Bundle Audit Committee 17 September 2020

1 10:00 - OPENING BUSINESS - OPEN SESSION

1.1 10:01 - AC20.64: Apologies for Absence

1.2 10:02 - AC20.65: Declarations of Interest

1.3 10:03 - AC20.66: Procedural Matters

1. To confirm the Minutes of the last meeting of the Committee held on 28/07/20 (Annex a) as a correct record; and
2. To review the Public Summary Action Log (Annex b)
3. To note the Standing Orders Amendments / Details of Breaches (Annex c)
4. To note the briefing paper in response to Action Log ref AC20/32.04: Summary of changes: standing down Health Emergency Control Centre (HECC) (Annex d)
5. To note Chair's Action in respect of the Digital Strategy deferment (Annex e)
6. To note Chair's Action in respect of final approval of the Annual Report and Accounts (Annex f)
7. To review and recommend to Board approval of the revised Finance & Performance Committee Terms of Reference (Annex g)
8. Tor review and recommend to Board approval of the revised Strategy, Partnerships & Population Health Committee Terms of Reference (Annex h)
9. To note that all operational Schemes of Reservation and Delegation (SORDs) are now agreed with the exception of Public Health and Workforce which are in the process of being progressed.

AC20.66a: Draft Minutes Approved by Chair - Audit Committee - Public Session - 28.07.20 - v0.2.docx

AC20.66b: Public Summary Action Log_Audit Committee_live.docx

AC20.66c Breach log extract_0420 to 0820.docx

AC20.66d: Briefing Paper for Audit Committee - standing down HECC.docx

AC20.66e: Chair's Action_Digital Strategy_July 20_V0.1.doc

AC20.66f: Audit_Chair's Action_Annual Report and Accounts_July 20_V.1.doc

AC20.66g: Finance and Performance Committee TOR v5.01.docx

AC20.66h: SPPH Committee TOR V5.02.doc

1.4 10:18 - AC20.67: Issues Discussed in Previous Private Committee Session

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

AC20.67 Private Session Items Reported in Public_Sep_2020.docx

1.5 10:19 - AC20.68: Chair's Assurance Report: Risk Management Group

The Audit Committee is asked to note the Risk Management Group (RMG) Chair's Assurance Report

AC20.68 RMG Meeting - Chair`s Assurance Report - v4 Final.docx

3.0 10:34 - AC20.69: Schedule of Financial Claims

The Committee is asked to note the report and give retrospective approval to the payment of the claims listed in the attached schedule.

AC20.69a: Schedule Financial Claims Report Cover Paper.docx

AC20.69b Schedule Financial Claims.xlsx

4.0 10:49 - AC20.70: Annual Review of Gifts & Hospitality and Declarations of Interest Register

The Audit Committee is asked to receive the Annual Declarations of Interests/Gifts and Hospitality for 2019/20 report.

AC20.70a Gifts Hosp DOI report_Sep_2020.1.docx

AC20.70b Appendix 1 - Board Member Declarations.docx

AC20.70c Appendix 2 Gift_DOI.docx

5.0 10:59 - AC20.71: Internal Audit Progress Report

The Audit Committee is asked to:

** Receive the progress report;*
** Identify alternative scope area for the Performance measure reporting to the Board – Accuracy of information review; and*
** Consider whether the All Wales Approved Clinicians and Section 12 (2) review is undertaken as part of the 2020/21 internal audit plan.*
** Receive and discuss the Limited Assurance reports.*

AC20.71a BCUHB Internal Audit Committee cover sheet September 2020.docx

AC20.71b: BCUHB Audit Committee progress report September 2020v1.docx

AC20.71c: Final Internal Audit Report Roster Management.pdf

AC20.71d: Final Internal Audit Report Decontamination.pdf

AC20.71e: Final Internal Audit report Salary overpayments.pdf

AC20.71f Final BCUHB 2020-21 Covid19 Governance Advisory Report.pdf

5.1 11:39 - AC20.72: Audit Wales Update Report

The Audit Committee is requested to:
• Receive the programme update
• Receive and discuss the reports on Counter Fraud services.

AC20.72a Coversheet - Audit Wales.docx

AC20.72b BCU audit_committee_update.pdf

AC20.72c National counter-fraud-report.pdf

AC20.72d_BCU_Counter_Fraud_Report.pdf

6.0 11:59 - AC20.73: Primary Care Dental Assurance Report

The Audit Committee is asked to note the contents of this paper and the actions implemented to provide assurance of the maintenance of an effective dental service during the Covid-19 pandemic and other processes to protect the public purse expenditure the management and commissioning of General Dental Services.

AC20.73 Board and Committee Dental Report 20200821 PG.docx

8.1 12:14 - AC20.74: End of Year Reporting - Committee Annual Reports

The Audit Committee is asked to receive the following annual reports:

** Remuneration & Terms of Service Committee*
** Stakeholder Reference Annual Report*
** Healthcare Professionals Forum*
** Finance & Performance Committee*
** Strategy, Partnership & Population Health Committee; and*

to note/approve that the Digital & Information Governance Committee, the Mental Health Act Committee / Power of Discharge Sub Committee and the Local Partnerships Forum Reports be approved via Chair's Action.

AC20.74a Committee Annual Reports_September 20_v0.1.docx

AC20.74b: R&TS Committee Annual Report 19 20 V1.0 Approved.docx

AC20.74c: SRG Annual Report 2019-20 v1.0.pdf

AC20.74d: Annual HPF Report 2019-2020 V1.0.pdf

AC20.74e FPC Committee Annual Report 2019-2020 v1.0.docx

AC20.74f SPPH Committee Annual Report 2019-2020 v1.0.docx

9.0 12:24 - AC20.75: Legislation Assurance Framework

The Audit Committee is asked to:

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

AC20.75 Legislation Assurance Framework_Sep_2020_.2.docx

10.0 12:34 - AC20.76: Issues of Significance for reporting to Board

10.1 12:35 - AC20.77: Date of Next Meeting: 17/12/20

10.2 12:36 - AC20.78: Exclusion of Press and Public

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

AUDIT COMMITTEE PUBLIC MEETING DRAFT
Minutes of the Meeting Held on 28.07.20
Via WebEx - the Health Board has determined that the public are excluded from attending the Committee's meeting in order to protect public health

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

In Attendance	
Neil Bradshaw	Assistant Director, Planning & Performance
Andrew Doughton	Performance Audit Lead, Audit Wales
Eric Gardiner	Finance Director, Provider Services
Dave Harries	Head of Internal Audit, NWSSP
Gill Harris	Deputy Chief Executive / Executive Director of Nursing & Midwifery
Sue Hill	Acting Executive Director of Finance
Huw Lloyd Jones	Audit Manager, Audit Wales
Nick Raynor	Audit Lead, Audit Wales
Dawn Sharp	Acting Board Secretary
Bethan Wassell	Statutory Compliance, Governance & Policy Manager
Mark Wilkinson	Executive Director, Planning & Performance

Agenda Item	**Action**
AC20/50: Opening Business and Apologies for Absence. The Chair welcomed members and attendees to the meeting. No apologies were received.	
AC20/51: Declarations of Interest. No declarations of interest were made at the meeting	
AC20/52: Procedural Matters. **RESOLVED:** That	

Agenda Item	Action
1. the Minutes of the last meeting of the Committee held on 29/06/20 be confirmed as a correct record 2. the Summary Action Log be received and further reviewed at the scheduled meeting in September.	
AC20/53: Issues Discussed in Previous Private Committee Session. **RESOLVED**: That the report on issues discussed in previous Private Committee be noted.	
AC20/54 Re-Setting Governance Arrangements. The Acting Board Secretary presented the report. Members noted that at the previous meeting, it had been agreed to bring back a paper confirming that the arrangements enacted during the pandemic had been stood down. Members also noted that business as usual had resumed for Board Committees in terms of their business cycles. The Acting Board Secretary concluded by drawing members attention to the Welsh Health Circular at Appendix Two and advised that the Health Board was required to make the necessary variations detailed to their Standing Orders and Reservation and Delegation of Powers by no later than the 30th of July. **RESOLVED:** That 1. the paper be noted; and 2. the re-set governance arrangements and associated Standing Orders changes be approved and Health Board Chair's action be sought to comply with the 30th July deadline as outlined above.	
AC20/55: Issues of Significance for Reporting to Board **RESOLVED:** That the Chair prepare his assurance report for the Board.	
AC20/56: Date of Next Meeting: 17/09/20	
AC20/57: Exclusion of Press and Public Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960".	

Audit Committee Summary Action Log: Public Committee

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Last updated 08.09.20				
Melanie Maxwell	**AC20/09.03:** Schedule of Financial Claims - Members noted that claims should be a fundamental driver in terms of Clinical Audit and would expect to see reference to this is the Clinical Audit Plan.	June	04/09/20 Update received from the Senior Associate Medical Director 04/09/20: This will be incorporated in the 2020/21 Plan. A column will be added to reflect this criteria.	close
Bethan Wassell	**AC20/13.02:** Legislation Assurance Report (LAF) - The Information and Consultation with Employees Regulations 1996 / 2004 to be reviewed with Associate Director of Health, Safety & Equalities. Requirements to be clarified and reported back to Committee	Sept	Meeting with Assistant Director of Health, Safety & Equality held 04/08/20. Legislation reviewed and reassigned to WOD (obligations further reaching than just H&S). Further details included in Legislation Assurance Framework Report included in September papers.	close
Sue Hill / Lawrence Osgood	**AC20/15.02:** Internal Audit - Agency Contract to be reviewed and revised to include agreement to random sampling of time sheets to promote agency self declarations of discrepancies.	June	All Wales Agency Nursing Services (AW4931) contract is due for renewal in February 2021. BCU has requested to NWSSP that any revisions to this contract include sample testing of timesheets.	close
Sue Hill	**AC20/32.03:** WAO/Interim Staffing Report – three recommendations identified and to be input into electronic system to enable live tracking/monitoring	Sept	Recommendations now live tracking in Teammate. Implementation date 31/10/20 (will be reported at December Committee)	close
Sue Hill	**AC20/32.04:** Paper required on summary of changes since the Health Emergency Control Centre (HECC) had been stood down	Sept	A briefing paper has been provided to the Committee summarising the changes resulting from standing down the HECC.	close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Justine Parry	**AC20/34.08:** Risk to be raised for delayed Risk Management implementation that dovetails with DIGG risks	Sept	Risk ID: 3548 / *Delay with Implementation of the Once for Wales Datix Programme may slow down system changes to Datix and its optimisation,* raised. Associate Director of Quality Assurance leading.	close
Matt Joyes	**AC20/35.01:** Schedule of Financial Claims. Recommendation wording to be revised to reflect this is a retrospective approval	Sept	Acting Associate Director of Quality Assurance confirmed 08/07/20 this would be made clear in all future reports.	close
Sue Hill / Gill Harris	**AC20/35.02:** Schedule of Financial Claims. Query whether Health Board is continuing to pay for services that it is no longer in receipt of	Sept	As agreed between the Welsh Government and NHS England, the Health Board is currently committed to block contracts with a number of our existing NHS providers; this means that we are paying for planned services even though the activity is significantly reduced due to the impact of Covid-19. A report was presented to F & P in August detailing the current position and an update will be provided at each F & P Committee meeting, while the contractual arrangement continues.	close
Gill Harris / Matt Joyes	**AC20/35.02:** Schedule of Financial Claims. Clarification on C17- 2852 required re whether joint liability (narrative suggests procedure was carried out at the Countess)	Sept	Update received form Acting Associate Director of Quality Assurance 08/07/20: The claim related to the care and treatment provided at YGC, not the earlier episode of care at Chester or later episode at Aintree, which were included in the description for context only and this should have been clearer in the report. In relation to the care and treatment at YGC, two expert clinical reports were critical of the care provided and on that basis Counsel's advice was to reach settlement for the YGC element of care.	close

Audit Committee

17.9.20

Record of Breaches of Publication of Committee Papers from 10.6.20 (since last reported to Audit Committee) not in accordance with Standing Orders

Meeting Date	Committee	Standing Order Requirement	Issue/Reason for Breach
15.6.20	Remuneration & Terms of Service Committee	Publication of papers 7 days before meeting	Whole Agenda - Complete set of papers published to ibabs as required but web publication did not happen until 8.10am the following day
25.6.20	Charitable Funds Committee	Publication of papers 7 days before meeting	Whole Agenda - Publication achieved on ibabs within required timescale but web publication not achieved until 10am following day
16.7.20	Finance and Performance Committee	Publication of papers 7 days before meeting	Revised paper uploaded to website following day (Q1 monitoring report)

Dawn Sharp

Acting Board Secretary

Briefing Paper for Audit Committee: AC20/32.04

Summary of changes: standing down Health Emergency Control Centre (HECC) June 2020

The Audit Committee received in July the paper, " Re-setting Governance Arrangements", which provided a detailed report on what had been re-established after the HECC was stood down in mid-June.

The following table highlights the key areas of change:

Action	**Covid -19 Responsibility**	**Currently Responsible**	**Debrief / Lessons Learned**
HECC stood down	Co-ordination of Health Board response	Executive Team	Workshop held 4/8; follow up workshop planned
Control Centres stood down	Regional / operational actions	Divisions	Feedback collated
Workstreams stood down	Functional actions	Division / Corporate teams	Feedback collated
Cabinet stood down	Board oversight of HECC	Health Board	
Test, Trace & Protect programme	Covid 19 cases and infection prevention	Director of Public Health	
Temporary Hospital management	Use of temporary facilities	Area Directors	Field Hospital review conducted by KPMG on behalf of WG: final report due to be published

The summarised "Lessons learned" were presented at the Executive Management Group in September and will be incorporated into the next version of the Health Board's Emergency plan.

Chair's Action on Urgent Matters

Health Board / Committee: Audit Committee

Title: Deferral of the Digital Strategy Review from the 2020/21 Internal Audit Plan to the 2021/22 Plan.

Introduction, Context and Justification for not submitting this matter to the full Board/Committee: Further to discussions between the Executive Medical Director, the Acting Board Secretary, the Chief Information Officer and Internal Audit, it is recommended that the Digital Strategy from the 2020/21 Internal Audit Plan is deferred. Chair's Action is required to ensure that the review is removed from the Internal Audit Plan prior to submission at September Audit Committee.

Issue for Consideration: Audit Committee Members will be aware that the Board previously accepted the benefit of a combined digitally enabled clinical strategy. The document presented to the Board in December was the last version presented prior to COVID-19. The assessment is that it would be more appropriate to undertake a review in the next financial year as progressing the review at this time would provide limited value. The Executive team agreed the deferral on 29/07/20.

Recommendation: The Audit Committee Chair is asked to approve the deferral of the Digital Strategy Review from the 2020/21 Internal Audit Plan to the 2021/22 Plan.

Name of individual being asked to agree the recommendation: Audit Committee Chair, Cllr Richard Medwyn Hughes.

Date when this Chair's Action will be reported to full Board/Committee: Audit Committee 17/09/20.

Independent Members Consulted:

1. Eifion Jones, 04/08/20

Comments: Deferral agreed.

2. Jacqueline Hughes, 04/08/20

Comments: Deferral agreed.

Recommendation Approved by:

Health Board / Committee Chair or Vice-Chair: Cllr Richard Medwyn Hughes, 04/08/20.

Chief Executive / Nominated Deputy: Simon Dean, 04/08/20
Board Secretary (*sign to confirm compliance with agreed process*): Dawn Sharp
Dated: 04/08/20

Chair's Action on Urgent Matters

Health Board / Committee: Audit Committee

Title: Final Approval of the Annual Report / Accounts

Introduction, Context and Justification for not submitting this matter to the full Board/Committee: Final approval of the Annual Report was delegated to Chair's Action at the Audit Committee on the 28/07/20. The Annual Accounts were received and approved at the Audit Committee on the 29/06/20.

