team

Service / Specialty

Date of presentation

Name of forum

Introduction / Background

Set the scene…..

- Outline why you conducted it and provide enough background information regarding the setting and history of the unit/team.
- State which guidelines/standards/research you selected to measure practice against?
- Explain treatment/care pathway (include relevant structures and processes).
- Refer to previous audits, associated findings or recommendations.

Aim / Goals

Specify your Aim:

- This will be an overarching statement, which highlights what you want to achieve.

Specify the Objectives:

- This breaks down the aim into manageable, measurable and objective actions.

Methodology

What was audited and how?

Include sample criteria:

- Inclusion/exclusion criteria?
- Random, stratified, etc.
- How many did you audit?
- Where applicable, demographics may be added.
- Specify the dates within which your sample falls.

Include data collection:

- Retrospective or prospective?
- Who collected the data?
- Provide details of your pilot study (numbers, changes made).

Standards

- What were the standards that you measured against?
- What was the evidence-base?

Results

What were your results against the standards you measured against.

- Draw out the meaningful data
  - Choose and appropriate graphical format. What is your n value and total? Don't forget your chart title.
  - Consider presenting percentages against each standard, alongside comparable data where applicable (e.g. previous findings or other dept).

Remember…….

- A consistent approach to use of numbers or percentages will minimise confusion.
- Maintain anonymity of clinicians and patients.

Conclusions

- Please highlight problem areas, improvement needs and any areas of good practice.
- Draw together your findings, highlighting main points for discussion and action.

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Recommendations / Action Plan

What now?

Include

Recommendations and relate back to your audit standards.

- Where were these discussed (forum).

Describe your action plan.

- Specify who is responsible for each action – ensure that they agree to this!
- Set timescales and review dates (if applicable) for each action.
- Make actions realistic and achievable.

Date for re-audit (if appropriate).

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Next steps

After presenting your findings:

Communication is key.

- Agree:
  - action plan following peer review discussion.
  - review date to monitor actions.
  - Re-audit date.
  - Consider: continuous measurement, research or other QI methodology (as appropriate).
- Ensure handover of actions to willing colleague if leaving.
- Agree on appropriate further dissemination of results to MDT colleagues.

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Appendix 3: Action planning template

Title			
Lead Auditor		**Author:**	
Contributors			
Approving Committee		**Date:**	
Is this on the risk register		**If yes, Score:**	

Action Plan:
(Please complete the action plan to specify how improvements will be made - i.e. what will be done, when and by whom?)

Issue Identified	**Improvement Action**	**By Who**	**By When**
Re-audit:	Date:	By Whom:	

Appendix 4 (overleaf): Template for final Clinical Audit report

Use attached guidance sheet: "Using Template Format for Clinical Audit Report".

Auditor (person conducting audit):	**Audit No:**	**Date:**
Audit Team members:	**Speciality / Service:**	

Full title of clinical audit project:
Include enough information to make the topic and location clear.

Introduction / background:
Set the scene for your audit. Outline why you conducted it and provide the reader with enough background information to understand the setting and history of the unit/team.

- What are the reasons for selecting this topic?
- Which guidelines/standards did you select to measure practice against?
- Refer to and summarise any relevant research or other forms of evidence.
- Outline topic-specific information and explain abbreviations or specialised terminology.
- Explain treatment/care pathway (including relevant structures and processes).
- Refer to previous audits and associated findings or recommendations.

Specify Aim:
This will be an overarching statement, which highlights what you want to achieve.
Specify Objectives:
This breaks down the aim into manageable, measurable and objective actions.

Standards:
What were the standards that you measured against – what was the evidence-base?

Methodology:
Explain the audit methodology you used, including sample criteria, time period and data sources used (i.e. what was audited and how?)

This section is important as it needs to make explicit the *'who, how, when and where'* elements of your project procedure. As in a scientific report, it is important that anyone wanting to replicate your project can do so by following your methodology.

The sample:

- Were there any inclusion/exclusion criteria?
- How was your sample selected? - random, stratified, etc.
- How did you identify participants? - Information Dept, admission book, etc.
- How many did you audit?
- If cases were missing - specify why (e.g. notes missing).
- Where applicable, demographics may be added (either here or in your results section)
- Specify the dates within which your sample falls.

The data collection:

- Was your data collection retrospective or prospective?
- Who collected the data?
- When were pro-forma/questionnaires completed/returned?

The pilot:

- Provide details of your pilot study (numbers, changes made).

Did you include your pilot data in your final analysis? If not, outline reason (e.g. data items changed significantly following pilot).

Results:
Provide the results of audit against the standards that you were measuring against and also any supporting or additional information. *Table format provided below*.

- Present only results that relate to the audit criteria.
- Don't be tempted to flood the reader with unnecessary data. The clarity of the point you are trying to communicate may be lost.
- Follow a logical order and grouping of results (such as the care pathway).
- Draw out the meaningful data and present in an accessible and graphical format (where applicable).
- Ensure all charts and tables are titled and state the 'n value' (total number 'out of').
- State how the data was stored and analysed (such as Excel or SPSS).
- It may be useful to use a table to present percentages against each standard, alongside comparable data where applicable (e.g. previous findings or other dept).
- A consistent approach to use of numbers or percentages will minimise confusion.
- Maintain anonymity of clinicians and patients.
- Use objective statements and avoid subjectivity.

No.	Standard	% Achieved	% Not Achieved
1.			
2.			
3.etc.			

Conclusions:
Please highlight problem areas, improvement needs and any areas of good practice.
Draw together your findings, highlighting main points for discussion and action.

Recommendations:
Clearly state your recommendations and relate back to your audit standards.

Action Plan:
Please complete the action plan to specify how improvements will be made - i.e. what will be done, when and by whom?
Complete the action plan to specify how improvements will be made (i.e. what will be done, when and by whom).
Following discussion of the recommendations at the appropriate forum, construct an action plan.

- Specify who is responsible for each action – ensure that they agree to this!
- Set timescales and review dates (if applicable) for each action.
- Make actions realistic and achievable.
- Set a date for re-audit (if appropriate).

Problem identified	Action	By Whom	By When
Re-audit:	Date:	By Whom:	

How has / will the clinical audit improve patient care? Please summarise the way in which your findings and implementation of recommendations will improve care.
References:
All full list of references should be provided using a recognised referencing system (such as Harvard).
Appendices:
Always include the clinical audit pro-forma within your appendices.
Ensure that a copy of the report is sent to the Clinical Audit and Effectiveness Department and the Specialty / Service clinical audit lead.

Cyfarfod a dyddiad: **Meeting and date:**	Audit Committee 12th December 2019
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Charity Funds Advisory Group Terms of Reference
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Rebecca Hughes, Charity Accountant/ Dawn Sharp, Acting Board Secretary.
Craffu blaenorol: **Prior Scrutiny:**	Charitable Funds Committee
Atodiadau **Appendices:**	Appendix 1: Charitable Funds Annual Report and Accounts 2018/19 Appendix 2: Extract from Letter from WAO re Funds held on Trust Appendix 3: Response letter to WAO

Argymhelliad / Recommendation:

The Committee is asked to note the Charitable Funds Annual Report and Accounts 2018/19, together with the letter from WAO and response.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The Charitable Funds Annual Report and Financial Statements provide the formally reported position for the Charity for 2018/19. The Charitable Funds Committee has delegated authority to approve the charity accounts. They are brought to the Audit Committee for information.

Cefndir / Background:

The Charitable Funds Accounts have been prepared in accordance with the timetable set by the Charity Commission and in line with Charities SORP.

The Annual Report and Accounts were approved by the Charitable Funds Committee on the 4th October 2019, signed by the Auditor General for Wales on the 9th October 2019 and they have been submitted to the Charity Commission. In preparing the accounts WAO issued the attached correspondence which the Committee are asked to note, together with the response as set out in Appendix 3.

The Board will formally receive the Accounts at the Trustees meeting on the 23rd January 2020.

Asesiad / Assessment:
Strategy Implications Aligned to the Awyr Las Charity Strategy. **Financial Implications** Compliance with the Charity SORP. **Risk Analysis** Not applicable. **Legal And Compliance** Compliance with Charity Committee regulations. **Impact Assessment** Not applicable.

Awyr Las Blue Sky

Elusen GIG Gogledd Cymru
The North Wales NHS Charity

Annual Report & Accounts
2018/19

Awyr Las / Blue Sky is the working title of Betsi Cadwaladr University Health Board Charity & Other Related Charities • Registered Charity Number 1138976


Awyr Las
Blue Sky
#teamirfon
YN CEFNOGI UNED ALAW
SUPPORTING THE ALAW UNIT

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Contents

Welcome from the Honorary President o

I am proud of many things we have all achieved in Wales, but I believe one of the finest things we have here in Wales is our National Health Service.

I am delighted that you are reading this Annual Report, because if you are it surely means that, like me, you truly care about ensuring that the most vulnerable in North Wales can receive the very best care and treatment when they need it most.

NHS Charities have now been in existence for 70 years, the same length of time as the NHS itself.

We in North Wales are blessed with a dedicated team of nurses, doctors, surgeons and support staff who show incredible compassion and commitment, innovation and professionalism.

I strongly believe we should all celebrate their achievements, but I feel we also need to recognise the limitations of our NHS.

The NHS has never been able to fund **everything** we would like to have in our hospitals or in our community healthcare services.

I feel we are fortunate to have Awyr Las, our NHS Charity, which plays a crucial role in enhancing our healthcare services in North Wales.

Donations to this charity give our various NHS teams the resources they need so that they might constantly strive towards better healthcare provision in North Wales, and improve the health and wellbeing for all families across the region.

In this report, you will see some fantastic examples of how this is happening.

In 2018, the year we celebrated the 70th anniversary of the NHS, I had the pleasure of supporting the Awyr Las #Give70 fundraising campaign.

I met many of the charity's frontline decision makers: the nurses, doctors and surgeons who are responsible for prioritising how donations should be directed to best help our patients.

f Awyr Las, Rt Hon Lord Barry Jones P.C.

I took part in the first NHS Big Tea in July and witnessed the pleasure on patients' faces when staff and volunteers organised Tea Parties and additional activities on hospital wards.

I was impressed to see others, including local businesses and community organisations, also getting behind this important initiative.

I chose to become involved in Awyr Las because I wanted to show my appreciation and also because I've seen first-hand the difference that donations given through the charity make to patients and their families.

Small changes, from additional arts supplies to keep children occupied or the introduction of complementary therapies for people undergoing cancer treatment. And then the large, for example new specialist equipment and modernised facilities.

These changes are funded through the charity and all have an impact on patients.

Many of us aren't even aware that we've been touched by the generosity of donors giving to Awyr Las when we go to our hospitals and use our community services.

In the past five years, the charity has funded over **£12 million** of improvements to local NHS healthcare services.

This includes funding for state-of-the-art equipment, new facilities, special projects and additional services, education, and research programmes.

This year, Awyr Las has been able to give **£1.7 million** to support NHS services across North Wales.

I am immensely proud of the impact that the charity has had on our local healthcare services, and I think all of us who have given through Awyr Las should be.

None of the impactful improvements we hear about in this report would be possible without the passion of those who are the beating heart of the charity: frontline NHS staff and the volunteers that support them. It certainly would not be possible without people like you.

On behalf of all of the NHS staff and patients that have benefitted from Awyr Las, I'd like to say a **huge thank you** to all those who give tirelessly to support the charity.

To the patients their families and friends. To NHS staff and their associates.

To our school children, local community groups and businesses; our national Foundations and Trusts.

These are wonderful people.

Since I was a young man I have worked hard to make sure the care and treatment that patients receive here in North Wales is always improving.

I pledge to continue to do that by continuing to campaign for our NHS and by supporting Awyr Las. In recent years, I have come to realise that the important extras the charity offers, which go **over and above** what the NHS can provide, do not just brighten patients' days.

Sometimes the equipment, improvements and research that Awyr Las funds give patients extra days, sometimes years, with their loved ones. That, to me, is priceless.

Here's to Awyr Las, our North Wales NHS Charity, and to our National Health Service. As we prepare to enter a new decade, may both continue to be cherished by us all and be enabled to flourish, so that **everyone** in North Wales has the opportunity to lead healthy, happy lives.

Barry Jones

RT HON LORD BARRY JONES P.C.
HONORARY PRESIDENT

What the Charity does

Number of funds
412

Income in 2018/19
£2M

Acute hospitals in North Wales
3

Community sites in North Wales
45

Population served by BCUHB
678K

Ensuring people across North Wales benefit from better NHS services when they need them the most.

Awyr Las (officially titled Betsi Cadwaladr University Health Board Charity and other related Charities) is a registered Charity (registered number 1138976) and is constituted under a trust deed dated 23rd September 2010.

Within the Charity group registration, there are two subsidiary charities: Betsi Cadwaladr University Health Board Charity and The North Wales Cancer Appeal.

The Betsi Cadwaladr University Health Board (BCUHB) is the Charity's legal corporate trustee. This means that, whilst the Board members are responsible for the administration of the funds, they are not individually trustees of the Charity.

Awyr Las is the umbrella charity for over 400 Charitable Funds. Together, these funds support wards, units, departments, specialities and community projects right across North Wales.

Donations given through the Charity help dedicated NHS staff in hospitals and in communities across North Wales to offer an enhanced healthcare service, offering patients and their families the very best care and treatment available.

The Charity's priorities are decided by frontline nursing and medical staff.

96%
OF DONATIONS WERE GIVEN TO DESIGNATED FUNDS

What is funded

Awyr Las funds state-of-the-art equipment and new facilities; extra staff training and world-class research; special projects and additional services; complementary therapies and extra patient comforts which all go over and above what NHS core funding can provide.

Since 2010 Awyr Las has funded over £25m of improvements to healthcare services across the region thanks to the generosity of local people, national Foundations and grateful patients from far and wide.

This support has made a real difference to the lives of patients and their families, and has benefitted some of the most vulnerable people in our community.

As the Charity does not replace statutory NHS funding, your donations genuinely improve the care available to local people in ways that would not otherwise be possible.

Funding allocation

The charity funds healthcare projects in hospital environments and the community.

Internal

Funding available to BCUHB members of staff to use for the benefit of their patients within a hospital or community healthcare setting.

External

Funding available to local Third Sector Organisations working in partnership with BCUHB on health-related projects based anywhere in North Wales, or higher education institutions hosting BCUHB research projects.

Up to £5,000

Projects costing £5,000 and under can be authorised by Fund Advisors (BCUHB staff that act as guardians for their funds). This enables frontline staff to quickly access funding that will enable them to implement ideas that will make a tangible difference for their patients.

More than £5,000

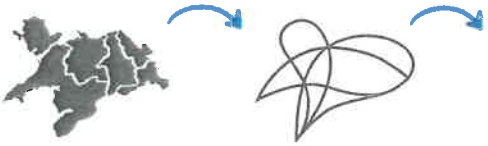
Higher value projects go through the Charity's formal application and scrutiny process. This ensures projects are robust, will make best use of the charity's funds, and reduces duplication.

Designated funds

These funds belong to the ward, service or department that the fund is aligned to. When donors choose to give to a specific healthcare area, their donation goes into a designated fund. Designated funds can only be used to fund projects within that healthcare area.

Non-designated funds

When a donor chooses to give to the charity without specifying a healthcare area, their gift is put towards non-designated funds. These important donations help all BCUHB staff to access grants for the benefit of their patients, even if they do not have a designated fund to draw upon.



Awyr Las Blue Sky

Values, Mission & Purpose

The Charity's overarching mission is to enhance BCUHB's ability to improve the health and wellbeing of people across North Wales and deliver excellent care.

The Charity exists for two reasons, both of which are equally important and both of which have a huge impact on the care and treatment that patients receive.

TO ENSURE THAT BCUHB CAN MEET ITS STRATEGIC PRIORITY OF IMPROVING HEALTHCARE

TO ENSURE THAT THOSE WHO WANT TO GIVE BACK TO SPECIFIC HEALTHCARE SERVICES ARE ABLE TO DO SO IN A WAY WHICH SUPPORTS LOCAL PRIORITIES

NHS Charities have been in existence since 1948 and have always played an important role in the above, but now they are needed more than ever. As we are living longer, many of us with complex health issues and diseases, there is a very real need for support from charitable sources in order to provide excellent care.

The Charity has traditionally focused on supporting secondary care, particularly cancer services, but there are two pressing issues which the Health Board needs to address:

- Ninety percent of the care people receive is from primary care and community services, and with predicted rises in cases of dementia and other mental health issues, cancer, diabetes and heart conditions there will be ever increasing demands on these services.

- There are also evident health inequalities in North Wales, with those living in the least deprived areas likely to live 13 years longer in better health than those living in the most deprived areas.

The challenge that faces the Charity is to effectively continue to provide the support needed on wards and departments in secondary care settings **and** secure the support to address the two pressing needs: to improve primary & community care provision and to reduce health inequality.

GUIDING PRINCIPLE

Patients are at the heart of Awyr Las

1

GUIDING PRINCIPLE

Frontline NHS staff are the lifeblood of Awyr Las

2

The Charity's Support Team – made up of finance, fundraising and administrative support staff – exists to ensure that the charity's mission can be carried out.

The Support Team:

- Manages the charity's financial accounts, investment portfolio and grants programmes;
- Provides assistance to and guidance for the Fund Advisors who oversee the Charity's different funds;
- Helps fundraisers who want to organise events and activities in aid of the Charity;
- Organises fundraising events and initiatives to raise money in aid of the Charity;
- Promotes the Charity to raise money and raise the profile of giving to all healthcare services, and;
- Keeps in touch with supporters.

The Support Team also ensures that Awyr Las maximises your donations, for example by reclaiming thousands of pounds in Gift Aid annually. Additionally, the Support Team provides assistance to independent charities, like the Leagues of Friends, which provide direct charitable support to BCUHB.

THE CHARITY'S VALUES REFLECT THOSE OF THE HEALTH BOARD

1. Put patients first
2. Work together
3. Value and respect each other
4. Learn and innovate
5. Communicate openly and honestly

£10,861 OF GIFT AID RECLAIMED FOR THE CHARITY

GUIDING PRINCIPLE

Be true to those who support Awyr Las

3

The year at a glance

INCOME & SOURCES

£1,950,000

The charity's total income from donations, legacies & fundraising*

4,819
DONATIONS GIVEN

£201
VALUE OF AVERAGE DONATION

35% of this come from
LEGACY GIFTS

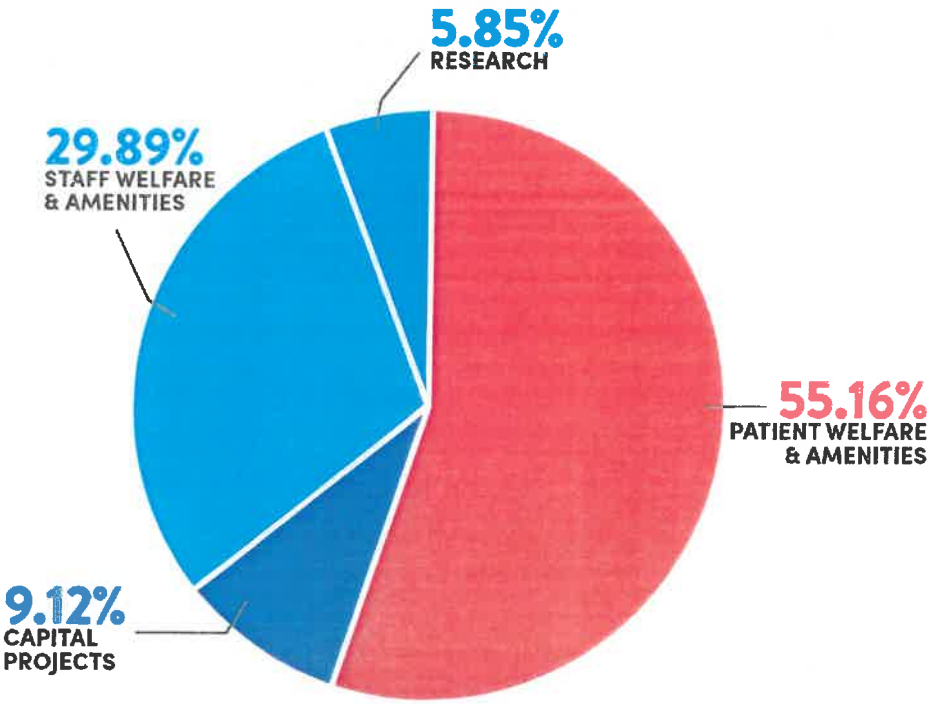
65% of this come from
DONATIONS AND FUND RAISING

8% of donations went towards
EARLY YEARS

33% of donations went towards
CANCER CARE

1% of donations went towards
MENTAL HEALTH

DISTRIBUTION OF EXPENDITURE 2018/19



Capital projects
£159,000

Staff welfare
£521,000

Research
£102,000

Patient welfare
£962,000

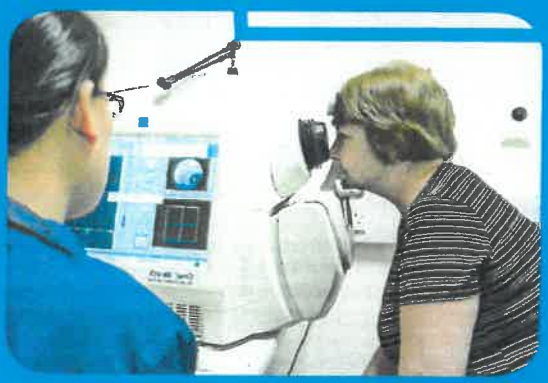
This year, Awyr Las funded

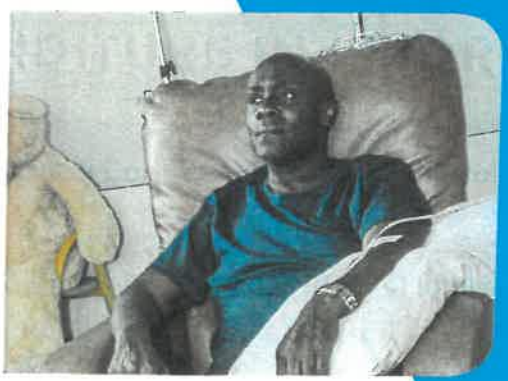
£1.7M

of services, improvements and activities across North Wales

SUPPORTING A WIDE RANGE OF HEALTH-RELATED ACTIVITIES:

- Enhanced Patient Care
- Equipment & Facilities
- Improved Environments
- Arts in Health
- Training & Education
- Research & Development





EXPENDITURE IN PRIORITY AREAS

- Cancer Care - £416,572 // 23% of total expenditure
- Early Years - £272,623 // 15% of total expenditure
- Mental Health - £60,688 // 3% of total expenditure

70 years of the NHS

Celebrating a special milestone

The 5th July 2018 marked 70 years since the birth of the NHS. Colleagues from wards, departments and services across BCUHB joined in the celebrations, alongside patients, local businesses, voluntary organisations and the wider community.

The #Give70 campaign was launched in April and encouraged BCUHB staff and the general public to take part in the anniversary celebrations.

Individuals were invited to do simple things to say thank you to the NHS services that mean the most to them.

The campaign used the milestone as an opportunity to ask individuals to undertake a fundraising activity that was 70 themed.

From pledges to run 70 miles before the anniversary month was over, to activities that aimed to raise £70; the involvement #Give70 generated was varied, generous and creative.

Staff were encouraged to hold tea parties for their patients and team members, with 85 different wards and departments holding a party on the anniversary. Over 200 people attended the main "Big 7Tea" parties, held in the main entrances of the 3 acute hospitals.

We held a **'WHERE THERE'S TEA THERE'S HOPE'** themed event.

Staff dressed up as characters from "Call the Midwife" at our event!

We had a display board with information about births throughout the past 70 years and vintage medical equipment on display.

As a thank you for their hard work, we invited retired staff to attend and be served tea & cake.

The day was a great success with past, present and future staff catching up and sharing stories. It was thoroughly enjoyed by all. We raised £1,630 for the Maternity Unit from this great day which we think is a fantastic achievement.

SUSAN HUGHES
MIDWIFE
MATERNITY UNIT
YSBYTY GWYNEDD

#Rhoi #Give70

LET'S RAISE A CUPPA

ON YOUR MARKS, GET SET, BAKE!

As part of the celebrations, BCUHB staff and their friends & family were invited to submit entries into the first Awyr Las Cake Decoarating Competition.

Nineteen talented bakers took part, with a public vote on Facebook deciding the top 3.

OVER 5,000 PEOPLE VOTED 5.2K

#NHS70 Park Run

350 RAN THE PARKRUN

On Saturday 9th June over 350 people (many in NHS themed fancy dress!) took part in a special Parkrun at Erddig to celebrate the anniversary of the NHS.

This was part of a UK-wide initiative which saw over 145,000 people take part in a Parkrun near them to mark #NHS70.

Thank you to Conwy Parkrun and Erddig Parkrun volunteers who joined in the celebrations locally!

Grants

This year, Awyr Las distributed £1.7m of grants across the Charity's four priority areas: Cancer Care, Early Years, Mental Health and Older People. The largest area of spending was Patient Amenities & Welfare, representing over half (55.16%) of the Charity's expenditure.

"The new laser has been a revelation to our service.

It is an essential bit of equipment for providing the most up to date and clinically proven treatments for all patients when they are diagnosed with head and neck cancers."

PROFESSOR ARVIND ARYA
MSC MD FRCS (ORL-HNS)

CONSULTANT ENT
HEAD & NECK / THYROID SURGEON

KEY INFO

PROJECT
CO2 Laser

COST
£55,235

THEME
Cancer Care

SITE
Ysbyty Glan Clwyd

The incidence of oropharyngeal cancers (OPC), primarily of the tonsil and tongue, is rapidly increasing.

Laser surgery has been proven to be a successful treatment for OPC and is becoming more commonplace in our clinical practice. Because of a rise in the number of OPC cases that were being diagnosed, the ENT team did not have the theatre equipment required to offer all patients the life-saving laser treatment. Only one laser was available, enabling the team to perform one operation per operating list. This sometimes resulted in delays to surgery.With funding from Awyr Las, the ENT team purchased a new CO2 Laser. Use of the new equipment reduces the need for chemotherapy and radiotherapy.

This is a better outcome for patients, reducing the length of treatment required and minimising the likelihood of complications after treatment. The laser equipment benefits all patients across North Wales, thanks to the centralisation of head and neck cancer services to Ysbyty Glan Clwyd.

The North Wales Clinical Research Centre (NWCRC), based in Wrexham, provides a world-class facility for undertaking clinical research, education & training, based on an innovative concept for collaborative working and increasing the transfer of knowledge.

It comprises research laboratories, clinical suites for undertaking non-laboratory based research, hot-desk facilities, offices, meeting and seminar rooms. The NWCRC provides a facility and service, allowing BCUHB staff to undertake laboratory based and non-laboratory based research investigations.

The aim of the NWCRC is to promote clinical research at BCUHB, and to encourage staff within the health board to undertake research activities, and to develop NWCRC as a centre of excellence for clinical research (locally, nationally and internationally).

Awyr Las provided £25,000 to purchase the initial equipment required to set up the centre to enable research to be undertaken.

KEY INFO

PROJECT
Start-up equipment for the NWCRC

COST
£25,000

THEME
Research & Development

SITE
North Wales Clinical Research Centre

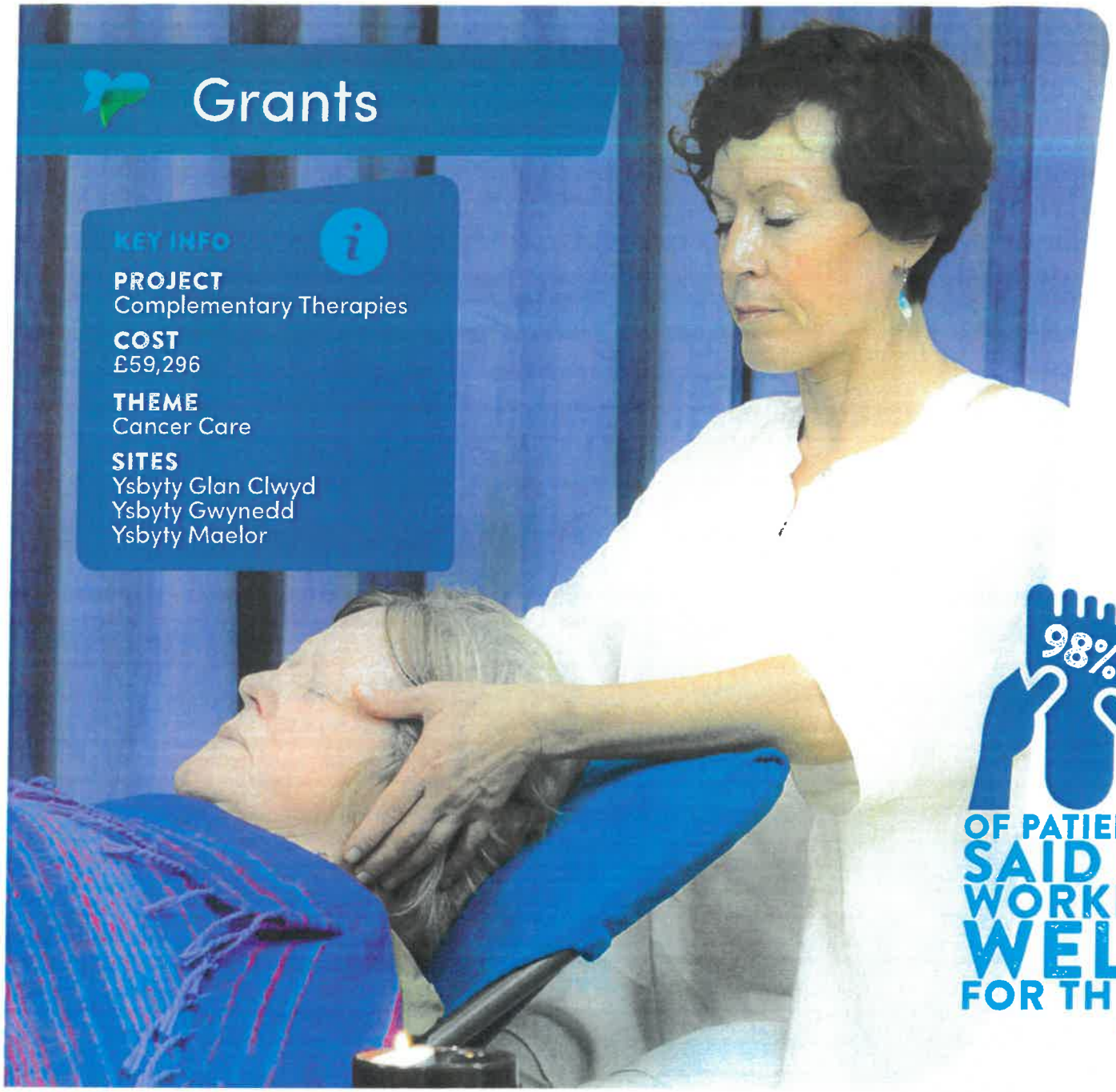
Professor Stephen Hughes, Academic and Scientific Director of the NWCRC said: "It's amazing to finally have the centre open. With this facility we now have a clinical research centre with fantastic equipment that allows the opportunity for our staff to be able to conduct cutting edge clinical research.

"Crucially, undertaking clinical research will benefit the people of North Wales at a national level and beyond. The aim of the research centre is to primarily provide a world class facility for our patients and members of the public, ensuring that North Wales is actively involved in undertaking cutting-edge clinical research.

"We have worked hard to get this facility open and we are looking forward to welcoming the public to the centre to see what we have happening.

"By having a research active Health Board, in turn will attract the very best clinicians and allied health professionals to the area, and will hopefully provide an opportunity for expansion and create new jobs."