Issue for Consideration: The submission of the Annual Report has been disrupted by the COVID-19 pandemic and has resulted in the final accounts being submitted (at Audit Committee 29/06/20) ahead of the Annual Report. Scrutiny of the Annual Report is as follows:

- Data used in the performance analysis section is validated by the Welsh Government
- Sustainability Report reviewed by Internal Audit
- Remuneration and staff report reviewed by Audit Wales

The following amendments were required prior to the final version of the Annual Report being submitted for approval via Audit Committee Chair's Action:

- Front cover / Contents page updating.
- Chairman's Introduction and the Chief Executive's Statement (current text from last year's report) to be drafted now the main body of the report is complete and can be read in its entirety.
- Web links to be reviewed/updated.
- Sign off dates / page references reviewed/updated.
- Well Being of Future Generations (WBFG) icons added to identify and evidence where the Health Board is specifically working to the WBFG principles.
- The Final Accounts and the Annual Governance Statement added to form one single file/document.

These amendments have now been actioned/completed.

Recommendation: The Audit Committee Chair is asked to approve the completed Annual Report and Accounts documents for submission to Welsh Government

Name of individual being asked to agree the recommendation: Audit Committee Chair, Cllr Richard Medwyn Hughes.

Date when this Chair's Action will be reported to full Board/Committee: Audit Committee 17/09/20.

Independent Members Consulted:

1. Lyn Meadows (approved 27/08/20)

Comments: None

2. Eifion Jones (approved 27/08/20)

Comments: None

Recommendation Approved by:

Health Board / Committee Chair or Vice-Chair: Cllr Richard Medwyn Hughes (approved 28/08/20).

Chief Executive / Nominated Deputy: Simon Dean (approved 28/08/20)
Board Secretary (*sign to confirm compliance with agreed process*): Dawn Sharp (approved 28/08/20).

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

FINANCE AND PERFORMANCE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as Finance and Performance Committee (F&P). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance and delivery. This includes the Board's Capital Programme and Workforce activity.

3. DELEGATED POWERS

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

3.1.1 Financial Management

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

3.1.2. Performance Management and accountability

- approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).
- ensure detailed scrutiny of the performance and resources dimensions of the ~~Integrated~~ Quality and Performance Report (~~IQPR~~QAP);

- monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets;
- review in year progress in implementing the financial and performance aspects of the Integrated Medium Term Plan (IMTP);
- review and monitor performance against external contracts
- receive assurance reports arising from Performance and Accountability Reviews of individual teams.
- Receive assurance reports in respect of the Shared Services Partnership.

3.1.3 Capital Expenditure and Working Capital

- approve and monitor progress of the Capital Programme.

3.1.4 Workforce

- Monitor performance against key workforce indicators as part of the ~~IQPR~~QAP;

- Monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans.

- Receive assurance reports in relation to workforce, to include job planning under Medical and Dental contracts for Consultants and Specialist and Associate Specialist (SAS) doctors and the application of rota management for junior doctors.

- To consider and determine any proposals from the Primary Care Panel (via the Executive Team) in relation to whether the Health Board should take on responsibility for certain GP Practices.

4. AUTHORITY

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

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

- other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

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

4.3 May consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business;

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

5. SUB-COMMITTEES

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

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board

6.2 In attendance

Executive Director of Finance (Lead Director)
Chief Executive
Executive Medical Director
Executive Director of Workforce and Organisational Development
Executive Director of Planning & Performance
Executive Director Nursing and Midwifery
~~Director of Turnaround~~

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

6.3 Member Appointments

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

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

the Board. Independent Members may be reappointed to the Committee up to a maximum period of 8 years.

6.4 Secretariat

Secretary – as determined by the Board Secretary.

6.5 Support to Committee Members

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

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

7. COMMITTEE MEETINGS

7.1 Quorum

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

7.2 Frequency of Meetings

7.2.1 Meetings shall be ~~routinely be held on a monthly basis.~~held at least 6 times per annum.

7.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

8.3.2 sharing of information

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

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

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

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

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

11. REVIEW

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

~~**Amendments recommended by Audit Committee 30.5.19**~~
~~**Ratified by Board 25.7.19**~~

~~**V5.0**~~
V5.01
Amendments agreed at Finance and Performance Committee 16.7.20
to be submitted to Audit Committee 17.9.20

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

STRATEGY, PARTNERSHIPS AND POPULATION HEALTH COMMITTEE

1 INTRODUCTION

1.1 The Board shall establish a committee to be known as the Strategy, Partnerships and Population Health Committee (SP&PH). The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2 PURPOSE

2.1 The purpose of the Committee is to provide advice and assurance to the Board with regard to the development of the Health Board's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales. The Committee will do this by ensuring that strategic collaboration and effective partnership arrangements are in place to improve population health and reduce health inequalities.

3 DELEGATED POWERS

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

3.1.1 ensure that current and emerging service strategies adhere to national policy and legislation , the priorities of the Health Board and are underpinned by robust population health needs assessment, workforce and financial plans and provide for sustainable futures;

3.1.2 receive regular assurance reports on health and care clusters and primary care development, recognising the central role played by primary care in the delivery of health and care.

3.1.3 advise and assure the Board in discharging its responsibilities with regard to the development of the Health Board's Medium and long term plans, together with the Annual Operating Plan;

3.1.4 ensure the Health Board's response to new and revised legislative requirements in relation to service planning and delivery, providing assurance that statutory duties will be appropriately discharged, ensuring strategic alignment between partnership plans developed with Local Authorities, Universities, third sector and other public sector organisations;

3.1.5 Receive regular performance and assurance reports from the Public Service Boards and Regional Partnership (Social Services and Partnership part 9 Board and Mental Health Partnership Board).

3.1.6 Ensure that the Health Board meets its duties in relation to Welsh language, civil contingencies legislation and emergency preparedness;

3.1.7 Ensure the alignment of supporting strategies such as Workforce, Capital Planning, Estates infrastructure and Information, Communications and Technology (ICT) in the development of the Strategic Plans;

3.1.8 Ensure that the partnership governance arrangements reflect the principles of good governance with the appropriate level of delegated authority and support to discharge their responsibilities; and monitor sources of assurances in respect of partnership matters ensuring these are sufficiently detailed to allow for specific evaluations of effectiveness.

3.1.9 Ensure appropriate arrangements for continuous engagement are in place; and review assurances on Consultation feedback.

4 AUTHORITY

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

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

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

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Strategy, Partnerships and Population Health matters.

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

5 SUB-COMMITTEES

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

6 MEMBERSHIP

6.1 Members

Four independent members of the Board

6.2 In attendance

Executive Director of Planning and Performance (Lead Director)
Executive Director of Public Health
Executive Director of Workforce and Organisational Development
Executive Director Primary and Community Services
Executive Medical Director
Finance Director – Strategy and Commissioning
Chair of Stakeholder Reference Group (by invitation)

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 up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

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

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1 Quorum

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

7.2 Frequency of Meetings

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

7.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

8.3.2 sharing of information

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

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

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

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

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

11. REVIEW

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

Draft 5.02 Agreed at SPPHC 13.8.20 for submission to Audit Committee 17.9.20 for approval

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 17/09/20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Summary of Business Considered in Private Session to be Reported in Public
Cyfarwyddwr Cyfrifol: Responsible Director:	Acting Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Acting Board Secretary
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the report.

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

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**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 the extraordinary private Committee meeting of: 28.07.20:

- BCUHB Annual Report and Annual Quality Statement progress update
- Auditor General's Report: Refurbishment of Ysbyty Glan Clwyd

Asesiad / Assessment & Analysis

Strategy Implications

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

Financial Implications

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

Risk Analysis

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

Legal and Compliance

Compliance with Standing Order 6.5.3

Impact Assessment

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

Audit Committee

17th September, 2020

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Chair's Report Assurance Report

Name of Group:	Risk Management Group (RMG)
Meeting dates:	22nd June 2020 27th July 2020
Name of Chair:	Gill Harris, Deputy Chief Executive Officer / Executive Director of Nursing and Midwifery Justine Parry, Assistant Director of Information Governance and Risk
Responsible Director:	Gill Harris, Deputy Chief Executive Officer / Executive Director of Nursing and Midwifery
Summary of business discussed:	This report summarises the activity of the Risk Management Group (RMG) and the Corporate Risk Management function in the lead up to the implementation of the new Risk Management principles on the 1st October 2020. Significant work is progressing across the Health Board, with the review, validation and realignment of all risks into the new Tier 3 format. Divisional meetings are continuing, with risk being a focal point. This is evident from the agendas and notes with support being provided from the Corporate Risk Team to ensure a consistent approach is being applied. A full review of all Tier 1 risks has been undertaken and proposals will be presented to each Executive Director and Committee Chair for review and approval. This will continue into the Board workshop planned for the 22nd September 2020 being facilitated by Amberwing, with arrangements currently being finalised. This report draws together significant updates from the last RMG meetings which were held on 22nd June and 27th July. It is worth noting that held on 27th July, 2020 wasn`t quorate and was chaired by the Assistant Director of Information Governance and Risk as both the Chair and Vice were busy attending another meeting. The corporate risk team has been aligned to Divisions in order to more effectively support them in navigating through the envisaged risk management changes as training, and effective communication are being used in calibrating our readiness and engagement. It is worth noting that the recent ratification of the new Risk Management Strategy by the Board and the ongoing implementation of the Health Board`s Annual Risk Management Improvement Plan are strong indicators of the Health Board`s commitment to improve and embed a positive management architecture and culture. 25% or 9 out of the 36 actions on the Annual Improvement Plan have been completed

	and are now green while the rest will be completed within the agreed timescales with scrutiny and oversight provided by the RMG as well as progress/assurance reported to relevant committees. At the RMG that held on 22nd June 2020, members noted that: • Most of the actions on the Action Tracker were out-of-date due to Covid-19 and however advised that these should be progressed by the next meeting planned for July 2020. • The Risk Management Procedural documents will now be updated following approval of the Risk Management Strategy and Policy at the last Audit Committee. • The RMG meeting will return to bi-monthly while all Divisions will be invited on a rotary basis to attend to present their extreme risks and explain the rationales for the extreme score and any wish for escalations. It is hoped that having Divisions present their extreme risks at the RMG will foster learning, engagement, accountability, improve the quality of risk entries and enable them to get their risks in the right shape for escalation. • The Terms of Reference and Cycle of Business will be updated to incorporate this important change to business. • Risk management workshops will be setup for senior managers, Operational leads and senior colleagues at the Service/Departmental and Divisional level in order ensure compliance with the revised Risk Management arrangements and to create a common understanding of risk management and what good risk management looks like. Four virtual workshops will be setup with an external facilitator while the corporate risk team will organise and deliver more workshops throughout the year. • Services, Departments and Divisions were advised to often consider the implication of Covid-19 on each of their risks each time they are reviewed and updated as risks will be different once we take Covid-19 into account. • Following some discussion, it was agreed that: - ▪ Risk IDs 2681 (Countess of Chester Hospital - Discontinued RTT for Patients in Wales) and 794 (Financial Stability - Health Board Financial achievement of the control total agreed with Welsh Government), should be closed with clear rationales articulated on Datix for doing so. ▪ Risk IDs 3438 (The Health Board is not financially sustainable in the medium to long term), and 3152 (Covid-19 Pandemic may exceed funding available for Welsh Government), should be urgently reviewed and escalation to the Board considered. • There hadn`t been any progress with regards to the All Wales Datix Project and concerns were raised around the lack of a national implementation plan which could shape and inform a local BCU implementation plan considering the fact that this

	is a huge project and until we have the National direction; we are unable to progress further. It was however noted that whilst work on some modules had made some progress, progress on the Risk management module was to commence very soon as it had been delayed by Covid-19. • System changes to Datix being requested by Services, Departments and Divisions will need to be submitted to the BCU All Wales Datix Implementation Group for review, approval and implementation so as to ensure consistency and a joined-up approach. • The Risk Management Action Module on Datix has now been activated and optimised for all Tier 1 risks. This important in enabling the identification of action owners/leads, action completion dates etc. Using the action module will also enable us to ensure that actions are SMART and whilst the focus for the moment is on capturing actions for Tier 1 risks, this will progressively be extended to include all risks on tiers 2 and 3. At the RMG that held on 27th July 2020, members noted that: • Decisions that are proposed will be made through Chair`s actions. Most of the actions on the tracker which were outstanding as per the last meeting have now been completed and turned green. • The Board will have two risk management workshops, the first on 20th August to be facilitated by the King`s Fund, will focus primarily on objective setting while the second planned for September will be facilitated by Amberwing and will concentrate on resetting our top level BAF and Corporate risks. The Board had previously asked all its Committees to review their respective Corporate risks in view of the impending resetting exercise outlined above. And in view of this, committees have paused the regular review of their risks on the Corporate Risk Register (CRR) for now albeit if there were any significant changes or new risks that needs to be escalated to the attention of the Committee and/or Board. • The refreshed Cycle of Business illustrating the reporting cycle/timescales for Divisions to the RMG was presented and members requested corrections of the names of some of the Divisions while Women`s and Maternity and Estates and Facilities were added as distinct Divisions. • There was some discussion around the need for the management and governance structures of the Health Board to align so as to facilitate timely, efficient and effective escalation of risks, issues and concerns. • Members scrutinised the CRR and noted that many of the items were dependent upon capital/revenue funding and it was recommended that clear guidance was needed regarding the budget setting process and in terms of prioritising capital/revenue that has been set for this year.

	• Health and Safety raised concerns around two risks (i.e. Fire Safety and Asbestos across some 27 buildings. After some discussions, members advised them to appropriately articulate and escalate these risks to the attention of the relevant committee and Board. • Regarding the ongoing piece of work around cleansing and sanitising risk registers, members agreed that this should be intensified and going forward Divisions will be expected to attend the RMG to present their extreme risks and take questions on why they have been scored high. • The following Divisions that were on the agenda presented their extreme risks: ▪ Area East ▪ North Wales Managed Clinical Services ▪ Wrexham Maelor Hospital • Wrexham Maelor Hospital presented their extreme risks and it was recommended that risk ID 3384 - (Delayed diagnosis due to delays to imaging in response to Covid-19), which sits with Radiology Secondary and applicable to all three sites should be taken off their risk register and transferred to North Wales Managed Clinical Services. While members noted that some fields on Datix are confusing, it was agreed that Datix should be updated to align with the current BCU structure. • Members after some discussions agreed that all Covid-19 risks should be regularly reviewed at the relevant local governance meetings and presented at the RMG for further scrutiny/review. Hence, Covid-19 Risk Register will continue to be an item on the RMG agenda. • Regarding the Once for Wales Risk Management Project, members were advised that the Redress; Claims; Mortality and Incident Modules of the new system would be launched on 1st April 2021 while the Risk Management Module will be launched much later. It was noted that the new Datix system will be managed on a national basis while training will be available to staff as the coding and options are likely to change. • The new Risk Management Strategy and Policy has now been uploaded on the intranet and the corporate risk team will where possible attend local Governance or Quality and Safety meetings to update staff on the imminent changes and address any concerns which they may raise. • It was noted that there were no issues of significance from the last Quality and Safety Group meeting.
Key assurances provided at these meetings:	• Progress with the Risk Management improvement plan including the implementation of the updated Risk Management Strategy and Policy were noted. • Divisional representation and reporting of extreme risks has commenced.