Grants



KEY INFO

PROJECT
Complementary Therapies

COST
£59,296

THEME
Cancer Care

SITES
Ysbyty Glan Clwyd
Ysbyty Gwynedd
Ysbyty Maelor

OF PATIENTS SAID IT WORKED WELL FOR THEM

The side effects of cancer and its treatments are often painful and debilitating, but through complementary therapies, we can offer respite, comfort and emotional support to patients when they need it the most.

Complementary therapies can help to rekindle the spirit in patients living with cancer, support them in making lifestyle changes, and motivate them to move forward in life.

While our NHS provides the life saving and life prolonging drugs, frontline staff, and basic facilities, we rely on the generosity of members of the public to ensure that we can continue to provide much valued added extras like complementary therapies, which are making a real difference to local cancer patients.

The provision of a complementary therapy service at all 3 acute sites has been made possible entirely by the support of generous communities, patients and families.

Inspired thinking offering massage to patients.

Very relaxing and takes thoughts and feelings of the chemotherapy away.

Wonderful. Thank you.

PATIENT
SHOOTING STAR UNIT WREXHAM

Chronic kidney disease (CKD): Can we target blood vessel health to prevent disease progression and improve renal replacement therapy?

CKD is a disease of progressively worsening kidney function, which increases the risk of heart disease and death and results in the need for a kidney transplant or dialysis (also known as renal replacement therapy). CKD has many possible causes including common conditions such as high blood pressure, diabetes and obesity.

There has been some previous research suggesting that exercise may help to delay the progression of kidney disease, but the results have been inconclusive and further, larger studies are needed. We also need to understand better the mechanism by which exercise might be beneficial; previous research has shown that exercise can improve the health of blood vessels in patients with chronic kidney disease and this may lead to improvements in kidney function.

This study is a collaboration between Bangor University and King's College, London. Researchers are going to see if a 12 month structured exercise programme can help improve blood vessel health and kidney function in patients with chronic kidney disease.

It is hoped that the results of these studies will show that increased physical activity helps slow down the progression of kidney disease in our patients and will make a difference to patients' lives by delaying the need for renal replacement therapy. Eventually, this may lead to exercise therapy being offered as part of routine care to all patients with CKD.

KEY INFO

PROJECT
Chronic kidney disease research project

COST
£29,041

THEME
Research & Development

SITE
Bangor University

Parents and carers are always encouraged to stay on the ward when their children are admitted. In many cases, this involves staying the night. By using money from the Ysbyty Gwynedd Children's Unit fund, we were able to purchase 6 foldaway beds that are both comfortable and compliant with infection prevention and manual handling requirements. The new beds are in daily use on the ward, ensuring families can stay together when their child is poorly.

LIZ FLETCHER
ASSISTANT AREA DIRECTOR (WEST)
CHILDREN'S SERVICES

KEY INFO

PROJECT
Beds for parents & carers

COST
£5,129

THEME
Early Years

SITE
Ysbyty Gwynedd

Grants: Hearts & Minds

In 2018/19, Awyr Las introduced a new small grants scheme: Hearts & Minds. The scheme was designed to be accessible to all staff, and would award small amounts of funding to frontline staff wishing to trial innovative or creative ideas. The scheme was made possible by a number of donors, with a large proportion of the funding was provided by Grŵp Cynefin.

In total, 52 applications were submitted representing projects across North Wales, in both acute hospitals and community sites.

Applicants were invited to submit requests for up to £1,000 towards a project that would benefit their patients.

The criteria was flexible, with the only stipulation being that projects must benefit patients in the following healthcare areas:

- Mental health
- Learning disability
- Stroke
- Dementia care

The quality of the applications very high.

Twelve applications were funded through the Hearts and Minds Fund, with an additional £5,000 of undesignated charitable funds being allocated for this purpose.

A further 4 applications were funded by approaching relevant Fund Advisors and requesting support from funds they oversee.

A total of £12,530 was granted to 16 of the 52 applicants.

Grŵp Cynefin
Mwy na thai • More than housing

Aromatherapy on the Acute Medical Unit

Louise Lewis, a Dementia Support Worker on Ysbyty Glan Clwyd's Acute Medical Unit (AMU), had an idea to use aromatherapy to help patients arriving on the ward to relax.

Lousie explained:

"AMU is an extremely busy unit. We accept patients from the Emergency Department who are being admitted into hospital. Patients can be transferred to and from AMU any time of the day or night. When they arrive with us, patients can be very tired, agitated, confused and upset.

"My Hearts & Minds idea was to make AMU a more calming and settled environment for patients by placing aromatherapy kits in every room. I already massage patients' hands and feet, and play relaxing music. The aromatherapy complements this and helps aid rest and relaxation for the patients."

KEY INFO

PROJECT
Aromatherapy on AMU

COST
£1,000

THEME
Mental Health

SITE
Ysbyty Glan Clwyd

PATIENT FEEDBACK

"It was wonderful coming from the ED into a lovely relaxing room. My husband is a lot more settled than he was."

Music Therapy on the Stroke Unit

The Ysbyty Glan Clwyd Stroke Unit team explored the therapeutic benefit of drumming to provide sensory feedback to affected upper and lower limbs following a stroke.

Structured drumming sessions were provided for patients on the unit. Following each session, staff conducted a short interview with each patient and explored the positive aspects of engaging in the group and to discuss how it could improve.

The feedback from patients was very positive and demonstrated that engagement with lively, stimulating music intervention improved their overall feeling of well being.

Kirsty Edwards, Occupational Therapist, said:

"As a team, we are so grateful to have been awarded the Hearts and Minds grant to pilot the effect of active music intervention on post-stroke rehabilitation.

"We hope that stroke patients in a ward environment will benefit physically and psychologically through engagement with lively, stimulating and interactive music intervention.

"Beth, our lead Occupational Therapist in Stroke at Ysbyty Glan Clwyd was awarded the first Welsh Stroke Researchers Cochrane fellowship last year.

"The award has allowed her to work on a systematic review with the Cochrane Stroke and Dementia Groups. The primary aim of the project is to support the fellows in completing a Cochrane review, but other important aims are to foster multidisciplinary and cross-border collaborative working.

"Beth is reviewing the effectiveness of aromatherapy based interventions and the review is now in the final stages prior to publication."

KEY INFO

PROJECT
Music therapy to aid stroke recovery

COST
£1,000

THEME
Stroke Care

SITE
Ysbyty Glan Clwyd

PATIENT FEEDBACK

- "The vibration in my affected arm was a good sensation"
- "Uplifted the mood of the ward"
- "Music is a great therapy"
- "It helped me to relax - to focus on doing something 'for me'"
- "The sound of the drum encouraged my participation"

#TeamIrfon

£180,000
AMOUNT RAISED TO DATE BY #TEAMIRFON

The #TeamIrfon campaign was established in 2014 after local Nurse Manager, Irfon Williams, was diagnosed with advanced bowel cancer at the age of 43.

Irfon initially wanted to raise £5,000 because he and his wife Becky had realised that being diagnosed with cancer and going through treatment has a huge impact on the mental health of patients and their families.

Irfon and Becky felt the mental health aspect of cancer care required more attention, so formed #Teamirfon to raise money to fund projects and facilities that specifically support the mental health of local cancer patients and families.

Devastatingly, Irfon died in May 2017; but his memory and #TeamIrfon lives on.

To date, over £180,000 has been raised and gone directly to local services. Becky now oversees #TeamIrfon alongside Matron Manon Williams. The dynamic pair, who have had huge support from their local community and generous businesses (including Watkin Jones and Dafydd Hardy), are dedicated to increasing support for bereaved families and continuing to fund mindfulness, complementary therapies and improved wigs for those patients who lose their hair.

Together supporters of #TeamIrfon are continuing to make Irfon's vision of better mental health support for people with cancer a reality.

Sybil Jones attends the Alaw Cancer Care Day Unit every Friday for chemo injections and bone strengtheners, and receives reflexology, which is funded through donations given to #TeamIrfon.

Sybil said:

"Sam provides reflexology for patients like me. She always manages to fit me in, even though her wonderful soothing foot reflexology is in demand from all of us on the Unit.

"I really don't think there is any better pain killer and because of her I really look forward to my weekly hospital visits. It's a wonderful service that she provides on the Alaw Unit."

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Below: Rhys Meirion and Côr Glanaethwy performing at the inaugural #TeamIrfon Christmas

The Livsey Trust

I know my uncle and aunt, Bob and Flora Livsey, would be thrilled to know that their legacy has had such a huge impact on people from their community here in North Wales. Thanks to them, so many people are able to get better care and treatment right here in Ysbyty Glan Clwyd.

Bob and Flora chose to remember the hospital in their will because they themselves had received such fantastic care. As the Trustee of the Fund they established, I am personally delighted to know that their gift has made such a difference and that it will go on helping local families for many years to come.

JOHN GRIFFITHS
BOB & FLORA'S NEPHEW AND TRUSTEE OF THE LIVSEY FUND

The late Bob and Flora Livsey decided to establish a Charitable Fund in their Will, with the intention of helping other patients being treated at Ysbyty Glan Clwyd in appreciation of the excellent medical care they had both received in the later years of their lives.

The Livsey Trust has now given £1,106,880 to support new equipment and better facilities. The impact of the couple's legacy is immense.

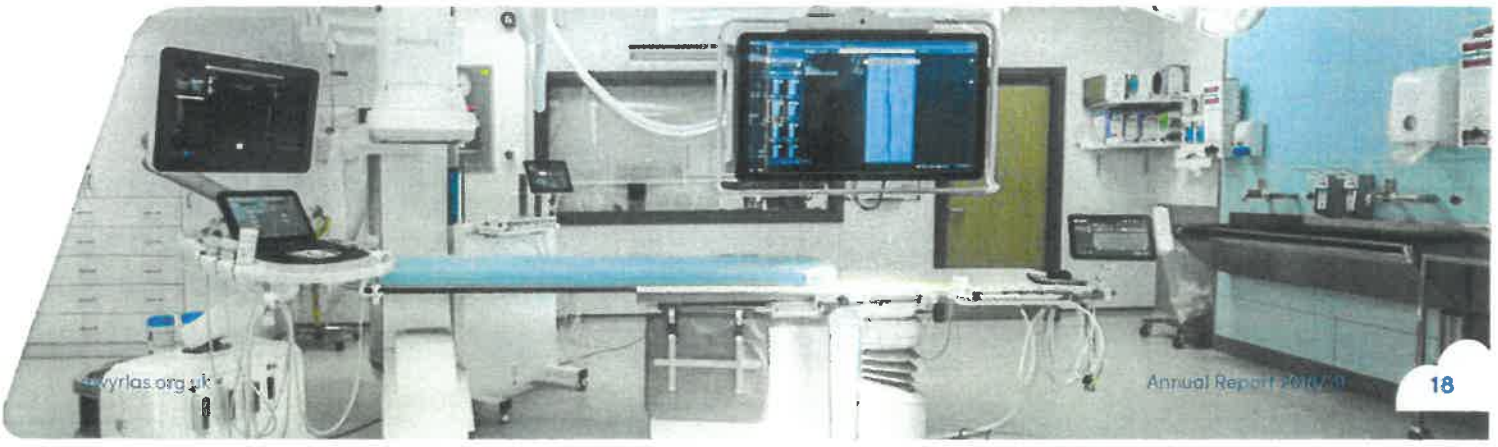
The Trust's most recent donation of £550,000 has helped to dramatically improve cardiac treatment at the hospital.

The Livsey Trust was a major driving force in developing a new state-of-the-art Hybrid Theatre for the hospital.

The new theatre forms part of a number of changes being made to vascular services in North Wales. The new centre at Glan Clwyd Hospital is now one of the best equipped in the UK, with expertise and facilities available around the clock to treat complex arterial cases.

The new theatre will give Interventional Radiologists and Vascular Surgeons the ability to perform traditional, open surgery and minimally invasive endovascular procedures on the same patients, at the same time, in the same place.

The 24-hour-a-day, 7-days-a-week consultant vascular emergency rota runs from Glan Clwyd Hospital, with the hybrid theatre providing state-of-the-art facilities to provide emergency vascular care.



The Robins volunteer scheme

Robins are renowned for their friendly nature

The Robins volunteer scheme is part-funded through donations given to Awyr Las, and the help the volunteers give in the hospitals is gratefully appreciated by everyone.

The purpose of the Robins scheme is to enhance the inpatient experience by introducing a volunteer befriending role onto the wards.

Robins are befrienders and provide practical support for patients.

This includes preparing hot & cold drinks, checking and refilling water jugs, spending time in general conversation, and providing a reading and writing service where appropriate.

Robins sometimes also go on errands to the hospital shop for patients.

They can assist nursing staff with bed making, help with storage of supplies, and tidy patient lockers.

Some Robins can offer a signposting service too, helping patients to understand the aditional support available to them in the community.

In 2018/19 almost £27,000 was dedicated to supporting the development of The Robins, BCUHB's volunteer programme.

ROGER'S STORY

A Robin volunteer who ensures patients at Abergele Hospital get their morning newspapers has been named a "Seren Betsi". The BCUHB Seren Betsi (Betsi Star) award is given to staff and volunteers that have excelled.

Roger Harvey heads out in all weather conditions to make paper deliveries to patients at the two hospitals, and even helped staff get into work during the heavy snow last Winter.

Roger, who has been volunteering at the hospital for more than 10 years, was inspired to help others after receiving care at Glan Clwyd Hospital for a stroke in 2005.

Roger was nominated for the award by Domestic Assistant Angela Fortune, who he sees on his visits to Abergele Hospital.

Angela said: "I nominated Roger because he's a volunteer, using his own car, time and money to help others, and puts a big smile on patients' faces when he comes in in the morning.

"Without Roger some people who enjoy reading the papers would not have this luxury to look forward to. We just want to say thank you to him for all that he does."

DONATIONS GIVEN TO THE ROBINS FUND VOLUNTEER EXPENSES INCLUDING TRAVEL, WHERE APPROPRIATE AND THE DISTINCTIVE RED T-SHIRTS WHICH ARE WORN WITH PRIDE BY OVER 200 PEOPLE ACROSS NORTH WALES

LAURA'S STORY

Laura McManus, from Talybont, near Barmouth, also received the Seren Betsi Award this year.

Sally Adams, Matron of Dolgellau Hospital, said: "Since Laura became a Robin here at Dolgellau Hospital I have noticed her incredibly kind approach with our patients.

"She has an excellent relationship with my staff on the ward and has a beautifully calming influence on everyone who is around her.

Laura said: "I'm delighted to receive the Seren Betsi Award as I'm really happy and privileged to be a Robin at Dolgellau Hospital."

Robiniaid | The Robins

ACHIEVEMENTS 2018/19

- 202 Robins provided support across North Wales
- Robins assisted at 3 acute and 13 community sites
- 19,968 hours of time was gifted to the Robins scheme
- 2 volunteers were awarded the 'Seren Betsi' Award

Winners of BCUHB Achievement Award for Outstanding Voluntary Contribution

EDWARD

It's a very rewarding role. It's nice to be able to help people.

FAZAL

I've learned valuable life skills from patients and from my co-workers who are all hugely inspiring.

CYNTHIA

When I go home at the end of the day I feel I have done something worthwhile.

Supporters

Every year, the Charity Support Team is overwhelmed by the efforts and achievements of Awyr Las' amazing supporters. This year is no exception. Support in 2018/19 ranged from 85 wards and departments holding "Big 7Tea" Parties to celebrate the 70th Anniversary of the NHS, to the Wrexham Maelor Children's Unit developing their Corporate Partnership with SP Energy Networks, which was instrumental in helping them to raise over £25,000 through their first charity ball. The Charity Support Team is immensely grateful for the generosity of the many individuals, local businesses, and community organisations that contribute to Awyr Las. Their support helps the charity to ensure NHS staff across North Wales can go above and beyond for their patients.