	• The design of a comprehensive training pack for staff has been completed and scrutinised by an external Risk Management specialist.
Key risks including mitigating actions and milestones	1. Compliance with the Risk Management Strategy and Policy. 2. Potential delay in timely implementing the Annual Risk Management Improvement Plan if there is a second devastating wave of Covid-19.
Special Measures Improvement Framework Theme/Expectation addressed	Area: Leadership and Improvement Capability
Issues to be referred to another Committee	None of note
Matters requiring escalation to the Board:	None of note
Well-being of Future Generations Act Sustainable Development Principle	The work of the Risk Management Group will help to underpin the delivery of the sustainable development principles by: • Fully embedding Enterprise Risk Management to proactively manage risk to the delivery of the Health Board's planning and risk assessment processes. • Working collaboratively across Wales to deliver solutions with partners to improve planning and system delivery.
Planned business for the next meeting:	Range of regular reports plus • Review of Corporate Risks • Review of Tier 2 Directorate and Divisional Risks • Update on Once for Wales Integrated Risk Management Project • 2020/21 Risk Management Improvement Plan. • Divisional Reporting on their extreme risks.
Date of next meeting:	24TH September 2020.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee – 17/09/2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Schedule of Closed Claims Over £50,000 - 2020/21 Quarter 1
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience Claims Managers
Craffu blaenorol: Prior Scrutiny:	Review by the Acting Associate Director of Quality Assurance /Assistant Director of Patient Safety and Experience and Executive Director of Nursing and Midwifery/Deputy CEO
Atodiadau Appendices:	Schedule of closed claims and financial value for quarter one of 2020/21 (over £50,000)

Argymhelliad / Recommendation:

The Committee is asked to note the report and give retrospective approval to the payment of the claims listed in the attached schedule.

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

Sefyllfa / Situation:

The attached report sets out total payment information for any claims against the Health Board with a spend of over £50,000 closed during Quarter 1 (April - June) of the 2020/21 financial year. This report formally summarises to the Audit Committee the authorities given by the Health Board's claims managers, directors responsible for claims management, Executive Team and Board.

This report is presented to the Audit Committee to support the discharge of its responsibility to ensure the provision of effective governance.

Cefndir / Background:

Claims Process (for assurance)

All Health Boards in Wales contribute to a liability fund and have a risk share agreement, known as the Welsh Risk Pool (WRP).

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

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

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

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

The Quality, Safety and Experience Committee receives a separate quarterly Patient Safety Report to provide assurance on the learning and improvement following claims. This report to the Audit Committee provides assurance on the correct authorisation of payments as shown on the attached schedule and to request retrospective approval by the Audit Committee for claims over £50,000.

Asesiad / Assessment & Analysis

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

Ref	Type	Area	Specialty	Incident Date	Opened date	Closed date	Description	Damages Authority Provided By	Damages Financial Payment Approval By	Costs Authority Provided By	Costs Financial Payment Approval By	Total (Payment summary)
C13-1170	Clinical Negligence	Central	General Medicine (Secondary)	6/24/2012	6/26/2013	5/27/2020	Failure to administer anti-epileptic medication Failure to have a care plan in place to take account of claimant's seizures.	Claims Manager	Executive Director of Nursing & Midwifery	Claims Manager	Executive Director of Nursing & Midwifery	£227,255.95
C14-1770	Clinical Negligence	Central	General Surgery (Secondary)	4/1/2009	12/11/2014	6/1/2020	In April 2009 patient attended for the removal of cyst/tumour from her abdomen. Advised it was non malignant. Patient developed back pain, weight loss and breathing difficulties. Patient diagnosed with cancer in her spine, liver, lung, bone and blood. Patient advised that x-rays in 2009 showed shadowing. Patient died in June 2013.	Executive Director of Finance	Executive Director of Nursing & Midwifery and Sue Hill, Executive Director of Finance	Claims Manager	Interim Assistant Director of Patient Safety and Experience	£382,617.57

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 17/09/20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Annual Declarations of Interests/Gifts and Hospitality for 2019/20
Cyfarwyddwr Cyfrifol: Responsible Director:	Dawn Sharp, Acting Board Secretary
Awdur yr Adroddiad Report Author:	Dawn Sharp, Acting Board Secretary
Craffu blaenorol: Prior Scrutiny:	Karl Woodward, Head of Counter Fraud in relation to a review of Gifts and Hospitality Declarations
Atodiadau Appendices:	Two

Argymhelliad / Recommendation:

That the Audit Committee receives the report.

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

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

Sefyllfa / Situation:

This annual update is provided in order to comply with Standing Orders 7.1-7.6

Cefndir / Background:

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

An electronic system was introduced in 2016 to record declarations of interest, gifts and hospitality and rolled out across the Health Board. The electronic forms contain the Internal Audit recommended counter-fraud statement. In the case of Board Members, submitted declarations of interest are required to be published and documented within the Annual Report in line with the commitment to openness and transparent governance. Board Members submitted declarations of interest for the 2019/20 period are documented in Appendix 1 and are included within the Annual Report due to be presented to the Annual meeting later this month. During meetings, Board Members are also obliged to declare any ad-hoc potential conflicts of interest as and when they arise, and this is recorded in the relevant Board/Committee minutes.

In terms of the wider organisation, staff at Band 8C and above (or equivalent pay where staff are not on A4C pay grades) are required to complete a declaration of interest form (even if this is a nil return) on an annual basis. In addition, and in line with recommendations from previous audits staff at Band 7 and above who are in positions to influence the purchasing of goods and services as well as fostering relationships with external organisations are required to submit declarations.

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

Asesiad / Assessment & Analysis

Strategy Implications

A copy of the electronic gifts and hospitality register for the period 1 April 2019 to 31 March 2020 is attached at Appendix 2. Declarations made with a value of £25 or below have not been included. All declarations have also been received by the Head of Counter Fraud. During the period there were two declarations of gifts made by the Executive Director of Public Health both to the value of £5 which were accepted from a staff member; and one declaration made by the Executive Director of Therapies and Health Sciences in respect of an invitation to an evening reception to the value of £25 which was declined.

Members will be aware that following the introduction of the electronic system there has been a continuous drive to increase the compliance figures for declarations of interest. Unfortunately the return rate figures for the last financial year were significantly down on the previous year reporting period (40% compared with 88% in the previous year). The impact of Covid may have had some impact on this coupled with vacancies and staff absences within the Office of the Board Secretary however it is envisaged that compliance figures should revert to their previous levels this year.

Adjustments to the electronic system are awaited to improve the process, particularly in terms of recording authorisations, the ability to distinguish between gifts which have been donated to Awyr Las and those gifts which have been received which were for example for use on wards but may have been logged in an individual's name. It is hoped that these upgrades to the system will be implemented by the Systems Team shortly however staff vacancies together with the advent of Covid have presented this so far.

Other Health Boards in Wales have expressed an interest in the BCU system and the Systems Team have confirmed that they have the necessary servers/infrastructure in place to support an all Wales rollout of the DOI system. The Systems Team were made aware earlier in the year that a module has been released in ESR to record DoI's and Gifts/Hospitality. The Team have looked at the module and the associated ESR report – but it does not compare to the level of information held within the BCU bespoke system or available reporting therefore it is intended to continue with the current database and to make this available to other Health Boards if they so wish.

Financial Implications

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

Risk Analysis

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

Legal and Compliance

Compliance with Standing Order 7.1-7.6

Impact Assessment

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

34. Other Information (continued)

As detailed in Note 30 Related Party Transaction, Board Members are required to make an annual Declaration of Interests, including nil returns where applicable. The following table provides details of all declarations of interest made during the 2019-20 financial year.

Name	Details of positions held during the financial year	Declaration	Details of interest declared
Directors/Executive Directors			
Mr G Doherty	Chief Executive	G	Spouse is employed by Health Education England.
Mr S Dean	Interim Chief Executive	G	Seconded civil servant employed by Welsh Government.
Mr A Thomas	Executive Director of Therapies and Health Sciences	G	Spouse is employed by Boots UK as an Accuracy Checking Technician.
Mrs L Singleton	Acting Associate Board Member Director of Mental Health and Learning Disabilities	A	Spouse is the owner of Gwynedd Forklifts and GFL Access.
Independent Board Members			
Mr M Polin OBE QPM	Chair	G	Spouse is employed by the Health Board.
Mrs M W Jones	Independent Member and Vice Chair	F, G	Chair of Council, Bangor University. Vice Chair of Arts Council Wales. Trustee of Kyffin Williams Trust. Trustee of Canolfan Gerdd William Mathias.
Mrs L Reid	Independent Member and Vice Chair (01.12.19 - 31.03.20)	C	Committee Chair for the Primary Care Appeals Service of NHS Resolution. Magistrate for the North Wales Criminal Bench Director of Anakrisis Ltd which provides specialist training and advisory services to NHS England, NHS Improvement and the Care Quality Commission
Cllr C Carlisle	Independent Member	F, G	County Councillor, Conwy Council. Deputy Chair, Clwyd West Conservatives. School Governor, Ysgol Bryn Elian. Member of the Conwy and Denbighshire Adoption Panel
Mr J Cuncliffe	Independent Member	F, G	Director of Abernet Ltd. Member of the Joint Audit Committee, North Wales Police and Crime Commissioner. Spouse is employed by the Health Board.
Prof N Callow	Independent Member (University Representative)	G	Dean of the College of Human Sciences at Bangor University
Mrs J F Hughes	Independent Member (Trades Union Representative)	G	Three children are employed, or volunteer, within the Health Board. Chair of the Welsh Council of the Society and College of Radiographers

Cllr R Medwyn Hughes	Independent Member (Local Authority Representative)	C, E, F	Director of Meditel Limited. Local Authority member, Gwynedd County Council. Member of the Care Scrutiny Committee and the Audit and Governance Committee. Bangor City Councillor. Chair of the Friends of the William Mathias Centre
Mr H E Jones	Independent Member	G	Member of Gwynedd Pension Board. Member of Gwynedd County Council Standards Committee. Justice of the Peace for North West Wales bench. Member of Adra (formerly Cartrefi Cymunedol Gwynedd). Member of Glas Cymru.
Mrs L Meadows	Independent Member	G	Trustee of Wirral Hospice St John's.
Mrs H Wilkinson	Independent Member	C	Chief Executive, Denbighshire Voluntary Services Council. Wales Committee Member of the National Lottery Community Fund.
Associate Board Members			
Mrs M Edwards	Associate Board Member - Director of Social Services	G	Corporate Director and Statutory Director of Social Services at Gwynedd Council. Lead Director for ADSS Cymru on the Welsh Language. Member of the Welsh Language Partnership Board. Chair of the Regional Integrated Commissioning Board. Member of the Regional Partnership Board.
Mr G Evans	Associate Board Member - Chair - Healthcare Professionals Forum	F, G	Member of the Welsh Therapy Advisory Committee (WTAC). Spouse is employed by the Health Board.
Mr Ff Williams	Associate Board Member - Chair - Stakeholder Reference Group	A, F	Chief Executive of Adra (formerly Cartrefi Cymunedol Gwynedd), a housing association based in Gwynedd but which operates across the whole of North Wales.

Appendix 2: BCUHB Electronic gifts and hospitality register for the period 1 April 2019 to 31 March 2020

Gift / Hosp ID	Gift Or Hospitality	Job Title	DonorType	OfferType	OfferDescription	Value	Employee Action	Submission Date
10392	Gift	Physiotherapist	An individual	Cash	£250.00 cash - donated by patient to put towards "something for the gym" (Rehab Unit Gym) To be deposited into Awyr Las - Rehab Account - WMH. 7B18	250	Accepted	15/04/2019 15:36
10395	Hospitality	Consultant Oncologist	A company	Accommodation Conference/meeting delegate place Travel Costs	To enable attendance at the American Society of Oncology Annual Meeting in Chicago USA June 2018	2700	Accepted	06/05/2019 18:45
10396	Gift	Occupational Therapist	An individual	Art or Ornament	Art painted by patient. Provided to physio to give to OT therefore OT was not around to decline offer.	80	Accepted	07/05/2019 16:15
10397	Hospitality	Lung Cancer Nurse Specialist	A company	Accommodation Conference/meeting delegate place Meal Travel Costs	To attend Lung Summit in London	350	Accepted	14/05/2019 13:50
10398	Hospitality	Head Of EBME	A company	Accommodation Meal	Visit to the manufacturing, decontamination and service facility in Halifax to observe the product development, testing, verification and quality assurance processes that the hospital beds are subjected to. Then view the decontamination and servicing facilities.	200	Accepted	15/05/2019 09:48
10399	Hospitality	Assistant Director Primary Care Contracting	An organisation	Meal	Networking Dinner for Optometrists and LHB Officers - representing HB and Exec Director of Primary Care	35	Accepted	17/05/2019 14:41
10400	Gift	Senior Finance Analyst, Management Accounts	An organisation	Food/drink	Invitation to a Gala Dinner - £30.00 Ticket price	30	Accepted	20/05/2019 15:25
10402	Hospitality	Chief Finance Officer	An organisation	Meal	Meal at the Gwynedd Business Week Gala Dinner on 23rd May 2019	30	Accepted	21/05/2019 15:09
10403	Hospitality	Consultant	A company	Accommodation Conference/meeting delegate place Travel Costs	Sponsorship to attend the British Academic Conference of Otolaryngologists, Manchester July 2018. Included travel costs, accommodation and sustenance.	500	Accepted	07/06/2019 11:46
10405	Hospitality	Medical Engineer	A company	Accommodation Meal	Factory visit to see how their hospital beds are manufactured & developed & their decontamination & servicing facility	200	Accepted	14/06/2019 08:57

Gift / Hosp ID	Gift Or Hospitality	Job Title	DonorType	OfferType	OfferDescription	Value	Employee Action	Submission Date
10406	Hospitality	Senior Pharmacist	A company	Conference/meeting delegate place	BPNG study day in Leeds 8th May 2019	160	Accepted	14/06/2019 12:12
10407	Hospitality	EBME Technician	A company	Accommodation Meal	Factory visit of the manufacturing, fabrication and development facility in Halifax where we also were shown the product development and testing processes along with the quality assurance processes. Also visited one of the decontamination and service centre's in Halifax where we were shown around the site and the procedures used.	200	Accepted	19/06/2019 09:25
10410	Hospitality	Clinical Fellow	A company	Conference/meeting delegate place	A one day conference	100	Accepted	01/07/2019 10:39
10411	Gift	Paediatric Oncology Specialist Nurse	An individual	Voucher	Various vouchers received from a fundraiser held for paediatric oncology services at central. 7 vouchers in all.	500	Accepted	03/07/2019 15:36
10413	Hospitality	Consultant	An organisation	Meal Tickets/entry to an event	Secretary for the study day - help organise and run the day. Delegate fee to attend is £55 and includes lunch on the day. Individual paid via cheque, but the treasurer has not cashed the cheque as I was advised the organising committee are exempt.	55	Accepted	10/07/2019 13:19
10414	Gift	Consultant Haematologist	An individual	Jewellery	Charm for Bracelet, given by patient. Discussed with Office of the Board Secretary and accepted on the basis that refusal would cause offence.	83.3	Accepted	10/07/2019 16:59
10415	Gift	Chest Physician	An individual	Food/drink	A bottle of wine - with a receipt enclosed, it was expensive, about 120 euros.	110	Accepted	24/07/2019 16:49
10416	Gift	Physiotherapy Team Leader And Clinical Specialist In Paediatric/learning Disabilities	An individual	Voucher	Amazon vouchers for purchasing of toys for children attending the Paediatric physiotherapy gait lab sessions.	265	Accepted	26/07/2019 16:14
10418	Hospitality	Clinical Fellow	An organisation	Conference/meeting delegate place	The conference was comprised of lectures, watching live procedures and practicing with simulators.	100	Accepted	23/08/2019 15:25
10419	Hospitality	Consultant	A company	Conference/meeting delegate place	Annual Ophthalmology congress run by the Royal College of Ophthalmologists	700	Accepted	04/09/2019 10:35
10420	Hospitality	Audiological Scientist	A company	Accommodation Meal Travel Costs	Travel, meal and 1 night hotel for attendance at free 1 day cochlear implant course 30th Sept 2019 at Addenbrookes, Cambridge. Course is focused on achieving efficiencies in cochlear implant pathway.	200	Accepted	05/09/2019 09:27

Gift / Hosp ID	Gift Or Hospitality	Job Title	DonorType	OfferType	OfferDescription	Value	Employee Action	Submission Date
10421	Hospitality	Principal Clinical Scientist	A company	Conference/meeting delegate place	Invitation to a meeting/workshop to discuss the direction of development of new technology for the benefit to NHS patients. Offer of travel, accommodation and meal costs to attend the 2 day meeting/workshop. Approval from line manager/leadership to attend.	500	Accepted	10/09/2019 19:02
10423	Hospitality	Stoma Nurse Practitioner	A company	Accommodation Conference/meeting delegate place Travel Costs	To attend ACSN conference (association of colorectal and stoma care nurses) for job development, networking and developing clinical practice.	809.12	Accepted	12/09/2019 16:23
10424	Hospitality	Blood Borne Virus Lead Pharmacist	A company	Accommodation Meal	Overnight accommodation, lunch, evening meal and breakfast. An unrestricted educational grant was provided to support the National Hepatitis C workshop in Cardiff which is held twice a year.	200	Accepted	23/09/2019 15:04
10425	Hospitality	Blood Borne Virus Lead Pharmacist	A company	Other	Free from Hepatitis C Educational material for use across the health board. : • Printed t-shirts (sizes will be medium, large and extra large) to be used by service providers to raise awareness of Hepatitis • A3 Educational posters • Patient information leaflets • Pull up banner • Credit card sized information material	800	Accepted	23/09/2019 15:19
10426	Hospitality	Blood Borne Virus Lead Pharmacist	A company	Accommodation Conference/meeting delegate place	Sponsorship to attend HIV Pharmacists Annual Meeting in Manchester 14th and 15th June 2019 - registration costs which included overnight stay in hotel and meals.	160	Declined	23/09/2019 16:32
10427	Hospitality	Consultant Psychiatrist	An organisation	Accommodation Conference/meeting delegate place Meal Travel Costs	Attendance at international conference on ADHD in Munich in November 2019	750	Accepted	03/10/2019 17:11
10428	Hospitality	Head Of Radioisotope Physics & Clinical Engineering	A company	Meal Travel Costs	Site visit as a member of BCUHB's evaluation team for the purchase of a replacement gamma camera	350	Accepted	07/10/2019 16:21
10429	Hospitality	Blood Borne Virus Lead Pharmacist	A company	Conference/meeting delegate place	Company supported meeting relating to HIV entitled 'Going the full 360' 20th June -21st June 2019 taking place in Berlin. The offer of attending the meeting was declined. Did not seek approval for accepting offer from Director as the offer was declined.	500	Declined	08/10/2019 10:46

Gift / Hosp ID	Gift Or Hospitality	Job Title	DonorType	OfferType	OfferDescription	Value	Employee Action	Submission Date
10430	Hospitality	Radiographer	A company	Meal Travel Costs	Train travel to London to view Intevo Bold Nuclear Medicine scanner at Kingston Hospital NHS Foundation Trust. Food was purchased for us at Euston station prior to returning home. This is part of the tendering process for a new scanner to be placed in Wrexham Maelor Hospital.	300	Accepted	09/10/2019 11:29
10431	Hospitality	Consultant Radiologist	A company	Meal Travel Costs Other	Hospitality for site visit for scanner evaluations as part of requirement for radiology procurement.	350	Accepted	14/10/2019 10:11
10432	Hospitality	Associate Specialist Medical Oncologist	A company	Accommodation Conference/meeting& training course delegate place Meal Travel Costs	Sponsorship to attend the ESMO (European Society of Medical Oncology) 2019 annual meeting	950	Accepted	21/10/2019 11:41
10433	Hospitality	Associate Specialist Medical Oncologist	A company	Accommodation Conference/meeting delegate place Meal Travel Costs	Sponsorship to attend the European International Kidney Cancer Symposium to include accommodation, travel and 2 meals. All transfers and other meal costs self-funded.	670	Accepted	21/10/2019 11:57
10434	Gift	Ward Manager	An individual	Jewellery	Costume rings in a box for all nursing staff on the Children's Unit that cared for patient (approx. 30) Also Popdolls for a few Dr's that also work on the Children's Unit (approx. 10)	300	Accepted	01/11/2019 14:11
10435	Hospitality	Head Of Fundraising : Awyr Las	An individual	Meal	Former patient contacted the Alaw Unit to tell them she wished to buy 100 staff members a Christmas dinner at Tresgawen Hall to show her appreciation of all they do. The Alaw Unit staff contacted myself, and, following advise from the Awyr Las accountant and BCUHB Board Secretary I contacted the individual to explain that the money must be given to Awyr Las and the dinner purchased through the charity, in line with process. Individual decided not to follow the BCUHB procedure and booked the restaurant themselves. Only cancer care staff in YG will attend.	2000	Accepted	05/11/2019 15:04
10437	Hospitality	Audiological Scientist	A company	Accommodation Conference/meeting delegate place Meal Travel Costs	Free 2-day clinical symposium - focus on ways of increasing service capacity for cochlear implants in response to introduction of NICE TA566 (2019). Acceptance of hospitality agreed with Director of Audiology.	250	Accepted	11/11/2019 10:59
10440	Gift	CHC Nurse Reviewer	An individual	Voucher	Received gift upon return from leave, envelope left on desk containing a gift voucher as a means of a thank you from a nursing member of staff in the nursing home. Declared it to head of nursing and discussed with Acting Board Secretary. The nurse involved would be highly offended by my refusing the gift and as such I am intending to share it with my colleagues during a staff meal out on the 11/12	30	Accepted	04/12/2019 12:37

Gift / Hosp ID	Gift Or Hospitality	Job Title	DonorType	OfferType	OfferDescription	Value	Employee Action	Submission Date
10441	Hospitality	Paediatric Pharmacist	A company	Accommodation Conference/meeting delegate place Meal Travel Costs	International Conference for Advancing Nutrition. Parenteral Nutrition in Neonates. 15/11/2019 at Goodenough College, London	235	Accepted	16/12/2019 11:11
10444	Gift	BCU Pharmacist	An organisation	Cash	Christmas Card was given to all employees. Same amount was given Emailed Acting Board Secretary	50	Accepted	23/12/2019 14:06
10445	Gift	Pharmacist	An organisation	Cash	All employees in the practice given a card with 50 pounds cash. Checked policy guidance with Acting Board Secretary	50	Accepted	23/12/2019 14:13
10446	Gift	Senior Nurse - Gpooh East	A company	Food/drink	M&S hamper totalling £40, contents of chocolates, shortbread, Christmas cake and Jaffa cakes. Gift was left in the office - was sent through the post and delivered by hospital porter team. Contacted Acting Board Secretary and advised the hamper shall be distributed out for the team	40	Accepted	23/12/2019 16:31
10449	Gift	Ward Manager	An individual	Stationery/pens	In-patient HMF purchased several staff, small presents for Christmas. These were mugs, stationary and books.	40	Accepted	24/12/2019 12:36
10451	Gift	Interim Ward Manager	An individual	Cash	£50 donation to the unit for Christmas and thanking for looking after patient	50	Accepted	02/01/2020 14:24
10453	Hospitality	North Wales Musculoskeletal Network Delivery Manager	An organisation	Conference/meeting delegate place	x2 guest places for myself and Clinical Lead for Orthopaedics to attend the next National Orthopaedic Alliance quarterly meeting in Birmingham as the guests of RJAH. Registered for two places (as there are limited spaces), with final attendance subject to approval from BCUHB. This would allow us to network and share best practice with leading Orthopaedic Centres in England and support the development of our own North Wales Orthopaedic Network. Please Note: approx. value of attendance unknown, so based on cost of x2 attendance of standard NHS events at £300	600	Accepted	07/01/2020 16:43
10454	Hospitality	Consultant	A company	Accommodation Travel Costs	Sponsorship for attendance at BACO conference, July 2018; initially £500 was funded but only £260 was required for transport and hotel. £240 was sent back to the company.	260	Accepted	08/01/2020 10:26
10457	Hospitality	Haematology Specialist Nurse	A company	Conference/meeting delegate place	Haemophilia Nursing Association conference in Birmingham April 2020. Tickets to the conference sponsored by SOBI UK. Asked by my manager to attend the event. SOBI UK purchase the tickets directly from the event organisers. At no point will I accept any direct payments / reimbursements from SOBI UK. Travel to event will be via BCUHB travel bureau request authorised by line manager.	250	Accepted	29/01/2020 12:28

Gift / Hosp ID	Gift Or Hospitality	Job Title	DonorType	OfferType	OfferDescription	Value	Employee Action	Submission Date
10461	Hospitality	Consultant Anaesthetist	A company	Accommodation Conference/meeting delegate place Travel Costs	meeting in Berlin 2-4 October 2019 Change pain masterclass - pain, patients and practice: is there a missing link?	600	Accepted	26/02/2020 11:45
10462	Hospitality	Haematology Specialist Nurse	A company	Accommodation Conference/meeting delegate place	Haemophilia conference including hotel room. Requested by line manager to attend. No expenses claimed by myself. Direct booking on conference which was free to NHS staff to attend. Company covered the cost of accommodation via direct payment to hotel.	159	Accepted	04/03/2020 13:07

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 17th September 2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Internal Audit Progress Report - 1st March to 31st August 2020**
Cyfarwyddwr Cyfrifol: Responsible Director:	Acting Board Secretary
Awdur yr Adroddiad Report Author:	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 1: Progress Report • Appendix 2: Roster management Limited Assurance Report • Appendix 3: Decontamination (19/20) Limited Assurance Report • Appendix 4: Salary overpayments (19/20) Limited Assurance Report • Appendix 5 : Advisory Review : Governance arrangements during Covid 19

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive the progress report;
- Identify alternative scope area for the Performance measure reporting to the Board – Accuracy of information review; and
- Consider whether the All Wales Approved Clinicians and Section 12 (2) review is undertaken as part of the 2020/21 internal audit plan.
- Consider the Advisory Review in respect of the Governance arrangements during Covid 19

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 four assurance reviews finalised since the last Committee meeting in March 2020, with the recorded assurance as follows:

- Substantial assurance (green) – one;
- Reasonable assurance (yellow) – three; and
- Limited assurance (amber) – three.

The report also details:

- Reviews issued at draft reporting stage as well as work in progress.

Asesiad / Assessment & Analysis

Strategy Implications

The Internal Audit plan for 2020/21 was approved by the Audit Committee in March 2020, with subsequent amendments at the June 2020 meeting.

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.

Internal Audit Progress Report

1st March 2020 to 31st August 2020

Audit Committee
2020/2021

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 2020/21 which have been finalised since the last Committee meeting, as well as those pertaining to the 2019/20 financial year. 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
Environmental sustainability Review completed July 2020 with Executive approval August 2020 *There remains a lack of any explicit detail concerning an overarching corporate environmental strategy.*	Substantial	-	1	-	The Health Board has followed the required reporting format as set out in both the NHS Wales Manual for Accounts 2019-20 and HM Treasury Guidance for reporting, in particular regarding the compilation of the data for inclusion in the performance tables. This reduces the likelihood of inconsistency between reporting years or individual subjectivity. 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 last year that the draft strategy would be completed by December 2019. The reported data was verified and accurate to relevant source information.
Budget setting – Ysbyty Wrexham Maelor Hospital (19/20) Review completed March 2020 with Executive approval July 2020	Reasonable	-	2	-	Budget Setting Our review sample comprised of fifteen cost centres with a total budgetary value of approximately £15.3m and represented 352.6 budgeted whole time equivalent (wte). We were able to fully reconcile the master working document to the opening budget statements and the closing Prophix pay budget by financial code file for each of the fifteen cost centres in our sample.

Title	Assurance Level	High	Medium	Low	Key Messages
The budget setting process is subject to continuous review and scrutiny by the senior finance team and whilst the budgets are subject to several revisions over the course of the budget setting period, final reconciliation documentation and appendices should be completed and retained.					Vacancy Costings The Budget Setting Methodology document set out the following conditions for costing vacant posts: • A4C vacancies will be costed at the bottom of scale increment. • Medical Consultant vacancies will be costed at top increment. • Other vacancy grades will be individually assessed but as a guide be costed at mid increment point. We sought a copy of the Prophix download detailing costings per individual or whole time equivalent. Unfortunately the required backing documentation had not been retained and was not available for review. As such we could not confirm that the above conditions had been met.
Welsh Risk Pool - Claims Management Standard (19/20) Review completed March 2020 with Executive approval June 2020 *We were able to reconcile all claims within our sample but noted that the overarching claims management Policy had still not been reviewed since June 2017.*	Reasonable	-	2	-	Between 1st April 2019 and 4th February 2020 forty-three claims totalling approximately £7.6m were submitted and approved by the Advisory Board and reimbursed by the Welsh Risk Pool. We reviewed the relevant documentation for the ten cases within our sample and found no issues of significance with regards to the administration of reimbursement documentation. We reviewed the finance documentation for all claims within our sample and verified a sample of invoices and finance request forms to the finance cost schedules. The following findings were noted: • Cost schedules, copy invoices, finance request forms and relevant backing documentation had been retained for all ten claim reimbursements reviewed. • We were able to verify and reconcile a sample of cost schedule costs to the retained invoices and backing documentation for each submission within our sample. • All clinical negligence claim payments were supported by an authorised finance request form.