SP ENERGY NETWORKS

Over the past two years we have been honoured to be principal sponsors of such a worthy cause for the Wrexham Maelor Children's Ward charity ball. SP Energy Networks are committed to supporting communities in North and Mid Wales, Cheshire, Mersey and North Shropshire through an extensive programme of local sponsorships and community engagement programmes. We congratulate the Wrexham Maelor Children's Ward charity team for putting on such fantastic events to help raise outstanding amounts of money for children and their families being treated on the ward.

PHIL JONES
HEAD OF DELIVERY
SP ENERGY NETWORKS

THE VALUE OF THE PARTNERSHIP EQUATES TO A

"Without the vital support from local companies such as SP Energy Networks we simply wouldn't make as much money to directly benefit our patients. Sponsorship of our charity ball allows us to achieve full cost recovery for the event which means all money raised directly benefits the Wrexham Maelor Children's Unit.

Last year, due to kind sponsorship and in-kind support, we raised an outstanding £25,500 profit, helping to support patients and families we care for through new equipment and enhanced facilities to brighten patients' days."

LESLEY JONES
CHILDREN'S WARD STAFF NURSE
CHARITY BALL COMMITTEE MEMBER

"Walking for Dementia" is a multi-day, long distance walk undertaken annually by a small group of volunteers. On the final day of the challenge, NHS staff and members of the public are invited to take part in the final section of the walk, to raise money for special Dementia Care projects in hospitals.

TOTAL RAISED TO DATE BY WALKING FOR DEMENTIA

"When I sat with my mother in the hospital and to be advised that she had dementia, little did I know how much it affects so many people and that there was a lot to understand about the disease.

When my mother passed away I honestly can say that the care and dignity from the nurses shown to my mum was exceptional and couldn't praise them enough. I felt that I needed to give something back and that is really how 'Walking for Dementia' started to challenge us all to raise money for the cause. This is our third year and feel that as a group we just want to carry on doing this for as long as our legs can do it and to make a difference to people's lives.

As a Fund Advisor on my own fund, I meet with staff from time to time, like Matron and the Dementia Support Workers, and discuss how we can best support patients and families affected by dementia. Matron will always contact me before any decision is made around funding, and we make sure that we all are in agreement about what would have the most impact for patients.

None of this could happen without the Awyr Las Support Team. The support we have had for the walks has been immense; from promoting the walk, social media coverage, helping to gain sponsorship, and more. I know the same support will be given to us with future events."

RONNIE BRIGHT
GENERAL OFFICE MANAGER
AWYR LAS FUND ADVISOR

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The Walking for Dementia events are fantastic for the staff at Llandudno Hospital; it's great for the team to see the walkers arriving on-site after their long walk. It reminds staff that the general public, and their colleagues in the wider NHS, value their wonderful work in caring for patients living with dementia.

The money raised by the walkers genuinely enhances the experience patients have at Llandudno Hospital. One of the most significant things we are able to do with funding from Awyr Las is improve the patient environment. This year, we were able to install an LED ceiling on Aberconwy Ward, which makes being on the ward a more relaxing experience for patients.

PHILLIP RATHBONE
MATRON
LLANDUDNO HOSPITAL

Supporters

Tesla Owners UK donated a RadioFlyer Mini Tesla each to the children's units in Wrexham Maelor and Glan Clwyd, to improve the experience of being in hospital for children.

Tesla Owners UK is the official Tesla Owners' Group in the UK as confirmed by Tesla. The RadioFlyer Mini Tesla scheme is supported by Elon Musk, who match funds each car. So far, the group has donated over 160 cars across the UK.

Tom Last, a member of Tesla Owners UK, said:

"Being local to North Wales, I wanted to ensure that the children's units in the area were able to benefit from this initiative. This world is a cruel place sometimes and if we can put a smile on someone's face, we will do our best."

The Alaw Day Cancer Unit team do such fantastic work, and I am privileged and honoured to try and raise funds for these vital causes.

My priority since losing my wife to breast cancer 13 years ago has always been the Alaw Day Cancer Unit, which helped Yvonne to try and overcome this awful disease.

Many friends have passed away from cancer also, so to me it is vital that I do what I can to raise funds every year for this brilliant cause. We are all in debt to the nurses and staff of Ysbyty Gwynedd.

MALCOLM PITTS
LONG-TERM FUNDRAISER

Karen Jutson was part of a trio that cycled 300 miles from London to Paris this year.

Karen chose to support the Special Care Baby Unit at Ysbyty Glan Clwyd.

Karen, who previously worked on the SCBU, said: "The joy I had helping precious babies and meeting their families was incredibly fulfilling.

"With the new SuRNICC (sub-regional neonatal intensive care centre) at Glan Clwyd Hospital, together with developing scientific advances, the future for our area looks extremely bright.

"I wanted to contribute to the centre by raising funds through this challenge, so the centre can continue to provide the best possible care."

Leah Malbon's brother, now 34, was diagnosed with with type one diabetes at the age of three.

Leah said: "My motivation for the London to Paris ride was based on a promise.

"On a recent occasion, when Stephen's health was particularly bad, I told him that the next challenge I did would be for him."

Leah chose to raise money for the Friends of Renal Care and Ward 12 (Renal & Diabetes), both at Ysbyty Glan Clwyd, where Stephen is a regular patient.

Volunteers from North Wales Garden World transformed North Wales Cancer Treatment Centre's Radiotherapy Garden.

The team tidied, weeded, and planted, and supplied lovely plants and furniture. Their hard work and generosity has made a huge difference to the area, and staff & patients are very grateful for the team's kindness.

North Wales Garden World

Five year review

Capital projects
£5,254,000

Practical improvements to the patient environment, including ward refurbishments and equipment.

Staff welfare
£2,357,000

Non-mandatory and specialist training & development opportunities for staff and projects to safeguard staff wellbeing.

Research
£332,000

Funding for research, development and innovation; from consumables for laboratories to PhDs.

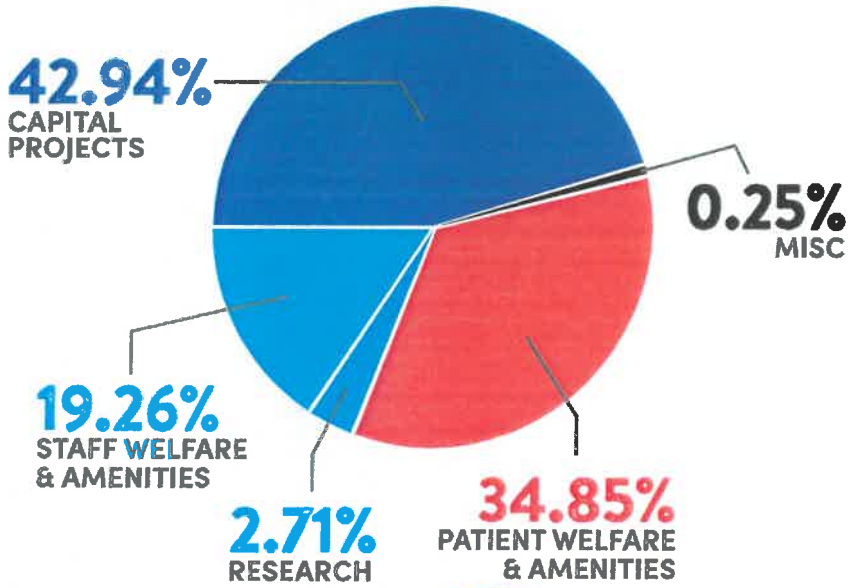
Patient welfare
£4,264,000

Projects that improve the experience of being in hospital, including arts in health initiatives and relatives' accommodation.

Miscellaneous
£30,000

Expenditure that does not fall into the other categories, including some administrative and legal services.

DISTRIBUTION OF EXPENDITURE (2014 - 2019)



SINCE 2014, DONATIONS TO AWYR LAS HAVE MADE IT POSSIBLE TO INVEST OVER
£12 MILLION
OF ADDITIONAL FUNDING INTO LOCAL NHS HEALTHCARE SERVICES

INCOME & SOURCES

2014 - 2019

£12,503,000

The charity's income from donations, legacies & fundraising*

LEGACY GIFTS

DONATIONS AND FUND RAISING

WERE MADE ONLINE

GIVING TRENDS

2014 - 2019

£1,975,372

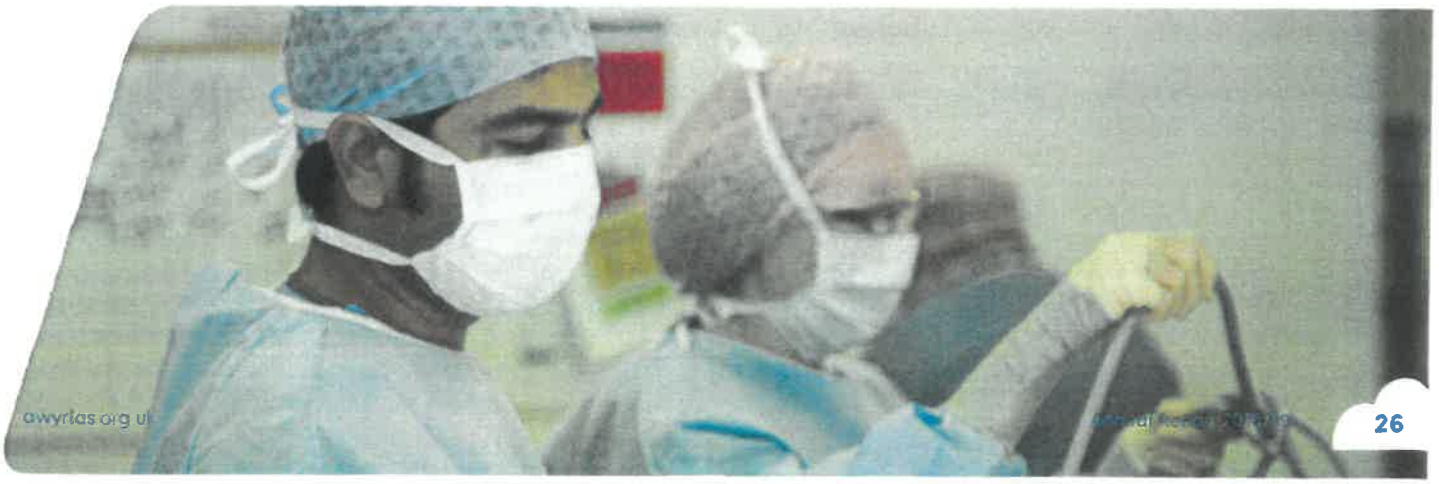
Amount given to the charity in memory of friends & loved ones

DESIGNATED FUNDS

GIVEN IN MEMORY

VALUE OF AVERAGE DONATION

DONATIONS GIVEN



Governance

The Charity's investments

Many of the donations and legacies the Charity receives cannot be spent immediately, as they need to be accumulated to be able to fund the most appropriate purchases that improve patient care.

Therefore, Awyr Las invests these donations in order to generate income and protect their value in real terms. The Charity's Investment Managers are currently Rothschild Wealth Management Limited.

The Trustee has adopted an ethical framework for investments, with underlying principles supporting an ethical component of the overall investment strategy.

This has given direction to the Investment Managers to develop a suitable investment strategy which is consistent with these ethical principles, whilst affording sufficient flexibility to provide the best balance of risk and reward for the Charity.

The portfolio is managed in accordance with this agreed strategy, which is as follows:

"It is recommended that there is negative exclusion of investment in companies manufacturing and distributing:

- **alcoholic products;**
- **tobacco products; and**
- **any products which may be considered in conflict with the Health Board's activities.**

Investment in companies:

- **which have a poor record in human rights and child exploitation; and/or**
- **which derive their profits from countries with poor human rights records**

should not be permitted.

In addition, investment in companies that demonstrate compliance with the principles of the Equality Act 2010 should be supported."

Investment performance is monitored by the Charitable Funds Committee at its quarterly meetings.

The Committee receives reports from the investment managers explaining the portfolio's performance, the level of risk seen and expectations for the future.

Organisation of the Charity's affairs

The Betsi Cadwaladr University Health Board Charity and other related Charities (the Charity, working name Awyr Las), registered charity number 1138976, is constituted under a trust deed dated 23" September 2010.

It is registered with the Charity Commission as the 'Umbrella Charity and Other Related Charities', with objects that the funds be used 'for any charitable purpose or purposes relating to the National Health Service'.

This registration arrangement, which simplifies the statutory reporting requirements, is formally recognised by a Declaration of Trust held by the Charity Commission.

Within this group registration arrangement there are two charities:

- Betsi Cadwaladr University Health Board Charity
- The North Wales Cancer Appeal (previously The Ron and Margaret Smith Cancer Appeal)

The Betsi Cadwaladr University Health Board is the legal Corporate Trustee of the Charity, which means that whilst the board members are responsible for the administration of the funds, they are not individually trustees of the Charity.

Trustee Recruitment, Appointment and Induction

The Board Members of the Health Board make up the corporate trustee. The Chair and Independent Members of the Health Board are appointed by the Minister for Health and Social Services of the Welsh Government, with the Executive Directors being appointed in accordance with Health Board policy.

New members of the Board are provided with appropriate induction and training on behalf of the Executive Director of Finance, along with previous year's Annual Reports and Financial Statements, copies of the Charity's Governing Documents and relevant Charity Commission publications.

Charity staff

The Charity does not directly employ any staff. The day to day management of the charity is delegated to the Executive Director of Finance.

Members of the Awyr Las Support Team are employed by the Health Board and then recharged to the charity in accordance with the proportion of their time that has been spent on charity work.

The Health Board Senior Manager responsible for the administration of the charity is Sue Hill, Executive Director of Finance. The Charity Accountant is Rebecca Hughes and the Head of Fundraising is Kirsty Thomson.

Key Management Personnel Remuneration

The trustees have concluded that the Corporate Trustee through the Charitable Funds Committee comprises the key management personnel of the Charity as they are in control of directing the Charity.

The Charity does not make any payments for remuneration nor to reimburse expenses to the Charity trustees for their work undertaken as trustee. Trustees are required to disclose all relevant interests, register them with the Health Board and withdraw from decisions where a conflict of interest arises. All related party transactions are disclosed in note 2 to the accounts.

The Charity's advisors

Bankers
NatWest Bank, 5 Queen St, Rhyl, Denbighshire, LL18 1RS

Investment advisors
Rothschild Wealth Management, New Court, St Swithin's Lane, London, EC4N 8AL

Registered auditors
Wales Audit Office, 24 Cathedral Road, Cardiff, CF11 9LJ

Board Members

Mr G Doherty
01/04/18 TO 31/03/19 Chief Executive

Dr E Moore
01/04/18 TO 31/03/19 Executive Medical Director & Deputy Chief Executive

Mrs G Harris
01/04/18 TO 31/03/19 Executive Director of Nursing & Midwifery

Ms D Carter
18/03/18 TO 31/03/19 Acting Executive Director of Nursing & Midwifery

Mr A Thomas
01/04/18 TO 31/03/19 Executive Director of Therapies & Health Sciences

Mr A Roach
01/04/18 TO 31/03/19 Director of Mental Health and Learning Disabilities & Associate Board Member

Mr G Lang
01/04/18 TO 13/05/18 Executive Director of Strategy

Mrs S Boxter
14/05/18 TO 18/11/18 Acting Executive Director of Strategy

Mr M Wilkinson
19/11/18 TO 31/03/19 Executive Director of Planning and Performance

Mrs S Green
01/04/18 TO 31/03/19 Executive Director of Workforce and Organisational Development

Ms T Owen
01/04/18 TO 31/03/19 Executive Director of Public Health

Mr R Favager
01/04/18 TO 31/03/19 Executive Director of Finance

Ms M Olsen
01/04/18 TO 30/06/18 Chief Operating Officer

Mrs G Lewis-Parry
01/04/18 TO 31/03/19 Board Secretary

Dr J C Stockport
01/10/18 TO 31/03/19 Executive Director Primary Care and Community Services

Dr P Higson OBE
01/04/18 TO 31/08/18 Chairman

Mr M Polin OBE QPM
01/09/18 TO 31/03/19 Chair

Mrs M Hanson
01/04/18 TO 31/05/18 Vice Chair

Mrs M W Jones
01/06/18 TO 31/03/19 Vice Chair
[Independent Member 01/04/18 to 31/05/18]

Prof J Rycroft-Malone
01/04/18 TO 31/03/19 Independent Member

Mr C Stradling
01/04/18 TO 31/08/18 Independent Member

Mrs L Meadows
01/04/18 TO 31/03/19 Independent Member

Board Members

Mrs B Russell Williams
01/04/18 TO 05/03/19 Independent Member

Mr J Cunliffe
01/04/18 TO 31/03/19 Independent Member

Cllr C Carlisle
01/04/18 TO 31/03/19 Independent Member

Cllr R M Hughes
18/03/18 TO 31/03/19 Independent Member

Ms J Hughes
01/06/18 TO 31/03/19 Independent Member

Ms H Wilkinson
01/09/18 TO 31/03/19 Independent Member

Ms L Reid
01/09/18 TO 31/03/19 Independent Member

Mr Ff Williams
01/04/18 TO 31/03/19 Associate Board Member and Chair (Stakeholder Reference Group)

Prof M Rees

01/04/18 TO 31/03/19 Associate Board Member and Chair (Healthcare Professional Forum)

Mrs N Stubbins

01/04/18 TO 31/05/18 Associate Board Member and Director of Social Services

Ms M Edwards

01/06/18 TO 31/03/19 Associate Board Member and Director of Social Services

Performance

The overall objective of the Charity is to provide additional support for the benefit of staff and patients within the Betsi Cadwaladr University Health Board in accordance with the wishes of the donors.