Title	Assurance Level	High	Medium	Low	Key Messages
					We confirmed that all claims within our review sample had been recorded within LaSPaR. We were able to fully reconcile LaSPaR financial claim aggregates to relevant cost schedules and to the financial report obtained directly from Welsh Risk Pool Services. The Health Board Claims Management Policy (PTR02) was due for review in June 2017. We confirmed during last year's review that a newly revised policy document had been developed and was in the final stages of Health Board policy approval. However the revised policy has not been published as of February 2020 and the outdated policy remains on the Health Board policies webpage.
Managed General Practitioner Practices (19/20) Review completed April 2020 with Executive approval August 2020 *We were unable to ascertain that risks relating to managed practices were captured as part of the Area management process or that they were subject to regular performance management.*	Reasonable	-	2	-	The review was focused on the fourteen managed practices [at the time of our review] that were under the direct management of the Area Teams. We reviewed Health Board meeting papers including the Integrated Quality Performance Report (IQPR), January 2020 and found reporting measures and targets have not yet been included at this level.We were provided with Key Performance Indicators (KPI) reports from East and West Area. KPIs are reported monthly with updates to Area Management Board meetings via the Assurance and Sustainability Group. We were advised that KPIs in relation to Managed Practices are currently under review and development. Overarching procedures providing direction, legislative, statutory requirements and Health Board requirements and performance targets were not in place.
Roster management Review completed May 2020 with Executive approval August 2020 *We have been*	Limited	1	-	-	To undertake this review, we used the payment files for January 2020 sent to Accounts Payable to identify our sample for review. To identify whether the controls were operating as expected, we allowed up to four days from the date of the shift to date of shift lockdown and identified our sample, by highest value. Due to COVID-19 and restrictions placed upon

Title	Assurance Level	High	Medium	Low	Key Messages
unable to fulfil the scope of this review due to COVID-19 restrictions. We could not verify that all shifts the Health Board has paid for were undertaken within our sample.					essential travel and testing at the sample of wards/departments. Through the Temporary Staffing Department, we contacted all agencies within our sample requesting they share copies of the timesheets they held - seven agencies in our sample were contacted requesting a copy of the timesheets be sent. Whilst we were able to verify seventeen (56%) shifts as having been worked [cost £12,214.84 and 55% of our sample), three agencies did not provide timesheet evidence to corroborate thirteen (44%) shifts receiving payment from the Health Board.
Decontamination (19/20) Review completed April 2020 with Executive approval June 2020 *Working in partnership with the Decontamination Advisor we identified some gaps in the completion of the self-audit tool within a sample of departments visited. We could find no evidence at health economy meetings that the self-audit tool and associated findings are discussed.*	Limited	2	1	-	The objective of this review, working in partnership with the Health Board Decontamination Advisor, was to ensure the requirements set out in IPC17 Decontamination of Medical Devices Procedure (Version 3.0) were being complied with. <u>Self-audit tool findings and evidence of submission</u> Although it was apparent by way of evidence provided that compliance of the audit tool was in place, we were unable to evidence that documentation for the self-audit tool within two of the departments had been completed. Without these being completed it makes it difficult for the Decontamination Advisor to complete his annual audits. <u>Governance arrangements, matters of significance are reported through to Quality and Safety Group</u> We focused on governance reporting arrangements from the Health Economy Local Infection Prevention Groups to Infection Prevention Sub Group, identifying matters of significance are reported to the Quality and Safety Group. Having reviewed the evidence provided, we note that issues of significance (IOS) can be seen on agendas and within minutes. However, we found little evidence to support that IOS are being escalated from the Health Economy Local

Title	Assurance Level	High	Medium	Low	Key Messages
					Infection Prevention Groups to the Infection Prevention Sub Group. Additionally, we note that several meetings have been cancelled - at the time of writing this report, East Health Economy Local Infection Prevention Group had not met since November 2019. Reviewing the area Health Economy Local Infection Prevention Groups, we were unable to see any discussion on the decontamination audit tools. This would allow for an opportunity for the area groups to monitor the department's action tracker completed on the back of the audit tool as well as any issues which departments may have highlighted.
Salary overpayments (19/20) Review completed March 2020 with Executive approval August 2020 *There is a large volume of long outstanding debts, which have historic payment plans in place, many of which were agreed to be repaid over a number of years. The Salary Overpayments / Underpayments Procedure has not been subject to review, consultation and approval at an appropriate level.*	Limited	2	-	-	The Payroll department maintains a spreadsheet/register providing details of Overpayments for monitoring and analysis purposes. The Overpayments register is shared with Finance and Workforce. Overpayments have largely occurred due to manager errors; mainly late submissions of leavers or changes forms. We were advised that the Payroll Manager has raised concerns with the Health Board Finance and Workforce & Organisational Development Senior Management (October 2019), highlighting that since July 2019 the value of Overpayments has been increasing. The new operational procedure *F14 Salary Overpayments / Underpayments* has been approved by the then Director of Finance - Operational Finance [Interim appointment who has now left the Health Board] and was subject to review and update by the Local Counter Fraud Services team. We were advised that the procedure became operational in July 2019, however during the course of the review it was evident that the procedure has not been subject to review, consultation and approval at an appropriate level.

Work in Progress Summary

4. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
NHS Wales staff survey – delivering the findings	Draft report issued for management review. We received a management response and agreed the final report with the Executive Director on the 1st June 2020 and issued the report on the 10th June 2020. We were asked to revisit the report on the 12th June 2020 and received additional information on the 26th June 2020 and re-issued a revised final report on the 6th July 2020 for approval.	27th February 2020
Recruitment: Medical and Dental Staff	Discussion draft report issued. We received a management response and a further update response on the 25th June 2020, updating the report and re-issuing for approval on the 29th June 2020.	4th March 2020
Joint follow-up with Conwy County Borough Council Internal Audit Service: Conwy Community Mental Health Team (CMHT)	The Health Board specific follow-up review was issued on the 5th December 2019 and we met with management on the 12th and 17th December 2019 to agree the report. We met with Conwy Internal Audit Services to discuss both reports on the 6th February 2020; the findings have been consolidated into one report. The Acting Director and Head of Internal Audit were scheduled to meet Conwy's Strategic Director of Social Care and Education and Internal Audit on the 23rd March 2020 to progress the combined draft report however this was cancelled due to COVID-19.	5th December 2019
Quality Impact Assessment	Draft report has been sent. We agreed an extension and received comments on the 11th June 2020 and re-issued on the 16th June 2020. We followed up a response and met on 29th June 2020 and re visited the report and issued on 30th June 2020. We followed up for a response on the 10th July 2020 requesting narrative. The Executive Director of Finance also followed this up on the 31st July 2020 requesting provision of management response.	19th March 2020
Cyber security	Draft report issued, and management response received 7th August 2020 (extension agreed due to COVID-19). This is now with the Chief Information Officer for final approval.	16th April 2020
North Denbighshire Community Hospital	Draft issued to Assistant Director of Planning & Performance. The issue of this report and the other Capital reports has been	25th March 2020

Review	Status	Date draft report issued
	subsequently the subject of correspondence between the Board Secretary and the Assistant Director of Planning and Performance (2nd June 2020, 9th July 2020). We were advised that this would result in a formal response by 31st July 2020, but to date nothing has been received.	
Substance Misuse Action funds	Draft report issued, note further actions as detailed above.	7th May 2020
YGC Redevelopment – Operation of the Pain/Gain Mechanism	Draft report issued, note further actions as detailed above	9th April 2020
YGC - Open Book Audit	Draft report issued, note further actions as detailed above	9th April 2020
Delivery of Savings Plans (20/21)	Draft report has been issued. We have been in regular dialogue with Finance Directorate colleagues and issued several updates on receipt of additional information: • Draft discussion report issued 29th May 2020 and was revised and re-issued 12th June 2020. • Further two revised discussion reports were issued 22nd and 23rd June 2020. • Formal draft issued 3rd July 2020. • Management response received 7th August 2020. • Revised final report issued on the 13th August 2020 incorporating inclusion of additional information.	29th May 2020
Governance Arrangements during the Covid-19 Pandemic (20/21)	Draft advisory report issued to Acting Director of Finance and Acting Board Secretary.	12th August 2020

Fieldwork

5. The following reviews are currently in progress:

- Health & Safety - The brief has been issued and we have been asked to delay the start of the review until October 2020.
- Security - The brief has been agreed and testing has commenced.
- Violence and Aggression – Obligatory responses to violence in healthcare – Draft brief has been discussed and sent for approval.
- Engaging of Interim Appointments - We have issued the draft brief and are meeting the Director of Finance early September 2020.
- Mental Health & Learning Disabilities Division - Governance arrangements – The review has commenced.

- Annual Quality Statement - The review is complete and a discussion meeting has been held to consider the findings, the report is due to be issued as a draft report imminently.
- HASCAS & Ockenden external reports: Recommendation progress and reporting - We have requested evidence to support the all recommendations that have been approved for closure (we have already reviewed four recommendations).
- IM&T Control and risk assessment - The brief has been agreed and review commenced.
- Disaster Recovery/Business Continuity Plan – Informatics - The brief has been agreed and the review commenced.
- Control of contractors – The draft brief has been issued to Operational Estates, Informatics and Medical Devices.
- Water management – We have issued the brief for discussion.
- Capital systems – We have issued the brief 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
No reviews in the period		

Delivering the Plan

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

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

10. The following review has been identified for deferment from the 2020/2021 original plan and has been agreed in principle with the Acting Board Secretary and Executive Team prior for Audit Committee approval:

    Digital Strategy

    The Board previously accepted the benefit of a combined digitally enabled clinical strategy. The document presented to the Board in December 2019 was the last version presented prior to COVID-19. Following discussion with the Executive Medical Director, the Acting Board Secretary, the Chief Information Officer, the assessment is

that it would be more appropriate to undertake a review in the next financial year as progressing the review at this time would provide limited value. The Executive team agreed the deferral on 29/07/20.

It is recommended that the Digital Strategy review is deferred to 2021/22 pending progress around implementing the digitally enabled clinical strategy.

11. In developing and having issued the audit brief to the Director of Performance for the *Performance measure reporting to the Board – Accuracy of information* we further discussed the scope of the review. In progressing this we were advised that the situation has moved on as RTT reporting has been formally stood down and is unlikely to be re-commenced as focus is now shifting towards risk stratified component waits rather than RTT nationally.

    As the Committee specifically requested this review and set the scope, it would appear that continuing with this scope would not add value for the Committee.

    Noting this and should the Committee agree, the Committee is requested to identify alternative areas of performance assurance it would prefer reviewing or whether there are any 'hot' areas emerging which the Committee are concerned with.

12. During our review into the governance arrangements within the Mental Health and Learning Disabilities Division, we were asked by the Head of Office [Office of the Medical Director] whether we would be able to include the *All Wales Approved Clinicians and Section 12 (2)* approval process noting this is a delegated function from Welsh Government to the Health Board, ensuring its National and Local reporting is operating in accordance with the Statutory Obligations and Safeguards for Mental Health – The Executive Medical Director is fully supportive of undertaking this review.

    Following discussion with the Acting Board Secretary, it is felt this review is better placed as a standalone review, recognising the all-Wales role it plays.

    The Committee is asked to consider whether this review is undertaken as part of the 2020/21 internal audit plan.

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 increased to 71% [1%] 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	Green	71%	80%	v>20%	10%<v <20%	v<10%

Indicator	Status	Actual	Target	Red	Amber	Green
[20 days per Internal Audit Charter and Service Level Agreement] with agreed extension by the Executive Lead at time of agreeing the audit brief						
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		
Risk Management	Q4		
Health and Safety	Q2	Draft brief has been issued.	
Security	Q2	Review has commenced.	
Violence and Aggression – Obligatory responses to violence in healthcare	Q3	Audit brief issued for approval.	
Engagement of interim appointments	Q2	Audit brief issued for Executive approval.	
Temporary Hospitals	Q2		
Decision making during COVID-19 – Advisory review	Q2	Draft report issued.	N/A
Mental Health & Learning Disabilities Division – Governance arrangements	Q2	Review in progress.	
Strategic planning, performance management and reporting			
Performance measure reporting to the Board – Accuracy of information	Q2	Draft brief issued.	
Improvement Groups	Q3		
Financial governance and management			
Delivery of savings against identified schemes	Q1	Draft report issued.	
Budgetary Control & Financial Reporting	Q2-3	Draft brief issued.	

Planned output	Outline timing	Status	Assurance
Financial Governance Cell - Consultancy	Q1-2	Final advisory paper on capital issued.	N/A
Quality and Safety			
Annual Quality Statement	Q2	Draft discussion report issued.	
HASCAS & Ockenden external reports – Recommendation progress and reporting	Q2-4	On-going review as and when evidence is received.	
Clinical Audit	Q4		
Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices	Q2		
Follow up of previous Healthcare Inspectorate Wales reports	Q2-4		
Information governance and security			
IM&T Control and risk assessment	Q2	Brief agreed and testing discussed with management.	
Information Governance Toolkit	Q2		
Disaster Recovery/Business Continuity Plan - Informatics	Q2-3	Review has commenced.	
Digital Strategy	Q3		Recommended for deferral by Committee.
Operational service and functional management			
Programme Management Office (PMO)	Q2-3		
Workforce management			
Roster Management	Q1	Final report issued.	Limited
Recruitment – Employment of locum doctors	Q2-3	Draft brief issued.	
Sickness management – Recording reason for the sickness episode	Q3		
Establishment control – Leaver management	Q2-3	Draft brief issued.	
On-Call arrangements	Q3		
Capital and estates management			
Environmental sustainability report	Q2	Final report issued.	Substantial
Control of Contractors	Q2-3	Draft brief issued.	
Statutory Compliance: Water Safety	Q2	Draft brief issued.	
Follow Up (capital and Estates)	Q1-4		

Planned output	Outline timing	Status	Assurance
Capital Systems	Q2	Draft brief issued.	
Integrated Audit and Assurance Plans: • North Denbighshire • Ablett Unit • Wrexham Maelor Hospital - Backlog maintenance requirements	Q1-4	The progression of the audit plans for these will be subject to Welsh Government approval of the projects. Noting the demands on the All Wales Capital Programme arising from the Covid 19 emergency, some slippage in the approval of these projects may be anticipated. Accordingly, we will continue to monitor progress and, as appropriate, revise/update the integrated audit plans to reflect any changes in the proposed deliver programmes.	
Compliance with the public sector internal audit standards – Contingency/assurance reviews			

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

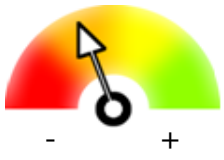
Roster Management

Final Internal Audit Report

BCU 2020/21

July 2020

NHS Wales Shared Services Partnership

Limited Assurance

Previous review rating N/A

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Review reference:	BCU-2021-36
Report status:	Final Internal Audit Report
Fieldwork commencement:	17th April 2020
Fieldwork completion:	30th April 2020
Discussion draft report issued:	1st May 2020
Draft report issued:	7th May 2020
Management response received:	30th June 2020
Final report issued:	10th July 2020
Auditor/s:	Head of Internal Audit Principal Auditor Deputy Head of Internal Audit
Executive sign off:	Director of Workforce & OD
Distribution:	Associate Director of Workforce Performance and Improvement Head of Resourcing E-Rostering Project Manager Temporary Staffing Manager Board Secretary Statutory Compliance, Governance and Policy Manager
Committee:	Audit Committee

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

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

1. Introduction and Background

The Health Board has published Policy *WP28a Rostering Policy* that outlines the roles and responsibilities for ensuring the accuracy of the roster prior to submission for payment. Specific responsibilities are detailed that focus on what to do with changes and finalising the roster, per the following extract:

15. Changes to Published Rosters

It will be the responsibility of the Department / Service / Ward Manager or designated deputy to amend rosters with shift and unavailability changes e.g. sickness, additional duties and any other changes to the roster on a daily basis

15.1 Post approval roster changes must be kept to a minimum to ensure the roster meets patient and service needs

15.2 Rosters must be updated in a timely manner on a daily basis in order to ensure they are an accurate and reliable record

15.3 Employees are responsible for negotiating their own changes once the roster is completed. These changes must be approved by the Department / Service / Ward Manager or designated deputy in his / her absence. Changes requested by the manager must also be discussed and agreed with the members of staff concerned.

15.4 All shift changes should take into account the band, skill mix, and competencies of the individuals.

15.5 Staff who has mentor responsibilities must ensure that adequate mentorship is provided for their student/s.

15.6 Rosters must be updated in an accurate and timely manner by the Department / Ward / Service Manager or deputy to enable the automatic generation of timesheets for payment.

19. Finalising the roster

It is important that rosters are finalised in order for data extractions for payroll to be completed without error. The Ward / department manager or designated manager is responsible for finalising the rota including for bank and agency workers by the 5th of the month (or the next working day). Failure to do so will potentially result in staff not receiving correct payments. Rotas should be finalised on a minimum of a weekly basis. This will enable time for staff to check their rota is recorded correctly for enhancement pay and to report any discrepancies to the manager.

On the 15th July 2019, the Health Board introduced self-billing for agency nurse payments whereby the payment is generated automatically once the agency shift has been finalised/locked down by the Ward/Department, thus enabling a payment feed to be generated from the system and submitted for payment. To ensure the shift can be locked/finalised, the Ward/Department Manager undertaking this must ensure a timesheet is retained to confirm the shift was worked.

Since the 15th July 2019 upto the 31st January 2020, the self-billing process has processed one hundred and forty one (141) payment files, sixteen thousand

nine hundred and eighty (16,980) invoices [agency timesheets], totalling £8,030,512.52[1].

2. Scope and Objectives

The scope of this review was limited to reviewing a sample of nurse agency payments and verifying supporting evidence to corroborate that the shift was undertaken.

The objective of this review was to ensure the Health Board was not paying for agency services it had not received due to a lack of internal control at ward level.

However, due to COVID-19 and restrictions placed upon essential travel and testing at the sample of wards/departments, through the Temporary Staffing Department, we contacted all agencies within our sample requesting they share copies of the timesheets they hold.

3. Associated Risks

The risks considered at the outset of this review were:

- Payments are made to agencies for shifts that were not worked;
- Internal controls are not complied with by the Ward/department manager or designated manager in approving shifts without the appropriate supporting timesheet; and
- Nurse establishment data is not accurately reported in accordance with the Nurse Staffing Levels (Wales) Act 2016.

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 Roster Management 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.

[1] Source: Report provided by the Accounts Payable Manager 3rd February 2020: 'Self bill batches 150719 to 310120'

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	Timesheets support the payment made		✓		

** 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 Roster Management.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as weakness in the operation of the designed system/control for Roster Management.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided to us at the start and during the review. We have relied solely on the documents, information and explanations provided, except where otherwise stated. We have not sought to or undertaken work to verify the accuracy of the information provided.

Timesheets support the payment made

To undertake this review, we used the payment files for January 2020 sent to Accounts Payable to identify our sample for review.

In obtaining our sample, we analysed the data and identified some high-level information.

Table 1 details the top ten wards/departments that paid agency shifts in January 2020 (by value).

Table 1 – Usage of nurse agency by total cost of shift for payments made in January 2020

Ward/Department	Number of shifts	Cost per the payment file (£)
(E) A & E	304	147,986.96
(C) A & E	207	122,356.64

Ward/Department	Number of shifts	Cost per the payment file (£)
(E) Erddig Respiratory	136	62,776.61
(E) Berwyn	106	52,997.90
(E) Fleming	101	47,935.13
(E) Acute Cardiac Unit	94	44,879.62
(E) Pantomime	84	40,866.45
(E) Bersham Stroke Unit	83	37,426.23
(E) Evington Ward	79	37,027.50
(E) G.P.OOH	53	32,377.10

Source: Payment files submitted to Accounts Payable in January 2020

In seeking agency staff, wards/departments must provide a reason for the additional resource. Table 2 provides details of the reason submitted and actual cost.

Table 2: Reason requested for agency nursing in January 2020 payment files

Request Reason	Number of shifts	Actual Cost (£)	Percentage (%)
Vacancies	1,702	830,682.72	65.5
Additional Service Demand	319	135,052.77	10.7
Sickness	217	92,157.32	7.3
Escalated beds	202	94,660.55	7.5
SafeCare	111	53,653.80	4.2
Enhanced Care Requirement	61	27,928.47	2.2
Other Staff Absence	49	24,577.28	1.9
Supernumerary Staff	14	7,775.14	0.6
SafeCare Redeployment	3	1,437.57	0.1
Total	2,678	1,267,925.62	100

Source: Payment files submitted to Accounts Payable in January 2020

To identify whether the controls were operating as expected, we allowed upto four days from the date of the shift to date of shift lockdown and identified our sample, by highest value.

The Temporary Staffing Department contacted the seven agencies in our sample on the 17th April 2020 requesting a copy of the timesheets be sent to us. Table 3 details our testing summary and findings. For all timesheets received, all timesheets matched the wards that locked-down the shift for payment.

Table 3 – Summary findings based upon timesheets returned from agencies

Agency	Shift timesheet(s) in the sample	Total Cost of shift(s) £	Summary of findings
Total Assist	2	1,431.92	Both timesheets noted a Band 6 however the Health Board engaged at Band 5; one timesheet did not record the actual break taken. Timesheet approver is different to that on the system.
Medical staffing	1	677.51	No timesheet was received from the agency.
Medacs	1	657.34	No band recorded on the timesheet; Timesheet approver is different to that on the system.
Med Staf Acute	11	8,362.24	No timesheets were received from the agency.
ID Medical	1	806.85	No timesheet was received from the agency.
Enferm	5	3,802.23	Two timesheets recorded a 30 minute break for a 19:45 to 08:15 shift, with the system deducting an hour. Timesheet approver is different to that on the system.
Bluestones	9	6,323.35	No band was recorded on any timesheet with one also not recording the break. Timesheet approver is different to that on the system.
Total	30	22,061.44	

Source: Timesheets provided by the four agencies that responded to the Health Board request

Whilst we were able to verify seventeen (56%) shifts having been worked [cost £12,214.84 and 55% of our sample), three agencies did not provide timesheet evidence to corroborate receiving payment from the Health Board.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - ISS.1 – Timsheet supporting payments (Operating effectiveness)	Risk
We have not been able to fulfil the scope of this review due to COVID-19 restrictions. We have relied upon evidence provided by agencies and are grateful to four of the seven agencies who assisted us with this review. We have been unable to verify that all shifts the Health Board has paid for were undertaken.	Health Board is not compliant with operational procedure and Standing Financial Instructions
Recommendation	**Priority level**
A full internal audit review is undertaken of the system when circumstances allow for further verification facilitated by ward/department visits.	High
Management Response	**Responsible Officer/ Deadline**
It is acknowledged that this Audit could not effectively take place as due to the outbreak of COVID-19 there was limited capacity internally and with external agencies to provide enough data to produce a robust set of findings. In light of this, the initial review has resulted in limited assurance with a recommendation to undertake a fuller review. Management are in agreement that next steps are to re-schedule the review in a timely manner to ensure stakeholders involved will have capacity to input into the audit. In the meantime BCUHB bank team is continuing to work with divisional managers over the importance of them carefully checking shifts worked before locking down the roster to authorise for payment. In addition the all Wales Agency Nursing Services (AW4931) contract is due for renewal in February 2021.	Head of Internal Audit/Associate Director of Workforce Performance and Improvement To be confirmed once COVID-19 limitations are eased. Associate Director of Workforce Performance and Improvement Actioned immediately.

BCU has requested to NWSSP that any revisions to this contract include sample testing of timesheets.	

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Decontamination

Internal Audit Report

BCU 2019/20

July 2020

NHS Wales Shared Services Partnership

Contents **Page**

Review reference:	BCU-1920-30
Report status:	Internal Audit Report
Fieldwork commencement:	13th February 2020
Fieldwork completion:	8th April 2020
Discussion draft report issued:	8th April 2020
Draft report issued:	10th June 2020
Management response received:	23rd June 2020
Final report issued:	23rd June 2020
Auditor/s:	Principal Auditor Head of Internal Audit
Executive sign off:	Executive Director Nursing and Midwifery
Distribution:	Decontamination Advisor Assistant Director Of Nursing - Infection Prevention 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

Decontamination is a term used to describe a range of processes, including cleaning, disinfection and/or sterilization, which remove or destroy contamination and thereby prevent infectious agents or other contaminants reaching a susceptible body site in sufficient quantities to cause infection or any other harmful response.

The Health Board has a legal obligation under the Health and Safety at Work Act (1974) and is also committed to continually improving the quality and safety of its services through ensuring every medical device will be adequately cleaned, disinfected or sterilized according to its function. This protects as far as reasonably practical the health, safety and welfare of its staff, patients and those recipients who are involved in inspection, service, repair or transportation of medical devices or equipment.

Compliance is required by all staff involved in decontamination which includes those directly involved in reprocessing equipment as well as those involved in procurement, management, storage and transportation.

The Health Board has published procedure IPC17 - Decontamination of Medical Devices Procedure (Version 3.0) which sets out key principles along with clear process on what to do, articulating roles and responsibilities within.

The Health Board receives a Welsh Government Decontamination Survey with associated action plan. The Health Board has established quarterly self-audit tool for all relevant areas to assess their own compliance, with an identified action plan to remedy any highlighted issues.

2. Scope and Objectives

The objective of this review was, working in partnership with the Health Board Decontamination Advisor, to ensure the requirements set out in IPC17 Decontamination of Medical Devices Procedure (Version 3.0) are being complied with.

The scope of this review was limited to:

- Reviewing the governance reporting arrangements from the Health Economy Local Infection Prevention Groups to Infection Prevention Sub Group and identify any matters of significance are reported to Quality and Safety Group.
- Reviewing receipt of the self-audit tool(s) to ensure all areas have submitted returns in accordance with the set timelines.
- Using the self-audit tool findings, we will identify a sample of areas to visit with the Decontamination Advisor and seek assurance of evidence at time of submission

3. Associated Risks

The associated risks identified at the outset of this review were:

- Breach of Health & Safety at Work Act (1974) COSHH Regulations

2002;

- Reputational risk through increased publicity of increased patient infection and any associated litigation; and
- Patient and staff safety is compromised through an inefficient process to destroy or remove contamination.

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 NHS Wales Staff Survey – Delivering the Findings 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	Self-audit tool findings and evidence of submission			✓	
2	Governance arrangements, matters of significance are reported through to Quality and Safety Group		✓		

** 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 Decontamination

Operation of System/Controls

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

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided to us by the Decontamination Advisor and the designated lead for the departments we visited - we would like to express our gratitude for their input and support during the review.

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

Background to audit tool

Following a decision at the Strategic Decontamination Group Meeting on the 16th April 2019, it was decided that the Decontamination Advisor would no longer be responsible for the co–ordination of audits. The responsibility for this process would now sit with the designated department leads/managers responsible for the decontamination processes within their units/departments.

It was agreed that the previous quarterly audit process would be changed to take place on a 6 monthly basis (audit deadline return dates 31st December and 30th June) as it was deemed by management to be more efficient. The first decontamination audit was due to be completed in December 2019.

To monitor this process the Decontamination Advisor undertakes an annual review of random units/departments carrying out the decontamination process. The current audit tool is being used for this processes with a random number of questions asked and evidence is provided.

Self-audit tool findings and evidence of submission

We identified Wrexham Maelor (Wrexham), Ysbyty Glan Clwyd (YGC), Ysbyty Gwynedd (YG) and Deeside Community Hospital to visit in partnership with the Decontamination Advisor. Using a sample of the self-audit tool questions, we sought evidence at to support their submission.

Although it was apparent by way of evidence provided that compliance of the audit tool was in place, we were unable to evidence that documentation for the self-audit tool within two of the departments had been completed. Without these being completed it makes it difficult for the Decontamination Advisor to complete his annual audits. The action tracker on the back of the audit tool will not be completed also, this allows the department to keep track of any issues which have been highlighted.

Another of the audit tools was also delayed in completion, we were advised this was due to confusion over the change from quarterly completion to every six months – we cannot corroborate this assertion.

Evidence of completed documentation for the traceability audit logs for Nasoendoscopes (a clinically invasive procedure) contained within the audit tool was provided, this enables the user to track the Nasoendoscopes through the whole process of decontamination.

In reviewing the audit tool it was noted that although questions on Control of Substances Hazardous to Health (COSHH) were asked concerning the storage of chemicals, no questions regarding the assessment of the chemicals were included as part of the audit tool. When staff were asked regarding assessments, safety data sheets on the chemicals were produced but no assessments. The COSHH assessment process will identify all hazardous substances used within the departments and also assess the use of these substances safely.

Table 1 records our findings by department we visited detailing the questions reviewed and evidence provided. Questions are numbered differently owing to the departments requiring different questions to be asked due to the working variations within departments.

Table 1: Decontamination Audit Tool findings from onsite visits

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
Central Area			
Endoscopy YGC 17/02/2020	20/12/19	1.4 Are all of the training records for each month team member in date?	All records up to date, checked also by the decontamination advisor with their annual audit.
		1.7 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		1.12 Are weekly taking place on AER's	Yes documentation displayed no lapses within the last month.
		1.16 Has annual re-re validation taken place?	Yes documentation kept in Sister's office.
		2.1 Are there dedicated wash hand basins in the decontamination area?	Observed.
		2.6 If no physical segregation, is there a clear SOP in place to manage the flow path of a scope from the dirty to clean area.	Paper format available and kept on the desktop of computer.
		2.12 What date was the last ventilation check carried out?	Informed it was kept in the Sister's office but we did not corroborate this.
		2.19 Is there an SOP in place to control access to all personnel involved in any maintenance/breakdown/testing activities?	Permits to work provided as evidence for control of contractors.
		3.6 Are gloves aprons and face visors in use for decontamination,	Observed that all personal protective equipment was available.

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
Central Area			
		in accordance with standard precautions?	
		3.9 Are brushes used during manual cleaning process single use?	Observed single use brushes.
		3.17 Do all manual pre wash decontamination activities take place using the submersion method?	Yes water line marks within the sink to prevent areolation.
ENT YGC 17/02/2020	17/12/19	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		1.13 Are weekly final rinse water tests taking place for AER's?	Ward undertake a weekly test as well as a company tests.
		2.2 Are there hand hygiene posters on display?	Yes observed.
		2.9 Are there twin sinks used for the manual cleaning stage?	Yes observed.
		2.12 If there is a drying cabinet in use is there an in date testing / maintenance / annual revalidation contract in place with the company.	Yes the documentation was supplied, testing and maintenance undertaken December 2019.
		3.6 Are gloves aprons and face visors in use for decontamination, in accordance with standard precautions?	All water tests recorded and kept in estates. Any issues estates contact the department.
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes, paper format available on the wards.
		3.9 If an electronic dosing system is in place, has it been validated and calibrated?	N/A electronic dosing system removed.
Deeside Community 17/02/2020	23/12/19	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.7 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed. From the information available within the documentation we completed a traceability audit log to establish that the information was complete.
		1.8 Is the Infection Prevention and Team actively involved providing advice and guidance on decontamination practises?	Information and contact details available on the self-audit tool.
		2.1 Are there dedicated wash hand basins in the decontamination area?	Yes observed.

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
Central Area			
		2.9 Is there a dedicated cupboard / room for the storage of equipment for the cleaning Environment?	Yes colour coded.
		2.12 Are all detergents/chemicals stored and disposed of in compliance with COSHH regulations?	Yes dedicated storage cupboard, however COSHH assessments require updating. Safety data sheets also require a review.
		3.3 Are all SOP's in place in the format agreed with the Decontamination Advisor?	Yes folder of evidence produced.
		3.9 Are all cloths used in any part of the decontamination process single use, non-linting and disposable	Yes standard across the health board where the Decontamination Advisor undertakes the self-audit tool.
		3.10 Does the leak test take place on the scope in accordance with the manufacturer's instructions?	Yes written into the safe operating procedure (page1, point 14).

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
East Area			
Endoscopy Wrexham 3/3/20	Contacted but no evidence provided	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.3 Are all of the training records for each team member in date?	All records up to date, checked also by the decontamination advisor with their annual audit.
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		1.7 Is the Infection Prevention and Team actively involved providing advice and guidance on decontamination practices?	Staff asked and replied that they were in regular contact with the Infection Prevention Team.
		2.4 Is the decontamination unit clear of clutter?	Yes observed.
		2.6 Does physical segregation exist between clean and dirty areas/processes?	Yes staff ran through the process.
		2.14 Has an assessment been carried out in relation to fumes/smells (COSHH requirements)?	Yes undertaken annually, company contacts both department and Decontamination advisor.
		2.15 Is there a dedicated cupboard /room for storage	Yes kept in domestics cupboard

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
East Area			
		equipment for the cleaning environment?	
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes all stages kept within one document currently out of date. Review date 17/07/19
		3.6 Are gloves aprons and face visors in use for decontamination, in accordance with standard precautions?	Yes observed
Outpatients Wrexham 3/3/20	23/12/19	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.3 Are all of the training records for each team member in date?	Yes, currently one member of staff required to be trained. Records of training are kept upstairs within theatres.
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		2.1 Are there dedicated wash hand basins in the decontamination area?	Yes observed.
		2.10 If drying cabinets are in use are the located in a 'clean' area.	Yes, clean area
		2.12 If there is a drying cabinet in use is there an in date testing/maintenance/annual revalidation contract in place with the company?	Yes in place examined on a quarterly basis by company. Company informs department and Decontamination Advisor when examinations are due.
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes stages kept within one folder. Needs to be finalised into one document.
		3.5 Is an SOP in place for the transportation of endoscopes? (describe in comments box or attach copy of SOP to audit return)	Yes stages kept within one folder. Needs to be finalised into one document.
		3.6 Are gloves aprons and face visors in use for decontamination, in accordance with standard precautions?	Yes observed.
Theatres Wrexham 3/3/20	Contacted but no evidence provided	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.3 Are all of the training records for each team member in date?	All records in place, evidence observed showing that the training is about to be updated with latest training. Checked also by the decontamination advisor with their annual audit.