In order to achieve this, the Charity continues to raise staff awareness of fundraising and of the availability of funds and the mechanisms for accessing them.

To ensure that the Charity's money is well spent and meets with its objectives, all applications for grants over £5,000 require approval from either the Charitable Funds Advisory Group or the Charitable Funds Committee, which is a Committee of the full Health Board.

The Charitable Funds Advisory Group was established at the start of 2016 to provide further scrutiny of applications.

The Advisory Group is a sub-committee of the Charitable Funds Committee and has a wide ranging membership, including medical staff, service mangers and patient representatives.

For applications between £5,001 and £25,000 the Advisory Group has delegated authority from the Committee to make a decision on approving or otherwise. For applications of over £25,000, the Advisory Group will provide comments for the Charitable Funds Committee's consideration to help inform their decision.

Applicants are required to provide details on key service benefits and ways to measure them, risks and mitigations, and how the proposal addresses health inequalities.

Charity Support Team

The Awyr Las Support Team grew this year.

Two new part-time members joining the team to help ensure that the Charity can keep its Fundraising Promise.

The Support Team prioritises building long-term relationships with supporters and the team aims to make sure all donors get the most out of their involvement with the charity.

The Support Team has helped over 100 different fundraisers and community groups organise fun, safe and sustainable fundraising events and activities over the year, and members of the team have also provided advice and support for external charities which independently support BCUHB healthcare services.

The team has proactively engaged with ongoing legal and regulatory changes, from GDPR to Fundraising Regulator reviews.

The Support Team has forged strong relationships with other NHS Charities to share best practice and work together where possible. The Charity did not receive any official fundraising-related complaints in the past year, though the Support Team did introduce new thanking procedures following feedback from donors concerning the time it sometimes took to receive an acknowledgement after a donation was made.

The Charity Support Team continues to make changes to its processes and partnerships with other teams within BCUHB to ensure the very best supporter care for all.

The Awyr Las Support Team has not uncovered any failure to comply with Fundraising Regulation by staff or Awyr Las volunteers in 2018/19.

The Awyr Las Support Team has chosen to not embark on contracting professional or commercial participators; the focus in 2018/19 has been on upskilling Support Team members and developing a dedicated, passionate crew to lead and support volunteers and supporters.

Grant-making

Awyr Las makes grants from both its restricted and unrestricted funds. These funds are further split into undesignated (general) funds and designated (earmarked) funds.

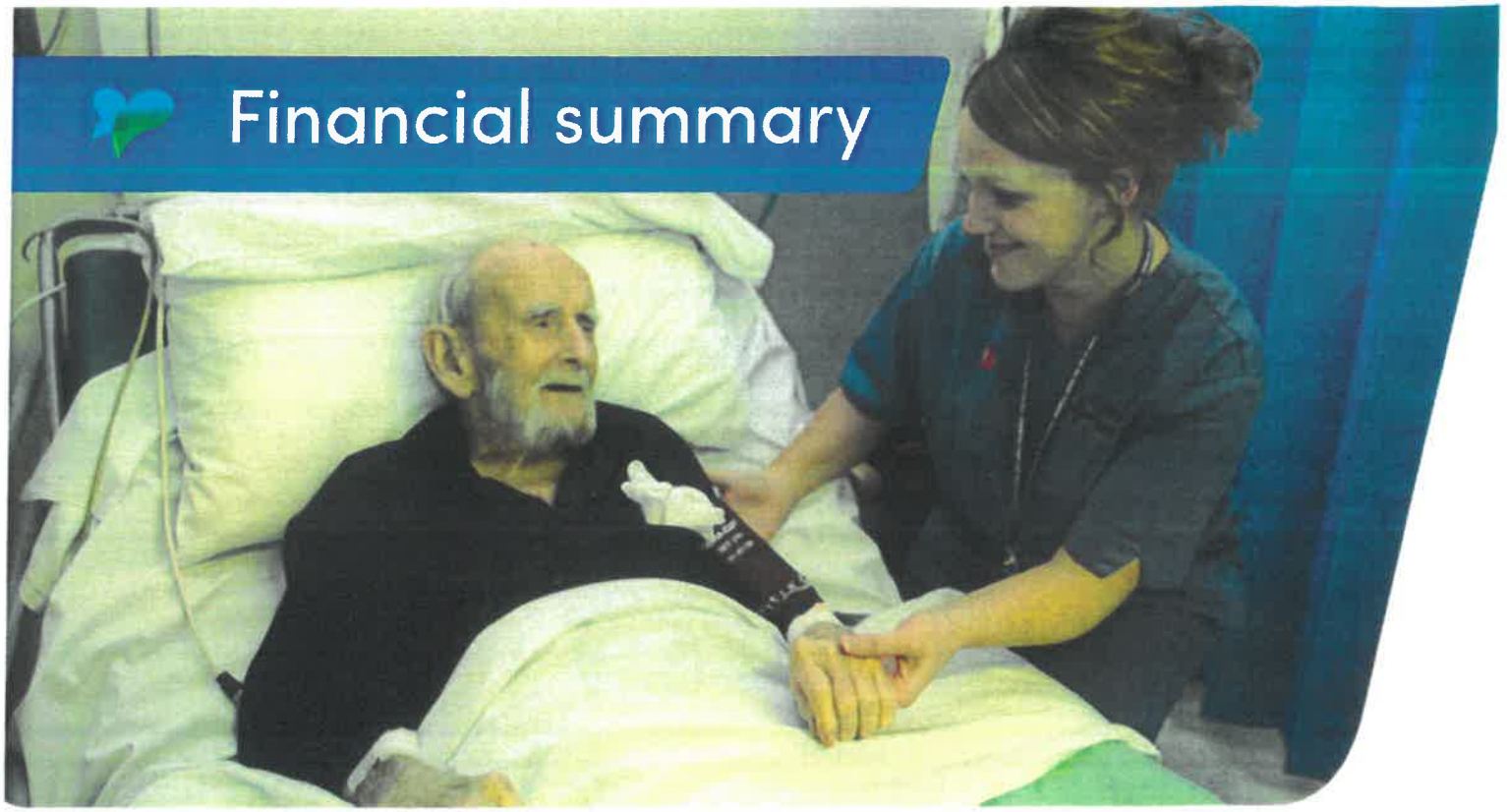
1. Undesignated funds – These funds are received by the Charity with no particular preference expressed by donors. They are used to fund things that are either needed across the region, or in areas/services that do not have their own fund. The Finance Director - Operational Finance acts as the Fund Advisor on undesignated funds and so can authorise expenditure up to £5,000. Undesignated funds have been decreasing in value significantly over the last few years. This is an ongoing challenge for the Charity as it limits the things that can be funded where there is no suitable designated fund.

2. Designated funds – Within Awyr Las, the majority of donations sit in one of the 400+ designated funds which are aligned to specific areas and/or services. Every fund has at least one Fund Advisor, who acts as the authorised signatory on the fund for purchases up to £5,000. Fund Advisors receive monthly statements outlining the income and expenditure on the fund. Fund Advisors are responsible for ensuring that the expenditure they authorise from their funds is appropriate and fits in with the objects of the fund and the Charity.

For all expenditure over £5,000, a scheme of delegation is in place whereby additional approvals are required from the senior team for that area in the Health Board and the Charitable Funds Committee (delegated to the Charitable Funds Advisory Group for applications £25,000 and under). This ensures that applications are fully reviewed and assessed alongside the objectives of the charity.

In planning activities for the year and when considering applications for grant funding, the trustees always consider the Charity Commission's guidance on public benefit.

Financial summary



The following figures are taken from the full accounts approved on 4th October 2019, which carry an unqualified audit report. The accounts should be viewed in full if more details are required. This part of the trustees' annual report comments on key features of those accounts. The full accounts have also been logged with the Charity Commission.

Almost all of the Charity's income comes from the voluntary efforts of NHS staff and the general public.

This year, donations generated £969,000 - 48% of the Charity's total income.

Fundraising accounted for 15% of the Charity's total income (£306,000).

Legacy gifts formed 33% of the Charity's income (£675,000).

Donations, fundraising and legacies combined account for 96% of the Charity's income this year (£1,950,000).

Investment of funds not immediately required by the Charity has generated £73,000 in returns, equating to 4% of Awyr Las' total income.

By supporting an existing fundraising event, or organising one of their own with the knowledge and approval of the Fundraising Support Team, thousands of people have had great fun whilst raising money for Awyr Las over the past year.

Committed volunteers, supported by the Fundraising Support Team, organised hundreds of 'in aid of' events; from small cake bakes to large-scale gala dinners this year, and supporters took part in organised events and challenges across the globe.

DONATIONS [48%]

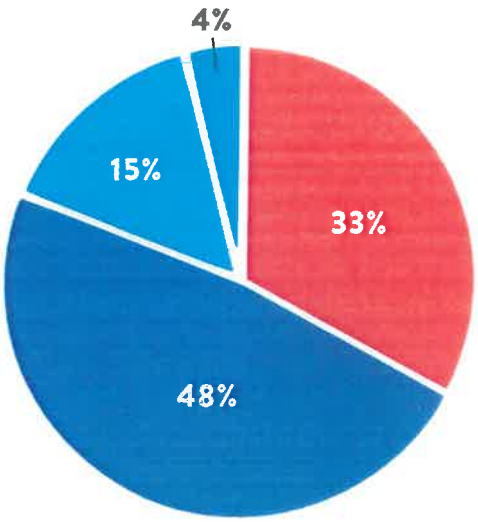
FUNDRAISING [15%]

INVESTMENTS [4%]

LEGACIES [33%]

TOTAL INCOME 2018/19

£2,023,000



Financial health

The assets and liabilities of Awyr Las as at 31st March 2019 are shown below, compared with the position at 31st March 2018.

Further details can be seen in the financial statements section.

Balance Sheet as at 31 March 2019

	Note	Unrestricted funds £000	Restricted Income funds £000	Total 31 March 2019 £000	Total 31 March 2018 £000
Fixed assets:					
Tangible assets	14	135	0	135	135
Investments	15	4,415	3,547	7,962	7,572
Total fixed assets		4,550	3,547	8,097	7,707
Current assets:					
Debtors	16	198	154	352	841
Cash and cash equivalents	17	511	399	910	876
Total current assets		709	553	1,262	1,717
Liabilities:					
Creditors: Amounts falling due within one year	18	(828)	(645)	(1,473)	(1,799)
Net current assets / (liabilities)		(119)	(92)	(211)	(82)
Total assets less current liabilities		4,431	3,455	7,886	7,625
Creditors: Amounts falling due after more than one year	18	(27)	(21)	(48)	(28)
Total net assets / (liabilities)		4,404	3,434	7,838	7,597
The funds of the charity:					
Restricted income funds	21		3,434	3,434	3,282
Unrestricted income funds	21	4,404		4,404	4,315
Total funds		4,404	3,434	7,838	7,597

Fixed asset investments are investments in quoted stocks and shares. Net current assets represent cash held plus money owed to the Charity, less money owed by the charity to others and any outstanding (commitments made for grant funding that has not yet been spent). Creditors falling due after more than one year represent commitments made for grant funding where the scheme runs for more than one year. Restricted designated funds represent the money held by the charity which can only be used for specific purposes. Unrestricted designated funds represent the 400 plus designated funds which are identified to specific areas and/or services. They have been created in line with sections 90 and 91 of the National Health Service Act 1977 which require that the trustees respect, as far as practicable, the specific intentions of the gifts received through wards, departments and specialties. By designating funds the trustees ensure that those gifts are channelled towards charitable purposes in those areas. General Funds represent those funds available for distribution by the trustees at their discretion.

Risk Analysis

Managing risk

As part of the Charitable Funds Committee meetings that take place at least four times a year, the trustees consider the major risks facing Awyr Las.

The Committee have reviewed systems and identified steps to mitigate those risks. Five major or moderate risks have been identified and arrangements have been put in place to mitigate those risks.

1. Fundraising

There are four themes under this risk: risk of non-compliance with fundraising regulations; the risk of involvement with third parties; the risk that the charity is not aware of all fundraising taking place in its name; and the risk that not all basic processes are in place to ensure the very best support.

To mitigate the first of these risks the Charity has become a member of the Fundraising Regulator and is a member of the Association of NHS Charities.

The Charity Support Team members are encouraged to attend workshops and carry out additional training to ensure all members are aware of existing and new regulation and guidance.

The Charity works with a number of third parties, including volunteer fundraisers. In order to ensure all arrangements with these third parties are clear and set out at the start of the collaboration, third parties and a representative from the Charity Support Team signs a Collaborative Working Agreement (CWA) which lays out the terms of the relationship.

The Charity has numerous supporters, many of whom organise fundraising events in aid of the Charity. The Charity Support Team continues to foster good working relationships with staff across North Wales to ensure good communication links with staff, the public and donors to make sure people are aware of the need to seek approval from the Charity Support Team for any fundraising being undertaken in the Charity's name.

A revised marketing and stewardship plan has been drawn up which is being implemented over the next 2 years. The plan is designed to help make sure all supporters receive recognition they deserve, and are kept abreast of how their donations make a difference should they choose to keep in touch with the Charity Support Team.

2. Fund Advisors

The Charity's Fund Advisors act on behalf of the Trustee in making certain decisions, but are not always aware of the Charity Commission guidelines that they need to follow. This creates a governance risk for the Charity.

To mitigate this risk a Fund Advisor Handbook has been developed to provide guidance and support to Fund Advisors in discharging their responsibilities. This document includes an Accountability Agreement for all Fund Advisors that ensures roles and responsibilities are understood and accepted.

All Fund Advisors are obliged to undertake an Annual Review of their fund. A rolling programme of Fund Advisor training has been established to minimise governance risk for the charity.

3. Appeals

There is a risk that the charity could give grants to and fundraise for items and services that are not strategic priorities.

The Charity Support team has launched a series of grants:

- The I CAN grant
- Hearts & Minds grants
- The Staff Experience grant

The purpose of these grant programmes is to identify priorities to be funded both now and in the future. The priorities that are presented by frontline staff are then categorised into 4 appeals:

- Older people
- Children and young people
- People with mental health problems
- Families affected by cancer

The appeals may support preventative programmes as well as new facilities, equipment and additional services for primary care and community settings as well as Ysbyty Glan Clwyd, Ysbyty Gwynedd and Wrexham Maelor.

4. Staff engagement

An engaged workforce is crucial to the success of the charity. There is a risk that staff are disengaged, or unaware of the charity, and so do not positively promote it with patients and potential donors.

To mitigate this, an action plan is being rolled out to better inform and involve all staff.

At the centre of this plan are Charity Champions who at ward, department or locality level can help promote the impact of the charity.

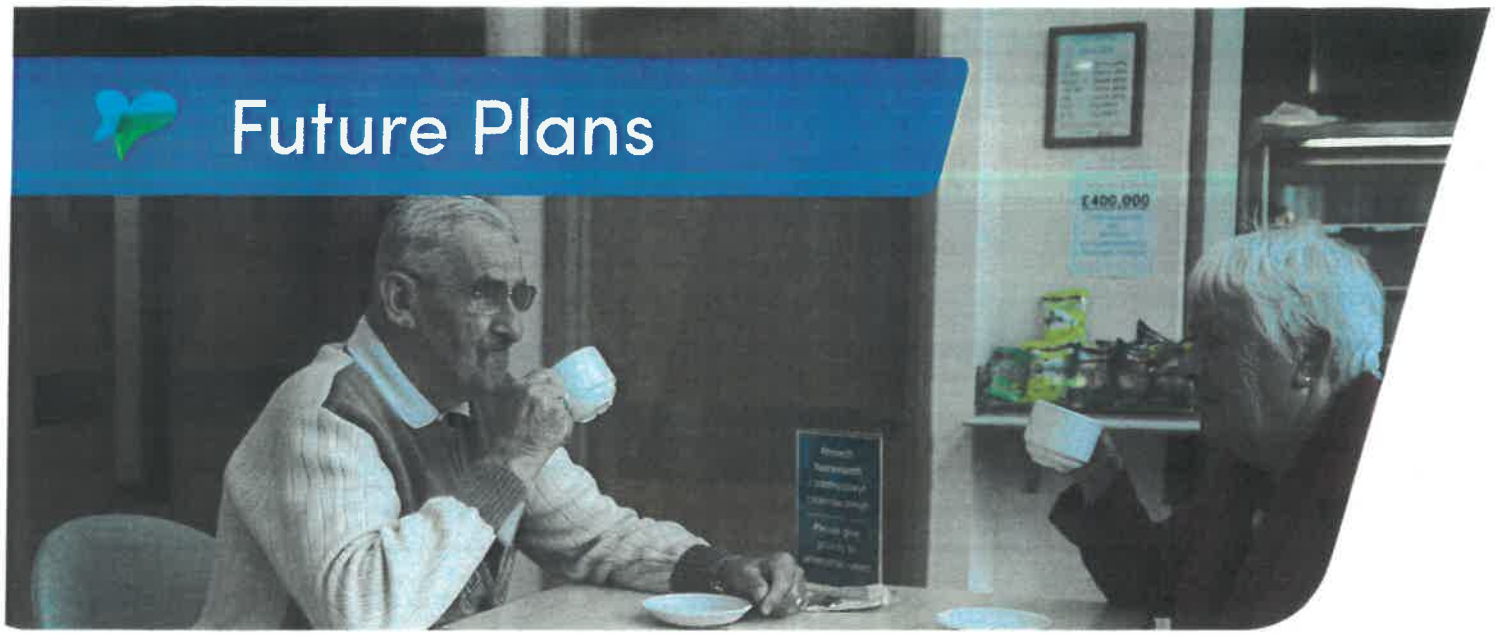
5. Investments

A large proportion of the charity's assets are held within the investment portfolio. There is a risk that the portfolio falls significantly in value and severely impairs the charity's ability to support future projects.

Monitoring of investments and the portfolio performance therefore needs to be a continual process. The charity's investment portfolio is monitored on a monthly basis by the Charity Support Team and on a quarterly basis by the Charitable Funds Committee.

The investment policy is reviewed by the Committee on an annual basis, in conjunction with the Investment Managers, to ensure it remains relevant to the charity's long-term strategy.

Future Plans



BENEFICIARIES

BENEFACTORS

BENDIGEDIG

BENEVOLENT

The charity's strategic plans are outlined in the Awyr Las Strategy for 2016 to 2021. The strategy highlights the importance of the four pillars of the Charity - the 'Bens'.

Beneficiaries:
The patients and families we serve

Benefactors:
The donors whose gifts ensure the Charity can continue to enhance healthcare provision

Bendigedig:
The NHS staff across North Wales

Benevolent:
The volunteers who give their time to support the Charity

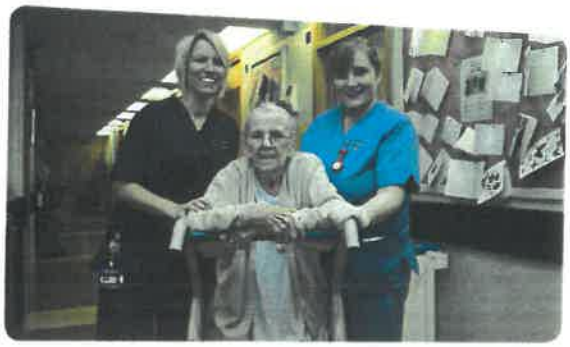
The 'Bens' lie at the heart of all Awyr Las' future plans.

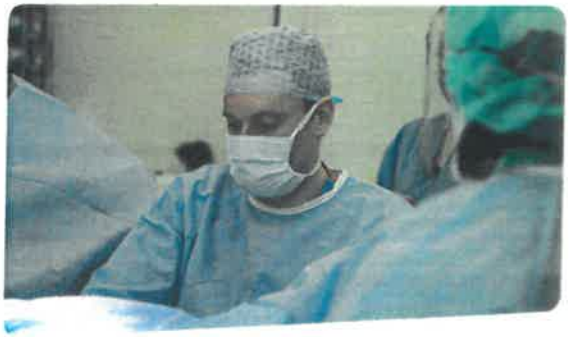
Principal Goals

The principal goals for the Charity are to help:

1. Create transformational change for the most vulnerable across the region

2. Support impactful change for patients and their families at a local level





Transformational Change

The Charity aims to prioritise programmes which help to improve the health and wellbeing of the most vulnerable across the region. Awyr Las provides support for all patients and service users but in order to help create transformational change, a greater emphasis is being placed on:

- Older people
- Children
- Mental Health services

Impactful Change

The Charity Support Team is working with operational staff, patients and their carers to identify local requirements (including new equipment and facilities; special project; research and education programmes) so that donations through the Charity will help support impactful change for patients and their families at a local level.

The Awyr Las Support Team is also focussing on achieving key operational goals, which are detailed in the Awyr Las Strategy for 2016-21, available to read in full at: awyrlas.org.uk/about-awyr-las.

Visibility

The Charity undertook a number of activities during the year to increase visibility and awareness of Awyr Las.

As part of this, the Awyr Las mascot, Nel Del, was used extensively throughought 2018/19 to engage with NHS staff, corporate supporters and the wider community.

Reserves Policy

Reserves that are part of a Charity's unrestricted funds which are freely available to spend on any of the Charity's purposes.

The reserves policy explains why a charity is holding a particular amount of reserves and should take into account the Charity's financial circumstances and other relevant factors.

To establish the Charity's target level of reserves, a number of factors were considered:

- Anticipated levels of income and expenditure for the current and future years.
- Anticipated levels of expenditure for the current and future years.
- Future needs and opportunities, commitments and risks.

This includes looking at future plans, projects or other spending needs that cannot be met from the income of a single year's budget.

Taking these into account, here is the Charity's reserves policy for 2018/19.

The reserves policy has the objective of ensuring that the Charity has sufficient funds available to maintain liquidity, cover unforeseen risks and provide for future opportunities.

The Charity relies heavily on income from donations, fundraising and legacies. These are unpredictable sources that can vary year to year. Therefore the Charity needs sufficient reserves to be able to continue its activities in the event of fluctuations in its income.

The Charity has a target level of reserves of £3,060,000.

This is based on the following calculation, with average figures taken from the last three years' of audited accounts:

- One year's administration costs (support costs, fundraising costs and investment management costs).
- 25% of the value of investments held.
- 25% of the grant funded activity expenditure.
- The target level of reserves will be reassessed on an annual basis.

The Trustee will review the actual reserves held against the target throughout the year, to ensure that sufficient funds are held within the charity, whilst also continuing to utilise funds within a reasonable period of receipt.

Wider Networks

Awyr Las is one of over 250 NHS linked charities in England and Wales who are eligible to join the Association of NHS Charities, now known as NHS Charities Together.

NHS CHARITIES TOGETHER

As a member charity of NHS Charities Together, Awyr Las has the opportunity to discuss matters of common concern and exchange information and experiences, join together to lobby government departments and others, and to participate in conferences and seminars which offer support and education for Charity Support Team staff.

Related parties

Members of the Health Board (and other senior staff) take decisions both on the Charity and Health Board matters but endeavor to keep the interests of each discrete. The Charity provides the majority of its grants to the Betsi Cadwaladr University Health Board.

Relationship with the wider community

The support given through Awyr Las and other charities that directly support North Wales' hospitals and community health care services has a huge impact on patients and also on staff. The Awyr Las Support Team and volunteers continue to forge strong relationships with NHS members of staff and local organisations and businesses that play a vital role in the success of the Charity.

The Awyr Las Support Team oversees Awyr Las' grant programmes and provides support and advice for the charity's many supporters. In addition, support is given to independent local charities that fund equipment and special services, such as 'Leagues of Friends' and the 'Maelor Voluntary Service'.

In 2018/19, 19 of these independent charities collectively gifted £1,246,160 to benefit BCUHB health services.

The donations given to BCUHB services from these organisations are not included in the Awyr Las accounts. Nevertheless, we thought it was important that these important charities be recognised in this report for their invaluable contribution to BCUHB's services and to their local communities.

As Vice President of Attend, the National Association that supports Leagues of Friends, I feel privileged to have met many members of these local groups over the years and I have been amazed to see the impressive work their volunteers do. They are magnificent citizens with considerable ability and hearts of gold.

On behalf of BCUHB, I would like to offer sincere thanks for all that these wonderful charities do.

With grateful thanks

RT HON LORD BARRY JONES P.C.
HONORARY PRESIDENT OF AWYR LAS & VICE PRESIDENT OF ATTEND

Accounts

BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY & OTHER RELATED CHARITIES

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2019

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

Statutory Background

The Betsi Cadwaladr University Local Health Board is the corporate trustee of the Charity under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990.

The Trustees have been appointed under s11 of the NHS and Community Care Act 1990.

Awyr Las, the working name of the Betsi Cadwaladr University Health Board Charity and other related Charities, is a registered charity and is constituted under a trust deed dated 23rd September 2010. Within the Charity group registration there are two subsidiary charities:

- Betsi Cadwaladr University Health Board Charity; and
- The North Wales Cancer Appeal.

Main Purpose of the Funds Held on Trust

The main purpose of the Charity is to apply income for any charitable purposes relating to the National Health Service wholly or mainly for the services provided by the Betsi Cadwaladr University Local Health Board.

Statement of Financial Activities for the year ended 31 March 2019

	Note	Unrestricted funds £000	Restricted income funds £000	Total Funds 2018-19 £000
Incoming resources from generated funds:				
Donations and legacies	3	911	733	1,644
Other trading activities	5	247	59	306
Investments	6	43	30	73
Total incoming resources		1,201	822	2,023
Expenditure on:				
Raising Funds	7	196	122	318
Charitable activities	8	1,124	714	1,838
Total expenditure		1,320	836	2,156
Net gains / (losses) on investments	15	229	145	374
Net income / (expenditure)		110	131	241
Transfer between funds	20	(21)	21	0
Net movement in funds		89	152	241
Reconciliation of Funds				
Total Funds brought forward	21	4,315	3,282	7,597
Total Funds carried forward		4,404	3,434	7,838

Accounts

Statement of Financial Activities for the year ended 31 March 2018

	Unrestricted funds £000	Restricted Income funds £000	Total Funds 2017-18 £000
Incoming resources from generated funds:			
Donations and legacies	1,137	876	2,013
Other trading activities	347	56	403
Investments	41	26	67
Total incoming resources	1,525	958	2,483
Expenditure on:			
Raising Funds	309	29	338
Charitable activities	1,391	1,371	2,762
Total expenditure	1,700	1,400	3,100
Net gains / (losses) on investments	83	37	120
Net income / (expenditure)	(92)	(405)	(497)
Transfer between funds	(103)	103	0
Net movement in funds	(195)	(302)	(497)
Reconciliation of Funds			
Total Funds brought forward	4,510	3,584	8,094
Total Funds carried forward	4,315	3,282	7,597

Balance Sheet as at 31 March 2019

	Note	Unrestricted funds £000	Restricted Income funds £000	Total 31 March 2019 £000	Total 31 March 2018 £000
Fixed assets:					
Tangible assets	14	135	0	135	135
Investments	15	4,415	3,547	7,962	7,572
Total fixed assets		4,550	3,547	8,097	7,707
Current assets:					
Debtors	16	198	154	352	841
Cash and cash equivalents	17	511	399	910	876
Total current assets		709	553	1,262	1,717
Liabilities:					
Creditors: Amounts falling due within one year	18	(628)	(645)	(1,473)	(1,799)
Net current assets / (liabilities)		(119)	(92)	(211)	(82)
Total assets less current liabilities		4,431	3,455	7,886	7,625
Creditors: Amounts falling due after more than one year	18	(27)	(21)	(48)	(28)
Total net assets / (liabilities)		4,404	3,434	7,838	7,597
The funds of the charity:					
Restricted income funds	21		3,434	3,434	3,282
Unrestricted income funds	21	4,404		4,404	4,315
Total funds		4,404	3,434	7,838	7,597

The notes on pages 48 to 65 form part of these accounts.

Signed: .....

Name: MS. SACKIE HUGHES ..... **(Chair of Trustees)**

Date: 4th October 2019

Statement of Cash Flows for the year ending 31 March 2019

	Note	Total Funds 2018-19 £000	Total Funds 2017-18 £000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	19	**(23)**	**391**
Cash flows from investing activities:			
Dividend, interest and rents from investments	6	73	67
Proceeds from the sale of investments	15	1,429	1,248
Purchase of investments	15	(1,408)	(1,182)
(Increase) / decrease in cash awaiting investment	15	(37)	(78)
Net cash provided by (used in) investing activities		**57**	**55**
Change in cash and cash equivalents in the reporting period		**34**	**446**
Cash and cash equivalents at the beginning of the reporting period	17	876	430
Cash and cash equivalents at the end of the reporting period	17	**910**	**876**

Note on The Accounts

1. Accounting Policies

(a) Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the Charity are a fall in income from donations or investment income but the Trustees have arrangements in place to mitigate those risks (see the risk management and reserves sections of the annual report for more information).

The Charity meets the definition of a public benefit entity under FRS 102.

(b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- A restricted fund or
- An endowment fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. The Charity's restricted funds tend to result from appeals or legacies for specified purposes.

(b) Funds structure (continued)

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. These funds are subanalysed between those where the Trustees have the discretion to spend the capital (expendable endowment) and those where there is no discretion to expend the capital (permanent endowment). The Charity has no permanent or expendable endowment funds.

Those funds which are neither endowment nor restricted income funds, are unrestricted income funds which are subanalysed between designated (earmarked) funds where the Trustees have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the Trustees' discretion, including the general fund which represents the Charity's reserves. The major funds held in each of these categories are disclosed in note 21.

(c) Incoming resources

Income consists of donations, legacies, income from charitable activities and investment income.

Donations are accounted for when received by the Charity. All other income is recognised once the Charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year and deferred and shown on the balance sheet as deferred income.

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable, whichever falls sooner.

Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the Charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

(e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(f) Recognition of expenditure and associated liabilities as a result of grants

Grants payable are payments made to linked, related party or third party NHS bodies and non NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are sick.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant
- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant
- There is an established pattern of practice which indicates to the recipient that we will honour our commitment.

The Trustees have control over the amount and timing of grant payments and consequently where approval has been given by the Trustees and any of the above criteria have been met then a liability is recognised.