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
East Area			
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		1.9 Does all testing and validation take place in accordance with WHTM 01-06?	Contracted out quarterly.
		2.2 Are there hand hygiene posters on display?	Yes observed.
		2.6 Does physical segregation exist between clean and dirty areas/processes?	Yes observed.
		2.11 If there is a drying cabinet in use is there an SOP in place for its control and use?	Yes observed.
		2.23 Are final rinse water tests recorded?	Yes observed.
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes two separate SOPs for dirty and clean area.
		3.6 Are gloves aprons and face visors in use for decontamination, in accordance with standard precautions?	Yes observed.
		3.12 Do all manual pre wash decontamination activities take place using the submersion method?	Observed activity in process when testing.
Other evidence of good practice provided at the time of the testing by theatres • Eqolab dosing system • Calibration Certificates • New traceability log book • Learning scenarios for staff • Purchase of COSHH cabinet and spillage kit			

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
West Area			
OPD YG 13/3/20	26/02/20 (Informed that the undertaking of the audit delayed due to the switch over from the quarterly audits.)	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Staff nurse.
		1.3 Are all of the training records for each team member in date?	All records up to date, checked also by the decontamination advisor with their annual audit.
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.

		1.10 Are daily test taking place on AER's?	Yes observed documentation, highlighting tests undertaken every morning.
		2.6 Does physical segregation exist between clean and dirty areas/processes?	Yes observed.
		2.11 If there is a drying cabinet in use is there an SOP in place for its control and use?	Yes observed.
		2.23 Are final rinse water tests recorded?	Yes observed, Estates undertake PH water tests and staff complete a final rinse.
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes observed. Review date 30/09/20.
		3.7 s the manual pre-washing sink in use marked with the water volume in accordance with the dosage required?	Yes observed.

Governance arrangements, matters of significance are reported through to Quality and Safety Group

Based on discussions with management at the outset of the review, we focused on governance reporting arrangements from the Health Economy Local Infection Prevention Groups to Infection Prevention Sub Group, identifying matters of significance are reported to the Quality and Safety Group.

We sought evidence of issues of significance for escalation regarding decontamination, in addition we also sampled agendas and minutes to establish that issues were being escalated within the Infection Prevention governance and reporting arrangements.

Having reviewed at all the evidence provided, we note that issues of significance (IOS) can be seen on the agendas and within minutes. However we found little evidence to support that IOS are being escalated from the Health Economy Local Infection Prevention Groups to the Infection Prevention Sub Group.

Additionally we note that several meetings have been cancelled - at the time of writing this report, East Health Economy Local Infection Prevention Group had not met since November 2019.

The findings below is the evidence of agendas and minutes provided to us concerning the Infection Prevention governance and reporting arrangements beginning with the Quality and Safety Group.

Quality & Safety Group (QSG)

We reviewed the minutes of QSG to identify issues of significance from the Infection Prevention Sub Group. It has been agreed with the Associate Director of Quality Assurance that the completion of quarterly reports (including the IOS) would be undertaken and presented to the QSG, our review identified the following:

- 8th May 2019 – Report from the Infection Prevention Sub Group escalating issues of significance.
- 11th June 2019 - Infection Prevention (IP) Report Q4 – January to March 2019, issues of significance included.
- 14th August 2019 - Infection Prevention (IP) Report Q1 (April to June 2019) issues of significance included.
- 8th November 2019 - Infection Prevention (IP) Report Q2 (July to September 2019) issues of significance included.
- 18th February 2020 – Evidence provided to us records that the Infection Prevention (IP) Report Q3 (October to December 2019) was forwarded for submission to QSG but we have been unable to locate the report on the official QSG agenda.

Infection Prevention Sub Group

We were provided with minutes from 27th August 2019, 22nd October 2019 and the 17th December 2019 (in draft), the meeting arranged for 11 February 2020, was cancelled.

Issues of significance for escalation to the QSG highlighted within the IPSG meetings on the 27th August 2019 and 22nd October 2019 regarding decontamination were sampled.

Infection Prevention Sub Group (IPSG) Tuesday 27 August 2019

Issues of Significance for Escalation to Quality & Safety Group (QSG)

- *IPSG 19/32 Decontamination Update - Laryngoscope Handles*
- *IPSG 19/32 Decontamination Update Welsh Government (WG) visit and Dental Survey*
- *IPSG 19/33.1 Quarter 1 Report - ADN IP – Mattress decontamination.*

Infection Prevention Sub Group (IPSG) Tuesday 22 October 2019

Issues of Significance for Escalation to Quality & Safety Group (QSG)

- *IPSG 19/50.3 Quarter 2 Central*

  Decontamination

  Autoclaves within HSDU YGC are nearing end of life and are damaged. This is highlighted via the decontamination risk register and will be progressed by the Theatre Manager with support from Chief Engineer.

We were able to corroborate that the IOS identified within the IPSG meeting on the 27th August 2019 were discussed within the QSG on the 4th October 2019.

However we unable to verify that the IOS regarding the autoclaves on the 22nd October had been escalated to the Quality and Safety Group. We were informed that minute taker was required to step out of the meeting for a short period and discussion may have taken place during this time - we are unable to corroborate this assertion.

West - Health Economy Local Infection Prevention Group

We were provided with minutes from the 26th July and the 27th September 2019. November 2019 meeting was cancelled [we have not been able to ascertain why it was cancelled] with January 2020 minutes still draft.

For the meeting 26th July no issues of significance for escalation reporting into the Infection Prevention Sub Group have been identified for the minutes.

For the meeting of 27th September 2019 mask fit testing was highlighted but we were unable to locate the issue within the minutes of the Infection Prevention Sub Group provided to us.

Minutes of Local Environmental Cleanliness, Decontamination, Infection Prevention and Antimicrobial Stewardship Joint Meeting 27 September 2019

020/03/19 - Issues of significance for escalation to next meetings of

- *Strategic Infection Prevention Group*
- *Hospital Management Team*
  - *Fit testing.*

Central - Health Economy Local Infection Prevention Groups

We were provided with minutes from 9th October 2019 and 26th February 2020 (draft); 11th December 2019 was cancelled due to the number of apologies received.

We were able to identify an issue with regards to the HSDU autoclaves within the 9th October 2019 minutes which has been escalated to the Infection Prevention Sub Group.

Health Economy Local Infection Prevention Group Meeting Wednesday 9th October 2019

HELIP19/07 Review Infection Prevention Risk Register Central

- *The life span of the HSDU autoclaves (scored 12) and has been escalated/managed through the Strategic Decontamination Group*

At the meeting of the 9th October 2019, the rate of infections has been highlighted as an issue of significance but we were unable to locate the issue within the minutes of the Infection Prevention Sub Groups provided to us:

Health Economy Local Infection Prevention Group Meeting Wednesday 9th October 2019

HELIP19/15 Issues of Significance for Escalation

- *Central has the highest rate of infections for the organisms under surveillance. There is a higher rate of antimicrobial resistance and CDI.*

For the meeting 26th February 2020 there were issues of significance identified within the minutes (draft) however at the time of writing this report the Infection Prevention Sub Group for April 2020 had not taken place and therefore we are unable to confirm the issues were formally escalated.

Health Economy Local Infection Prevention Group Wednesday 26th February 2020

LIPG20/15 Issues of Significance for Escalation

- *K Boardman was delighted to announce Ward 19 would be moving on the 31st March 2020 to a nicer area for COTE patients.*
- *The Antimicrobial business case is being completed and escalated, no developments.*
- *A Griffiths advised escalation of the new risk in terms of the risk register.*

East - Health Economy Local Infection Prevention Group

We were provided with agendas from the 10th September 2019, 12th November 2019 and the 10th December 2019. We were provided with the minutes for the 9th July 2019, 10th September 2019 and the 12th November 2019.

Meetings scheduled for the 13th August 2019, 8th October 2019, 10th December 2019 and the 19th February 2020 were stood down and we have not been able to ascertain at the time of this report, why the four meetings were postponed.

For the meeting of 9th July 2019 the issue below has been highlighted but we were unable to locate the issue within the minutes of the Infection Prevention Sub Group provided to us.

Local Infection Prevention Group (WMH) Tuesday 9th July 2019

Issues of Significance for Escalation to Next Meeting of SIPG and/or Next Strategic Decontamination Group

- *The classification of the Theatre Recovery area being deemed an augmented care area is to taken to IPSG.*

For the meeting of the 10th September 2019 and the 12th November 2019 no issues of significance for escalation reporting into the Infection Prevention Sub Group have been identified from the minutes.

As a point of note the area Health Economy Local Infection Prevention Groups we were unable to see any discussion on the decontamination audit tools. This would allow for an opportunity for the area groups to monitor the department's action tracker completed on the back of the audit tool as well as any issues which departments may have highlighted.

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 – Governance – Local Infection Prevention Groups (Operating effectiveness)	Risk
The review has identified a lack of reporting of issues of significance for escalation from the Local Infection Prevention Groups through the Infection Prevention Sub Group. Evidence provided to us demonstrates that several meetings have been cancelled which undermine the delivery of governance and assurance reporting.	Issues not escalated.
Recommendation	**Priority level**
The Local Health Economy Local Infection Prevention Groups ensure all issues of significance recorded in Minutes are escalated.	**High**
Management Response	**Responsible Officer/ Deadline**
Decontamination to become a standing agenda item on all LIPGs, with minutes including and Issues of Significance to be escalated to the IPSG.	Assistant Director Of Nursing - Infection Prevention June 2020

Finding - ISS.2 – Self-audit tool (Operating effectiveness)	Risk
The Decontamination Department demonstrated a planned approach with the self-audit tool, however we noted the following: • Self-audit tools are not routinely discussed at the Local Health Economy Local Infection Prevention Groups. • The review identified Self audit tool not being completed within two departments. • No questions on the undertaking of COSHH assessments were included within the self-audit tool.	Lack of monitoring for the completion of the self-audit tool.
Recommendation 2	**Priority level**
Chairs of the Local Health Economy Local Infection Prevention Groups ensure self-audit tools are routinely presented and discussed in accordance with current timescales.	**High**
Recommendation 3	**Priority level**
Decontamination Advisor to include a question on COSHH assessment which identifies that the chemicals have been assessed correctly for the area and reviewed.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A Decontamination/Infection Nurse role has been agreed and funding. This has been out for expressions of interest and will interview w/c 13th July 2020. This post will support the Decontamination advisor pan BCU supporting the governance structure regarding practice, self-audit and reporting.	Assistant Director Of Nursing - Infection Prevention August 2010

Decontamination to become a standing agenda item on all LIPGs, with minutes including and Issues of Significance to be escalated to the IPSG. Question on COSHH assessments to be added to audit tool.	Assistant Director Of Nursing - Infection Prevention June 2020 Decontamination Advisor June 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.

Betsi Cadwaladr University Health Board

Salary Overpayments

Final Internal Audit Report

BCU 2019/20

August 2020

NHS Wales Shared Services Partnership

Contents **Page**

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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 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

Betsi Cadwaladr University Health Board has recently updated the financial procedure for Recovery of Overpayments. The new operational procedure F14 Salary Overpayments / Underpayments has been approved by the Director of Finance – Operational Finance and was subject to review/update by the Local Counter Fraud Services team. The new procedure became operational on July 2019 and this together with the SFIs aim to address resolving Overpayments fairly and equitably, without financial loss to the Health Board.

The Salary Overpayments / Underpayments Procedure has not been subject to review, consultation and approval at an appropriate level. Several parties raised concerns that the procedure has not been appropriately authorised and communicated and that the old version is still on the intranet.

Section 10.4.3 Debt Recovery of the Health Board Standing Financial Instructions (SFIs) states that "Overpayments should be detected (or preferably prevented) and recovery initiated".

The Health Board recognises that it has a duty to ensure that all employees are paid correctly and receive the monies to which they are entitled. Unfortunately, on occasions incorrect payments do occur, making it necessary to rectify the error and pay or recover all monies due.

A salary overpayment normally arises as the result of either an 'error of calculation' to an existing employee or as the result of incorrect, insufficient or late notification of a change to the individual's circumstances or contract of employment. The Payroll Department continue to pay the salary to the employee at the level recorded on the Electronic Staff Record (ESR), as they have not been informed by the Line Manager of a change in contracted weekly hours or sessions as the employee reduced their hours or sessions, or left employment at the Health Board and the employee is considered to be an ex-employee, leading to a salary overpayment.

2. Scope and Objectives

The overall objective of the review was to review the adequacy of arrangements to ensure identified Overpayments are repaid to the Health Board in an acceptable and timely manner and in accordance with the operational procedure F14 Salary Overpayments / Underpayments Procedure.

The scope of the audit review was limited to the following aspects:

- Overpayments are appropriately recorded and reports submitted to the Health Board on a timely manner to monitor any specific problem areas;
- Ensure Payroll department has adequate controls in place to detect , prevent and manage Overpayments;
- Recovery of Overpayments will be managed and processed in accordance with the Health Board procedures.

3. Associated Risks

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

- Overpayments are not recovered resulting in financial loss to the Health Board;
- Inadequate controls may lead to excessive level of Salary Overpayments.

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 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	Payroll Department has adequate controls in place to detect, prevent and manage overpayments				✓
2	Overpayments are recorded and reported to Health Board in a timely manner.		✓		

Assurance Summary					
3	Recovery of Overpayments is managed and processed in accordance with Health Board procedures.		✓		

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

Design of Systems/Controls

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

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as weakness in the operation of the designed system/control for the Salary Overpayments review.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided to us at the start and during the review. We have relied solely on the documents, information and explanations provided, except where otherwise stated. We have not sought to or undertaken work to verify the accuracy of the information provided.

The Payroll department maintains a spreadsheet/register providing details of Overpayments for monitoring and analysis purposes. The Overpayments register is shared with Finance and Workforce. Payroll Key Performance Indicators (KPI) in place are: Overpayments made at each pay period, showing number, reason and value etc.; these are shared with the Director of Workforce & Organisational Development and Finance on monthly basis and year to end together with other KPIs in respect of; number & value of manual payments made; Payroll accuracy.

For the period July 19 to September 19, Overpayments made were as follows:-

July 19 (m4)	**Employee**	**Finance**	**Manager**	**Medical Staffing**	**Manager Self Service (MSS)**	**Payroll**	**Grand Total**
Number of Overpayments	-	-	36	3	12	**5**	56
Gross Amount of Overpayments	-	-	£76,876	£8,807	£23,923	**£2,684**	£112,290

% Amount of Overpayments	-	-	68.46%	7.84%	21.30%	**2.39%**	100.00%

August 19 (m5)	**Employee**	**Finance**	**Manager**	**Medical Staffing**	**Manager Self Service (MSS)**	**Payroll**	**Grand Total**
Number of Overpayments	1	1	41	3	16	**3**	65
Gross Amount of Overpayments	£121	£503	£76,982	£26,374	£15,668	**£6,032**	£125,680
% Amount of Overpayments	0.10%	0.40%	61.25%	20.99%	12.47%	**4.80%**	100.00%

September 19 (m6)	**Employee**	**Finance**	**Manager**	**Medical Staffing**	**Manager Self Service (MSS)**	**Payroll**	**Grand Total**
Number of Overpayments	4	-	43	4	8	**1**	60
Gross Amount of Overpayments	£2,423	-	£131,113	£13,218	£8,591	**£89**	£155,434
% Amount of Overpayments	1.56%	-	84.35%	8.50%	5.53%	**0.06%**	100.00%

From our testing of the above, we were able to confirm:

- These figures show that Payroll errors resulting in Overpayments for the period July 19 to September 19 were as follows:-

  July 19 - £2684.34, 2.39% of total Overpayments.