Grants are not usually awarded with conditions attached. However, when they are those conditions have to be met before the liability is recognised.

Where an intention has not been communicated, then no expenditure is recognised but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met then no liability is recognised but a contingent liability is disclosed.

(g) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include staff costs, costs of administration, internal and external audit costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 11.

(h) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the Charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the Charity's objects. The costs of generating funds represent fundraising costs together with investment management fees. Fundraising costs include expenses for fundraising activities and a fee paid to a related party, the Health Board, under a fundraising agreement. The fee is used to pay the salaries and overhead costs of the Health Boards' fundraising office.

(i) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 8.

(j) Tangible assets

Tangible fixed assets are stated at cost less accumulated depreciation and accumulated impairment losses. Cost includes the original purchase price (or value of the asset on a full replacement cost basis if donated), costs directly attributable to bringing the asset to its working condition for its intended use, dismantling and restoration costs. Tangible fixed assets are capitalised if they are capable of being used for more than one year and have a cost equal to or greater than £5,000.

Land is stated at open market value. Valuations are carried out professionally at five-yearly intervals. No depreciation is applied to land.

Tangible fixed assets are derecognised on disposal or when no future economic benefits are expected. On disposal, the difference between the net disposal proceeds and the carrying amount is recognised in the Statement of Financial Activities (SoFA).

(k) Investments

Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair value (market value) at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year.

The main form of financial risk faced by the Charity is that of volatility in equity markets and other investment markets due to wider economic conditions, the attitude of investors to investment risk and changes in sentiment concerning equities and within particular sectors. Further information on the Charity's investments can be found in note 15.

(l) Debtors

Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

(m) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in notice interest bearing savings accounts.

(n) Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long term creditors.

(o) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later). Unrealised gains and losses are calculated as the difference between the closing and opening carrying values, adjusted for purchases and sales.

2. Related party transactions

During the year none of the Trustee's Representatives or members of the key management staff or their close relatives have undertaken any material transactions with the Betsi Cadwaladr University Health Board Charitable Funds.

Board Members (and other senior staff) take decisions both on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public.

The Charity has made grant payments for revenue and capital to the Betsi Cadwaladr University Health Board. Such payments are for specific items which are in furtherance of the Charity's objectives. The Betsi Cadwaladr University Health Board prepares its accounts in accordance with the Government Financial Reporting Manual (FReM) and International Finanical Reporting Standards (IFRS), whereas the Charity prepares its accounts in accordance with FRS 102. The Charity therefore recognises a constructive obligation when it awards a grant, whereas the Health Board recognises it when the grant is received. This creates a timing issue as the Charity recognises expenditure before the Health Board does.

In its accounts and under FRS 102, the Charity recognises that it has made grant payments to the Betsi Cadwaladr University Health Board totalling £1.74 million (2017-18: £2.86 million). Under the FReM and IFRS, grant payments to the Betsi Cadwaladr University Health Board totalled £2.11 million (2017-18: £1.66 million). The audited accounts of the Betsi Cadwaladr University Health Board are included in their annual report and are available from their website.

Material transactions between the Charity and related parties disclosed during 2018-19 were as follows:	Expenditure with related party £000	Amounts owed to related party £000	Income from related party £000	Amounts owed by related party £000
Bangor University	70	62	0	0
Conwy County Borough Council	6	0	0	0
Arts Council of Wales	0	0	10	10
North Wales Police & Crime Commissioner	1	0	0	0

A number of the Health Board's members have declared interests in related parties as follows:

Name	Details	Interests
Mr G Doherty	Chief Executive	• Trustee of Dangerpoint, a charity which provides health and safety training to children across North Wales. This role is not remunerated. • Wife is employed by Health Education England.
Dr E Moore	Medical Director / Deputy Chief Executive	• Wife is the Clinical Director of Breast and Endocrine Surgery at the Royal Liverpool and Broadgreen University Teaching Hospital NHS Trust.
Mr A Thomas	Executive Director of Therapies and Health Sciences	• Panel member of the Health Care Professions Council. • Spouse is employed by Boots as an Accuracy Checking Technician.
Mr G Lang	Executive Director of Strategy (01/04/2018 - 13/05/2018)	• Governor of Coleg Cambria
Mr R Favager	Executive Director of Finance	• Daughter is on the NHS Wales Finance Graduate Scheme at the Health Board.
Dr J C Stockport	Executive Director Primary Care and Community Services (01/10/2018 - 31/03/2019)	• Occasional advice as a World Health Organisation expert consultant on integrated primary care. Basic expenses are reimbursed; no salary is taken.
Dr P Higson	Chair (01/04/2018 - 31/08/2018)	• Trustee of Cartrefi Cymru. • Self employed Clinical Psychologist.
Mr M Polin OBE QPM	Chair (01/09/2018 - 31/03/2019)	• Wife is employed by the Health Board.
Mrs M Hanson	Vice Chair (01/04/2018 - 31/05/2018)	• Husband is the Member of Parliament for Delyn.
Mrs M W Jones	Independent Member and Vice Chair	• Member of Snowdonia National Park Authority: April 2018 - July 2018. • Member of Pwyllgor Mind Cymru: April 2018 - July 2018. • Vice Chair of Arts Council Wales. • Chair of Council, Bangor University. • Trustee of Canolfan Gerdd William Mathias. • Trustee of Kyffin Williams Trust. • Sister and two nieces are employees of the Health Board.
Prof J Rycroft-Malone	Independent Member	• Programme Director - National Institute for Health NIHR HS&DR Research Programme. • Husband is employed by the Health Board.

(Table continued overleaf)

Accounts

Name	Details	Interests
Mr C Stradling	Independent Member (01/04/2018 - 05/03/2019)	• Deputy Chair of the Local Democracy and Boundary Commission for Wales. • Member of the Snowdonia National Park Authority.
Mrs B Russell Williams	Independent Member (01/04/2018 - 05/03/2019)	• Chief Executive Officer Mantell Gwynedd (Third sector umbrella body) • A number of family members are employed by the Health Board.
Mr J Cunliffe	Independent Member	• Director of Abernet Ltd. • Member of the Joint Audit Committee, North Wales Police & Crime Commissioner. • Spouse is employed by the Health Board.
Cllr C Carlisle	Independent Member	• Cabinet Member for Children, Families and Safeguarding for Conwy County Borough Council. • Deputy Leader of Conwy County Borough Council. • Member of Conwy & Denbighshire Joint Adoption Panel. • Lead Member for children on Conwy County Borough Council. • Group Leader of the Conservative Group of Conwy County Borough Council. • Deputy Chair (political) of the Clwyd West Conservatives. • Secretary of Old Colwyn local football club. • Committee member of Old Colwyn Residents Association. • Committee member of Tan Lan Community Centre.
Ms H Wilkinson	Independent Member (01/09/2018 - 31/03/2019)	• Chief Executive of Denbighshire Voluntary Services Council (NEWVOL).
Mrs L J Reid	Independent Member (01/09/2018 - 31/03/2019)	• Anakrisis Ltd (Management Consultancy) - provides consultancy and training to NHS organisations in England. • Tribunal Chair for the Medical Practitioners Tribunal Service of the General Medical Council. • Magistrate for the North Wales Family and Criminal Benches - HM Court and Tribunal Service. • Specialist advisor to the Care Quality Commission. • Spouse is a local GP practicing in Denbighshire.
Mr Ff Williams	Associate Board Member - Chair, Stakeholder Reference Group	• Chief Executive of Cartrefi Cymunedol Gwynedd, a housing association operating predominantly out of Gwynedd. In this role works closely with Health Board Area Directors. • Wife is employed by the Health Board. • Sister and Brother-in-Law work for Mental Health Services in Bangor (Childrens Services).

3. Income from donations and legacies

	Unrestricted funds £000	Restricted Income funds £000	Total 2018-19 £000	Total 2017-18 £000
Donations	911	58	969	1,170
Legacies	0	675	675	843
	911	733	1,644	2,013

4. Role of volunteers

Like all charities, the Betsi Cadwaladr University Health Board Charity is reliant on a team of volunteers for our smooth running. Our volunteers perform two roles:

• Fund Advisors – Within the Charity there are 379 designated funds which are identified to specific areas and/or services. Every fund has at least one Fund Advisor, who acts as the authorised signatory on the fund for purchases up to £5,000 and receives monthly statements as to the income and expenditure on the fund. Fund Advisors are responsible for ensuring that the expenditure they authorise from their funds is appropriate and fits in with the objects of the fund and the Charity. They are also responsible for ensuring that their designated fund is never in a deficit position.

• Fundraisers – A number of volunteers actively support the Charity by running in aid of events such as coffee mornings, sponsored walks and sports tournaments, as well as supporting events directly organised by the Charity.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

5. Other trading activities

Income from other trading activities arises from fundraising events that are organised by the Charity, or by volunteers in aid of the Charity. These include events such as coffee mornings, cake bakes, sporting challenges and sponsored walks.

6. Gross investment income

	Unrestricted funds £000	Restricted Income funds £000	Total 2018-19 £000	Total 2017-18 £000
Fixed asset equity and similar investments	42	30	72	67
Short term investments, deposits and cash on deposit	1	0	1	0
	43	**30**	**73**	**67**

7. Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted Income funds £000	Total 2018-19 £000	Total 2017-18 £000
Fundraising office	125	89	214	195
Fundraising events	35	6	41	85
Investment management	27	20	47	46
Support costs	9	7	16	12
	196	**122**	**318**	**338**

8. Analysis of expenditure on charitable activity

	Grant funded activity £000	Support costs £000	Total 2018-19 £000	Total 2017-18 £000
Grants for NHS Capital expenditure	159	33	**192**	1,143
Staff education and welfare	521	24	**545**	681
Patient education and welfare	962	33	**995**	919
Medical research	102	4	**106**	(12)
Other	0	0	**0**	31
	1,744	**94**	**1,838**	**2,762**

9. Analysis of grants

The Charity does not make grants to individuals. All grants are made to the Health Board to provide for the care of NHS patients in furtherance of our charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and the actual funds spent on each category of charitable activity, is disclosed in note 8.

The Trustees operate a scheme of delegation for the charitable funds, under which Fund Advisors manage the day to day disbursements on their projects, in accordance with the directions set out by the Trustees in the Charity Standing Financial Instructions. Funds managed under the scheme of delegation represent ongoing activities and it is not possible to segment these activities into discrete individual grant awards. The Trustees do make grant awards based on invited applications from the Health Board.

10. Movements in funding commitments

	Current liabilities £000	Non-current liabilities £000	Total 31 March 2019 £000	Total 31 March 2018 £000
Opening balance at 1 April (see note 18)	1,409	28	1,437	297
Movement in liabilities	(538)	20	(518)	1,140
Closing balance at 31 March (see note 18)	**871**	**48**	**919**	**1,437**

As described in notes 8 and 9, the Charity awards a number of grants in the year. Many grants are awarded and paid out in the same financial year. However, some grants, especially those relating to research and development or for funding specific posts are multi-year grants paid over a longer period.

11. Allocation of support costs

Governance costs are those support costs which relate to the strategic and day to day management of a charity.

Support and overhead costs are allocated between fundraising activities and charitable activities based on the proportion of expenditure incurred against them both during the year. These support and overhead costs are then further allocated to unrestricted and restricted funds based on the balance held in these funds.

	Raising funds £000	Charitable activities £000	Total 2018-19 £000	Total 2017-18 £000
Governance				
External audit	1	9	10	10
Finance and administration	7	41	48	47
Total governance	8	50	58	57
Finance and administration	7	41	48	49
Other costs	1	3	4	9
	16	**94**	**110**	**115**

11. Allocation of support costs (continued)

	Unrestricted funds £000	Restricted Income funds £000	Total Funds 2018-19 £000	Total Funds 2017-18 £000
Raising funds	9	7	16	12
Charitable activities	53	41	94	103
	62	48	110	115

12. Trustees' remuneration, benefits and expenses

The Charity does not make any payments for remuneration nor to reimburse expenses to the Charity Trustees for their work undertaken as Trustees.

13. Auditors remuneration

The auditors remuneration of £10,250 (2017-18: £10,250) related solely to the audit of the statutory annual report and accounts.

14. Tangible fixed assets

	Freehold land 2018-19 £000	Freehold land 2017-18 £000
Cost and valuation		
Balance brought forward	135	0
Additions	0	135
Disposals	0	0
Balance at 31st March	135	135
Depreciation and impairments		
Balance brought forward	0	0
Disposals	0	0
Impairment	0	0
Balance at 31st March	0	0
Net book value at 1st April	135	0
Net book value at 31st March	135	135

During 2017-18, a piece of land located in Porthmadog was donated to the Charity, for the benefit of the Madog Community & Hospital fund. The land was independently and professionally valued at open market value by the District Valuer in March 2018. There has been no impairment to the land in 2018-19. The Charity intends to dispose of the land on the open market.

15. Fixed asset investments

Movement in fixed assets investments

	Total 2018-19 £000	Total 2017-18 £000
Market value brought forward	7,572	7,440
Add: additions to investments at cost	1,408	1,182
Less disposals at carrying value	(1,414)	(1,208)
Increase / (decrease) in cash awaiting investment	22	38
Add net gain / (loss) on revaluation	374	120
Market value as at 31st March	7,962	7,572

15. Fixed asset investments (continued)

All investments are carried at their fair value.

All of the Charity's investments are held within a portfolio managed by Rothschild Wealth Management Limited. The key objective of the portfolio is to preserve and grow the investments' value in real terms, in order to continue to support charitable distributions over the long term. In order to meet this objective, the Trustees have agreed on a 'balanced' approach for the investment strategy. A 'balanced' portfolio is intended to achieve steady growth over the long term through a diversified approach to investment. Attention is paid to avoiding the worst of the downside and capturing some, but not all, of the upside of financial market returns. Capital preservation in real terms over a long time horizon is the primary objective, and some volatility is acceptable in order to achieve this.

In line with this investment strategy, at the 31st March 2019 the portfolio had a 69% allocation to return assets. Return assets are expected to drive long-term performance but are also likely to be volatile over shorter periods. In addition, the portfolio held a 31% allocation to diversifying assets. These assets are included to provide real diversification and protection in difficult market conditions. Overall, the portfolios remain relatively defensively positioned. This approach provides protection on the downside, but allows the addition of return assets opportunistically, taking advantage of attractive prices particularly during market turbulence.

The environment for investors remains challenging and fraught with risks. In managing our portfolios, Rothschild Wealth Management Limited assess these risks and the potential impact they will have on the portfolio on an on-going basis. They also adjust investments to make the most of opportunities and to protect against risks as they see them. Risks promote uncertainty and make markets unpredictable over short periods. A solid allocation to diversifying assets and portfolio protection has therefore been maintained, resulting in risk within the portfolio being considerably lower than the broader equity markets.

16. Analysis of current debtors

Debtors under 1 year	Total 31 March 2019 £000	Total 31 March 2018 £000
Accrued income	340	708
Prepayments	1	2
Other debtors	11	131
	352	**841**

17. Analysis of cash and cash equivalents

	Total 31 March 2019 £000	Total 31 March 2018 £000
Cash in hand	910	876
	910	876

No cash or cash equivalents or current asset investments were held in non-cash investments or outside of the UK.

18. Analysis of liabilities

	Total 31 March 2019 £000	Total 31 March 2018 £000
Creditors under 1 year		
Trade creditors	120	47
Creditors owed to BCU	401	215
Accruals for grants owed to NHS bodies	871	1,409
Other accruals	81	128
	1,473	1,799
Creditors over 1 year		
Accruals for grants owed to NHS bodies	48	28
	48	28
Total creditors	1,521	1,827

19. Reconciliation of net income / expenditure to net cash flow from operating activities

	Total 2018-19 £000	Total 2017-18 £000
Net income / (expenditure) (per Statement of Financial Activities)	241	(497)
Adjustment for:		
(Gains) / losses on investments	(374)	(120)
Dividends, interest and rents from investments	(73)	(67)
Donated fixed assets	0	(135)
(Increase) / decrease in debtors	489	(141)
Increase / (decrease) in creditors	(306)	1,351
Net cash provided by (used in) operating activities	(23)	391

20. Transfer between funds

There have been the following transfers between material designated funds:

- £11,067 was transferred from General Funds (unrestricted) to North Wales Cancer Appeal (restricted) to refund the costs of the Charity.

- £10,102 was transferred from General Funds (unrestricted) to various restricted funds to reimburse net overall charity costs, less income from interest and investment gain/ loss.

21. Analysis of funds

a. Analysis of restricted fund movements

	Balance 1 April 2018 £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2019 £000
General Fund, YG	455	77	(19)	0	21	534
North Wales Cancer Appeal	240	45	(21)	11	9	284
General Fund, YGC	247	33	(11)	0	11	280
Wrexham Medical Institute	273	2	(11)	0	10	274
BCU Legacies Fund	57	193	0	0	0	250
Cardiology Fund, YMW	138	87	(8)	0	7	224
General Fund, Llandudno	169	32	(7)	0	8	202
Leukaemia/Allied Blood Disease, YMW	166	2	(7)	0	6	167
General Fund, YMW	160	1	(7)	0	6	160
Pathology Leukaemia/Haematology, YG	115	1	(6)	0	4	114
Cardiology Department, YGC	176	1	(114)	0	5	68
Cancer Fund, YGC	155	120	(287)	0	12	0
Other Funds	931	228	(338)	10	46	877
	3,282	822	(836)	21	145	3,434

The objects of each of the restricted funds are to benefit the patients of the area, department or service stated in the funds' name, in accordance with the Charity's overall objectives. There is one fund listed above that is not aligned to a specific area:

•The BCU Legacies fund holds the accruals for legacies where probate has been granted, but we have not yet received the cash. This fund is used to protect the designated funds from fluctuations in the final legacy received. When the legacy is received it will be credited to the designated fund specified in the Will and the accrual will be reversed out from the BCU Legacies fund.

The Trustees have set an opening or closing balance of £100,000 or above as the threshold for the separate reporting of material designated funds. In the interests of accountability and transparency a complete breakdown of all such funds is available upon written request.

21. Analysis of funds (continued)

b. Analysis of unrestricted and material designated fund movements

	Balance 1 April 2018 £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2019 £000
Investment Gains	431	229	0	0	0	660
Cancer Fund, YGC	560	97	(42)	0	0	615
Alaw Ward, YG	248	158	0	0	0	406
Cancer Support Group, YMW	254	102	(53)	0	0	303
Staff Development Fund	205	0	(50)	0	0	155
Madog Community & Hospital	135	0	0	0	0	135
General Fund, Llandudno	130	0	0	0	0	130
General Fund, YG	130	0	0	0	0	130
Cardiology Department, YGC	102	12	0	0	0	114
Gynae Services - West	104	1	0	0	0	105
Palliative Care Fund, YMW	133	11	(40)	0	0	104
Diabetes & Endocrinology, Centre	101	2	(5)	0	0	98
Other Funds	1,782	589	(1,130)	(21)	229	1,449
	4,315	1,201	(1,320)	(21)	229	4,404

The objects of each of the unrestricted funds are to benefit the patients of the area, department or service stated in the funds' name, in accordance with the Charity's overall objectives. There is one fund listed above that is not aligned to a specific area:

• The Investment Gains fund holds the unallocated and unrealised gains and losses on the investment portfolio. This fund is used to protect the other designated funds from fluctuations in the investment values.

The General Funds include all donations for which a donor has not expressed any preference as to how the funds shall be spent. These funds are applied for any charitable purpose to the benefit of the patients of the Health Board, at the discretion of the Trustees.

The Trustees have set an opening or closing balance of £100,000 or above as the threshold for the separate reporting of material designated funds. In the interests of accountability and transparency a complete breakdown of all such funds is available upon written request.

22. Post balance sheet events

There is one post balance sheet event which has not been adjusted for in the accounts.

The accounting statements are required to reflect the conditions applying at the end of the financial year. No adjustments are therefore made for any changes in the market value of the investments between the 1st April 2019 and the date the accounting statements are approved. The market value of the investments held by the Charity as at the 31st March 2019 have increased by a material amount in the intervening period as follows:

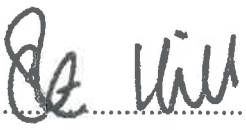
	31 March 2019 £000	20 September 2019 £000	Movement £000	Movement %
Investments	7,962	8,325	363	4.56%

Statement of the Trustee's Finance Representative's Responsibilities

As the Trustee's Finance Representative for the Charity, I am responsible for:

- the maintenance of financial records appropriate to the activities of the funds.
- the establishment and monitoring of a system of internal control.
- the establishment of arrangements for the prevention of fraud and corruption.
- the preparation of annual financial statements which give a true and fair view of the Charity and the results of its operations.

In fulfilment of these responsibilities I confirm that the financial statements set out on pages 29 to 45 attached have been compiled from and are in accordance with the financial records maintained by the Trustee and with applicable accounting standards and policies for the NHS.



Trustee's Finance Representative

4th October 2019

Accounts

Statement of the Trustee's Responsibilities in Respect of the Accounts

The Trustee's Representatives are required under the National Health Services Act 1997 to prepare accounts for each financial year. The Welsh Government, with the approval of HM Treasury, directs that these accounts give a true and fair view of the financial position of the Charity. In preparing those accounts, the Trustee's Representatives are required to:

- apply on a consistent basis accounting policies laid down by the First Minister for Wales with the approval of HM Treasury.

- make judgements and estimates which are reasonable and prudent.

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Trustee's Representatives confirm that they have complied with the above requirements in preparing the accounts.

The Trustee's Representatives are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Charity and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Government. They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

By order of the Trustees

.....

Trustee's Representative

4th October 2019

.....

Trustee's Finance Representative

4th October 2019

Audit report of the Auditor General to the Trustee of the Betsi Cadwaladr University Health Board Charity

Report on the audit of the financial statements

Opinion

I have audited the financial statements of Betsi Cadwaladr University Health Board Charity for the year ended 31 March 2019 under the Charities Act 2011. These comprise the Statement of Financial Activities, the Balance Sheet, the Statement of Cash Flows and the related notes, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 the Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of the charity as at 31 March 2019 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)). My responsibilities under those standards are further described in the auditors responsibilities for the audit of the financial statements section of my report. I am independent of the charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Audit report of the Auditor General to the Trustee of the Betsi Cadwaladr University Health Board Charity

Report on the audit of the financial statements (continued)

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the trustees use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the trustees have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the charitys ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Report on other requirements

Other information

The other information comprises the information included in the annual report other than the financial statements and my auditors report thereon. The trustees are responsible for the other information in the annual report and accounts. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Audit report of the Auditor General to the Trustee of the Betsi Cadwaladr University Health Board Charity

Matters on which I report by exception

I have nothing to report in respect of the following matters, which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustees report;
- sufficient accounting records have not been kept;
- the financial statements are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit.

Responsibilities

Responsibilities of the trustees for the financial statements

As explained more fully in the statement of trustees responsibilities, the trustees are responsible for preparing the financial statements in accordance with the Charities Act 2011, for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charitys ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Audit report of the Auditor General to the Trustee of the Betsi Cadwaladr University Health Board Charity

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditors report.

Adrian Crompton
Auditor General for Wales
9 October 2019

24 Cathedral Road
Cardiff
CF11 9LJ

SUPPORT AWYR LAS

Your North Wales NHS Charity

There are many ways in which you can help your local NHS Charity, either as an individual, a business, community group, school or other organisation:

- Support the ward that's close to your heart with a regular gift or a one-off donation
- Sponsor one of our priority projects and fundraise for a cause throughout the year
- Take part in a fundraising event, or organise your own
- Leave a gift in your will
- Share the Charity's work on social media and encourage others to do the same

Text AWYR LAS to 70500 to give £5 now

100% of your donation will go to the charity

For more information about how you can get involved and make a difference for patients across North Wales, please contact the Awyr Las Support Team.

01248 384 395

awyrlas@wales.nhs.uk

awyrlas.org.uk

/awyrlascharity

The address of the charity and the corporate trustee's principal office is:

Awyr Las
Ysbyty Gwynedd
Penrhosgarnedd
Bangor
LL57 2PW

Awyr Las: The North Wales NHS Charity
Registered Charity Number 1138976

Declarations of Interest relating to the BCULHB Charitable Funds

You will be aware that the Health Board is required to disclose details of related party transactions in the financial statements of both the Board and the Charitable Funds.

The Board has arrangements are in place to obtain details of member and senior officer declarations. However, neither the declaration of interest form nor the guidance make explicit reference to the Charitable Funds. Consequently, there is a risk that those making declarations do not consider the Charity.

In our report to the Trustees following our audit of the Charitable Funds 2016-17 accounts, we recommended that the declaration form and associated guidance should be amended to explicitly refer to the Charity. This recommendation was accepted in full by management, and it is therefore extremely disappointing that it has not been implemented by the Health Board when gathering declarations in either of the two subsequent financial years.

I am therefore writing you to separately on this specific matter, as we consider it essential that it is now addressed ahead of the preparation of the 2019-20 financial statements.

I should also be grateful if this letter, together with the Health Board's response to it, could be placed on the agenda of a future Audit Committee meeting.

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

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St Asaph Business Park
St Asaph
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[redacted]
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24 Cathedral Road
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Ein cyf / Our ref:
Eich cyf / Your ref:
☎: 01745 448788 ext 6464
Gofynnwch am / Ask for: Dawn Sharp
E-bost / Email: Dawn.Sharp@wales.nhs.uk
Dyddiad / Date: 4th December 2019

Dear [redacted]

Declarations of Interest relating to the BCUHB Charitable Funds

I refer to your letter of 9th October 2019.

I just wanted to formally confirm my correspondence with [redacted] via email on 25th October 2019 attached as Appendix 1.

[redacted] has confirmed that this addresses the recommendation in full and I can confirm that the BCUHB Systems Team have enacted the further change proposed in my email of 25th October as extracted below:-

> The Health Board has a duty to fulfil the highest standards of corporate governance. The Standards of Business Conduct Policy applies to all Board Members and staff and requires individuals to declare any outside interests that could conflict with, have the potential to conflict, or could be perceived to conflict with the interests of the Health Board. Board Members and all relevant staff (who are in a position to influence, direct/advise the trustees of the Awyr Las charity) should also ensure that they declare all relevant relationships for the charity Awyr Las.

I will ensure that this correspondence is reported to the Audit Committee as requested.

Yours sincerely

Dawn Sharp
Acting Board Secretary

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Appendix 1

From: [redacted]
Sent: 28 October 2019 10:32
To: [redacted]
Subject: RE: WAO letter re Funds Held on Trust

Hi Dawn

Thanks for the comprehensive reply. Yes happy that this addresses the recommendation in full.

Much appreciated
[redacted]

From: [redacted]
Sent: 25 October 2019 15:41
To: [redacted]>
Cc: [redacted]
Subject: WAO letter re Funds Held on Trust

EXTERNAL: This email originated from outside the WAO.

[redacted]

Following on from our earlier conversation I will of course respond formally to your letter however as agreed I thought it best to set out in an email where we are currently. As you know the original recommendation was to:

"Enhance the supporting guidance for completion of the DOI form to help ensure that Board Members and other relevant staff declare all relevant relationships for the Charity".

As this crossed over with the ISO 260 recommendation made on the HB accounts we issued further guidance to Members of the Board via direct email but also amended the guidance on the DOI site so that it picked up all other relevant staff and was visible to all. This was subsequently amended to pick up Internal Audit recommendations regarding posts below 8C that may be in a position to influence purchasing etc. as detailed below:-

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

Declaration of Interests and Gifts & Hospitality

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. Additionally posts within some departments at Band 7 to 8B which may be in a position to influence purchasing and foster relationships with external organisations are required to complete an annual declaration. Declarations are now to be made using the electronic system and can be made from any computer including an ipad, however you will need to know your Nadex number and you password in order to access the system from an ipad. If you require assistance please contact Dawn Sharp on 01745 586464 or via email: - Dawn.Sharp@wales.nhs.uk

In order to complete the electronic form you will need to also know you staff number which is on your payslip.

Please click here to access the electronic system

Declarations of interest – these should be completed at the start of the financial year, in as much detail as possible, particularly disclosing any positions on Committees or outside bodies that you might hold even if these are appointments in connection with another organisation.

It is important that you declare all relevant relationships. Your declarations should be as complete as possible.

It is the responsibility of individuals in terms of what is disclosed, but by way of example, listed below are what might be considered relevant areas for disclosure. If in doubt, it is better to make a disclosure:-

- Elected Member of a local authority (self or spouse) or any other political appointment
- Director of a Company
- Other Public Appointments
- Trustee of a Charitable organisation
- School Governor
- Appointment to outside bodies e.g. linked to Elected Member appointment
- Spouse's employment
- Any appointment to a Committee/Panel etc. particularly if appointed as a Chair
- Family Members also employed by the Health Board.

The Health Board has a duty to fulfil the highest standards of corporate governance. The Standards of Business Conduct Policy applies to all Board Members and staff and requires individuals to declare any outside interests that could conflict with, have the potential to conflict, or could be perceived to conflict with the interests of the Health Board.

In order for BCUHB to maintain the highest standards of integrity and reputation, it is essential that you declare any interest that you, or members of your family may have that could give the appearance of a conflict, even where no actual conflict exists.

Conflicts of interest are not restricted to just financial interest but include non-financial interests as well, for instance enhancement of an individual's position or professional reputation; access to privileged information or facilities.

Declarations of interest should be updated throughout the year as and when changes occur."

It was thought that this sufficiently addressed the recommendation in terms of it being a generic request for interests in all bodies (public or other). It was not until I had further correspondence with [redacted] and yourself in January/February 2019 following the report within the ISO 260 reported to Charitable Funds Committee on 13.12.18 that it was understood that the steps we had taken did not meet the intended requirements of your recommendation. As agreed with you I requested that the form be changed and this is what it currently shows:-

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Betsi Cadwaladr
University Health Board

Mandatory annual declarations of interests are required from Board members, all senior employees (band 8c and above), all Consultants and employees of any pay band who are in departments able to influence the purchasing of goods/services as well as fostering relationships with external organisations (as determined by a Director). Annual declarations must be submitted at the commencement of the financial year even if a nil return (nothing to declare).

For all other staff a declaration is to be submitted only when an interest or potential conflict arises.

The Health Board has a duty to fulfil the highest standards of corporate governance. The Standards of Business Conduct Policy applies to all Board Members and staff and requires individuals to declare any outside interests that could conflict with, have the potential to conflict, or could be perceived to conflict with the interests of the Health Board.

In order for BCUHB to maintain the highest standards of integrity and reputation, it is essential that you declare any interest that you, or members of your family may have that could give the appearance of a conflict, even where no actual conflict exists.

Conflicts of interest are not restricted to just financial interest but include non-financial interests as well, for instance enhancement of an individual's position or professional reputation; access to privileged information or facilities.

Declarations of interest should be updated throughout the year as and when changes occur.

The Standards of Business Conduct Policy (OBS02) should be referred to for further guidance.

I have since also strengthened the wording on the website as follows:-

The Health Board has a duty to fulfil the highest standards of corporate governance. The Standards of Business Conduct Policy applies to all Board Members and staff and requires individuals to declare any outside interests that could conflict with, have the potential to conflict, or could be perceived to conflict with the interests of the Health Board. Board Members and all relevant staff (who are in a position to influence, direct/advise the trustees of the Awyr Las charity) should also ensure that they declare all relevant relationships for the charity Awyr Las.

And with your agreement I shall ask [redacted] to further amend the paragraph within the form to align with the above.

I think the issue here is one of timing as at the point the Charitable Funds Committee received the further recommendation in the ISO 260 in December 2018 the majority of Board Members declarations for the last financial year would have been submitted. It was never the intention not to seek to address the recommendations from the audit in full.

Are you happy that this addresses the recommendation in full?

Kind regards

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

Dawn Sharp
Acting Board Secretary