  August 19 - £6031.50, 4.8% of total Overpayments.

  September 19 - £89.35, 0.06% of total Overpayments.
- Overpayments have largely occurred due to manager errors mainly late submissions of leavers or changes forms.
- We were advised that the Payroll Manager has raised concerns with the Health Board Finance and Workforce & Organisational Development Senior Management (October 2019), that since July 2019 the value of Overpayments has increased over a three month period from £112,290 (July) to £155,434 (September).
- Payroll process leavers documentation within the month of notification if documentation is submitted to the Payroll department within the agreed timescales. Forms submitted prior to cut-off dates are processed within

that month's pay run. The majority of Overpayments occurred where termination forms had not been submitted to Payroll in a timely manner.

- An "Overpayments Protocol" is available to payroll staff, which provides guidance in respect of the recovery of Overpayments. The Protocol was out of date (06/2015) and we were advised that a new policy is currently being developed.

Deductions from pay as a result of an Overpayment are processed in accordance with Health Board Overpayment Procedure.

- Overpayments are reported as part of the quarterly conformance report presented by the Director of Finance to the audit committee, to provide an update on conformance with the Health Board's Standing Financial Instructions (SFIs). From October 2019 Workforce have also included Overpayments data in their monthly reporting dashboards. We reviewed monthly reporting dashboards for October & November 2019, divisions and directorates who have not met targets, showing as "Red".

- The new operational procedure F14 *Salary Overpayments / Underpayments* has been approved by the Director of Finance - Operational Finance and was subject to review and update by the Local Counter Fraud Services team. We were advised that the procedure became operational on July 2019, however during course of audit it was evident that the procedure has not been subject to review, consultation and approval at an appropriate level. Several parties raised concerns that the procedure has not been appropriately authorised and communicated and that the old version is still on the intranet.

The Governance and Policy Manager/Office of the Board Secretary advised the following:-

30/05/19 - Audit Committee received the Local Counter Fraud Services (LCFS) Annual Report 2018/19. The report noted:-

An improved Local Management Procedure F14: Salary Overpayments/ Underpayments has been prepared with Finance and NWSSP-Employment Services for consideration of Health Board Management.

Audit Committee Minute AC19/49 documents that the 'Annual Report be endorsed'. In Committee, an Independent Member requested a copy of the Local Management Procedure (F14) for Salary Overpayments / Underpayments. This was duly sent on the 14/08/19 by the Head of Counter Fraud, along with contacts for the relevant departments involved in the document development (WOD/Finance/Payroll) should there be any specific queries. No further questions were raised.

12/09/19 - Audit Committee received the LCFS Progress Report. The report noted:

The LCFS team have fraud proofed the Health Board's Local Management Procedure (F14) on Salary Overpayments and Underpayments, this has

been circulated to the Director of Finance: Operational Finance for approval prior to implementation. This has been implemented from July 2019.

Audit Committee Minute AC19/72 documents that 'That the report be noted along with the specific requests made".

Section 10 of the Overpayments Procedure informs the following: -

"Line Managers, who have caused an overpayment, due to their late submission of staff related information on changes to individual employee's contracted weekly hours or sessions to the Payroll Department, will receive a letter from the Finance department, informing them of the breach (as shown in Appendix 3: 1st Breach - Salary overpayment letter, Appendix 4: 2nd Breach - Salary overpayment letter and Appendix 5: Escalation letter).

Once a manager has had more than two breaches, in a financial year, the Finance department will contact Senior Management, to bring the matter to their attention as it is the responsibility of Senior Management to immediately discuss the issue with the Line Manager to ensure that the appropriate Disciplinary Action is taken ensuring compliance with Health Board policies and submission deadlines for the submission of changes to contracted weekly hours or sessions of the individual employee as per Establishment Control process and proceeding to the Payroll Department, to prevent further Salary Overpayments or underpayments being caused by the actions of the Line Manager".

We have been informed that this process is not followed and these letters had never been sent either to line managers or senior management, therefore no action taken against managers to ensure compliance with deadlines for payroll submission.

Recovery of Overpayments will be managed and processed in accordance with the Health Board procedure.

The following is an extract from Appendix 1 of the new Overpayments Finance Procedure/Repayment:-

"Any amount of the debt which is due to the salary overpayment and which is not repaid to the Health Board within 6 months, from the date of the invoice, will be charged to the debtor at an interest rate on the monies owed - interest currently stands at 8% per annum - until repaid in full".

Before the new procedure was approved, no interest was ever applied on monies owed, unless the case had be referred to the debt-collecting agency.

In April 2019, officers in Workforce & Organisational Development (WOD) responded to the Director of Operational Finance with observations of the revised procedure including a comment *"…believe the policy will need to go through the policy group and trade unions for ratification"*. The Director of Operational Finance, in reply to WOD colleagues, requested they liaise directly with the Head of Local Counter Fraud Services to progress. It does not appear this dialogue was progressed at the time.

In December 2019, the Director of Workforce & Organisational Development queried with the Director of Finance the consultation and approval process for the Overpayments procedure.

The Executive Director of Finance has queried with the Local Counter Fraud Manager and the Financial Accountant / Financial Control, whether consultation had taken place.

The Financial Accountant advised the following:-

- *Interest has been applied to Salary Overpayments with agreed instalment plans longer than six months old since July 2019. The total charged up until December 2019 was £2,460.89 against 13 invoices.*
- *The policy on the intranet is an older version which doesn't mention interest charges, this may suggest that the latest version hasn't been through the committee approval process (the Execs Team and then a relevant Board Committee) which would allow Governance to update the intranet pages.*
- *Finance to put a freeze on agreeing any further interest charges until they establish the consultation and approval process that was followed.*

The following is an extract from Appendix 1 of the new Overpayments Finance Procedure/Repayment:-

"If the debtor is able to prove that they are unable to make an immediate repayment of the outstanding debt in full, then the debt may be repaid over a period not exceeding the overpayment period, ***with a maximum period of 6 months****, when agreed by the Accounts Receivable Manager".*

Our understanding of this section is that in all cases, the repayment period should not exceed a maximum period of 6 months. However, both the Accounts Receivable Manager and the Local Counter Fraud Manager advised that it may be possible for somebody to repay over a longer period than 6 months provided interest is charged until the debt is repaid.

We understand that the new procedure has not been subject to formal consultation and approval and therefore this section of the procedure maybe revisited for further clarification.

The following table shows the number and value of outstanding /unpaid Salary Overpayments bills for the period August 19 to December 19:-

Number of bills O/S	**Total O/S Balance**	**Current**	**1-30**	**31-60**	**61-90**	**91-180**	**181-364**	**1 Yr Plus**
491 Dec 19	**£565,129.41 100%**	£38,217.65 7%	£66,072.59 12%	£30,823.70 5%	£90,789.39 16%	£67,563.11 12%	£100,609.60 18%	£171,053.37 30%
484 Nov 19	**£583,981.98 100%**	£102,579.66 18%	£30,955.76 5%	£88,277.00 15%	£12,352.92 2%	£68,598.89 12%	£110,050.77 19%	£171,166.98 29%

460 Oct 19	**£534,653.53 100%**	£57,353.24 11%	£97,619.70 18%	£12,972.91 3%	£23,955.98 5%	£66,180.96 12%	£98,210.90 18%	£178,359.84 33%
449 Sep 19	**£515,042.40 100%**	£114,071.77 22%	£14,741.30 3%	£28,016.05 5%	£47,974.03 9%	£26,255.42 5%	£105,826.33 21%	£178,157.50 35%
405 Aug 19	**£434,070.48 100%**	£16,312.30 4%	£33,444.18 8%	£53,105.99 12%	£3,276.30 1%	£69,927.18 16%	£90,797.41 21%	£167,207.12 38%

As at August 2019, Salary Overpayments debts over six months old and those over one year old were 59% of total Salary Overpayments debts outstanding, 56% in September 19, 51% in October 19, 48% in November 19 and 48% in December 19. We could not establish action taken by management to manage and reduce old outstanding items, in particular those over one year old, of which some are dated back to 2008.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**-**	**-**	**2**

Finding 1 - (Design) Overpayments Procedure	Risk
The Salary Overpayments / Underpayments Procedure has not been subject to review, consultation and approval at an appropriate level. Several parties raised concerns that the procedure has not been appropriately authorised and communicated and that the old version is still on the intranet. Interest has been applied to salary Overpayments with agreed instalment plans longer than six months old since July 2019. The total charged up until December 2019 was £2,460.89 against 13 invoices – These were raised without due authority as there is no governing policy that supports this. Staff side have expressed concern in that regard and whether consultation had taken place with Workforce or Unions about the application of the interest charge. According to the Health Board Overpayments Procedure, line managers, who have caused an Overpayment, due to their late submission of staff related information on changes to individual employee's contracted weekly hours or sessions to the Payroll department, will receive a letter from the Finance department, informing them of the breach. We have been informed that this process is not followed and these letters had never been sent either to line managers or senior management, therefore no action taken against managers to ensure compliance with deadlines for payroll submission.	Inadequate governance and control framework leading to confusion and inadequate clarity on how to deal with salary Overpayments. Overpayments are not recovered resulting in financial loss to the Health Board.
Recommendation 1	**Priority level**

The Executive Director of Finance considers writing-off the 13 invoices where interest has been levied as there is no governing policy or agreed procedure which allows the Health Board to raise such interest charges. The Overpayments procedure should be subject to consultation and approval at appropriate level, including unions and staff side group. The correct approval body within the Health Board should review and approve the revised Overpayments procedure.	**High**
Management Response 1	**Responsible Officer/ Deadline**
The Finance Department recognises that the latest approved version of financial procedure **F14 Salary Overpayments / Underpayments Procedure** does not include any provision for charging of interest on salary overpayments being repaid over a longer term. The Accounts Receivable team will contact each individual affected and will arrange for these thirteen invoices to be cancelled so that only the original overpaid amounts remain outstanding. The updated overpayments procedure will now be subject to a consultation process before being submitted for approval in accordance with policy **OBS1 – Management of Policies & Procedures & Other Written Control Documents**. Whilst this consultation process will focus on the need for the Health Board to recover all salary overpayments in full it will also consider the underlying reasons for overpayments occurring and the impact on the individuals affected.	Financial Accountant – Reporting and Control 31st December 2020

Finding 2 - (Operation) Outstanding Debts	Risk
There is a large volume of long outstanding debts, which have historic payment plans in place, many of which were agreed to be repaid over a number of years. As in December 2019 Salary Overpayments over six months old were £101k and £171k over one year old. In August 19 , Salary Overpayments debts over six months old and those over one year old were 59% of total Salary Overpayments debts outstanding, 56% in September 19, 51% in October 19, 48% in November 19 and 48% in December 19.	Overpayments are not recovered resulting in financial loss to the Health Board.
Recommendation 2	**Priority level**
The Health Board should continue to pursue recovery of debts in accordance with updated policy and a more consistent and systematic approach be followed to collect and clear long outstanding debts.	**High**
Management Response 2	**Responsible Officer/ Deadline**
The Finance Department recognises the risk associated with outstanding invoices for salary overpayments particularly where these are being repaid over an extended period. During the last twelve months, the Accounts Receivable team has contacted all salary overpayment debtors with an instalment plan and has discussed potential ways to reduce the repayment term. Whilst this has in some cases successfully resulted in increased instalments, or debtors repaying the outstanding amount in full, many have referred to the terms of their original agreement. The Accounts	Financial Accountant – Reporting and Control 30th September 2020

Receivable team will continue to monitor longer-term salary overpayments and will contact this group of debtors again before the end of September 2020. The team also monitors compliance with agreed instalment plans each month and contacts debtors where payments have not been received within expected timescales. The updated financial procedure **F14 Salary Overpayments / Underpayments Procedure** is currently subject to a consultation process after which it will be submitted for approval in accordance with policy **OBS1 – Management of Polices & Procedures & Other Written Control Documents.** Until the procedure is approved, Accounts Receivable will continue to manage salary overpayments in line with the most recently approved version of the procedure, dated March 2018. This version of the procedure is published on the Health Board's intranet site and is available by email on request. Whilst this version does not include provision for the charging of interest on invoices being paid by instalments over extended periods, the Accounts Receivable team seeks repayment over the same timeframe that the overpayment occurred and preferably no longer than six months. Alongside the option of repayment by instalment, the Health Board offers a number of other payment methods including salary deductions and payment by debit or credit card. The Accounts Receivable Manager now prepares a monthly report of salary overpayments where there may have been a breach of Health Board procedures and shares this report with colleagues within the Finance Department and Workforce & Organisational Development.	

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

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

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

Governance Arrangements during the Covid-19 Pandemic

Advisory Review Final Report

2020/21

Betsi Cadwaladr University Health Board

Audit and Assurance Services

Private and Confidential

Contents

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Auditors:	Head of Internal Audit Deputy Head of Internal Audit Audit Manager - Capital
Executive sign off:	Acting Director of Finance Acting Board Secretary
Distribution:	Acting Director of Finance Acting Board Secretary Chief Finance Officer – Central Area
Committee:	Audit Committee

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

Please note:
This advisory review 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. Advisory review 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 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

The NHS in Wales continues to face unprecedented pressure in planning and providing services to meet the needs of those who are affected by Covid-19 and other essential services.

At the time of this report, the number of cases of Covid-19 across Wales is in decline and there is an opportunity for NHS Wales organisations (organisations) to take stock following the initial peak of cases experienced between March and June 2020.

This advisory review was requested by the Acting Director of Finance to assess the adjusted financial and overall governance arrangements that were put in place to enable Betsi Cadwaladr University Health Board (Health Board) to maintain appropriate governance whilst enabling its senior leadership team to respond to the rapidly developing emergency.

At the time that many of the adjustments to governance arrangements were being made, the Health Board area had lower incidence than other NHS Wales organisations but has experienced challenges later than others. It is against this backdrop that we have assessed the effectiveness of those arrangements, whether they complied with Welsh Government guidance. The key objective of the review is to provide independent, timely feedback to enable changes to be made to temporary governance arrangements if they are to be used in the future.

This review was completed during July 2020 and involved meeting key members and officers of the Health Board as well as reviewing associated documentation supplied, where available. Whilst we have assessed this information against Welsh Government and other national guidance, we have not undertaken detailed operational testing of the arrangements in place. We worked closely with Audit Wales to avoid unnecessary duplication with their work, sharing information where relevant and undertaking a number of meetings together.

Further detail regarding the scope of the review, the guidance used as the basis of the assessment and the review work undertaken are included in the appendices to this report.

We would like to thank the Chair, Executive Directors and Independent Members for their time and contribution to this review.

2. Executive Summary

Main Observations

The Health Board's temporary governance arrangements operated effectively during the peak. The Health Board complied with the guidance and the principles issued by Welsh Government.

Board, Audit Committee and Quality, Safety and Experience Committee meetings continued during the peak and the business of those meetings was appropriate, balanced with regular Board briefings of Members outside of the formal Committee forums.

To enable decisions reserved to the Board to be acted upon quickly and

seamlessly, the Health Board established a 'Cabinet' that met in addition to the Board and Board Briefings, where Chair's Actions were ratified for key decisions around the three Ysbyty Enfys Hospitals.

'Virtual' meetings using Webex were introduced early on with all planned meetings having progressed and the disciplines and etiquette involved evolving, particularly in relation to the live streaming of Board meetings through Youtube.

The Command Structure operated effectively and enabled the Health Board to take decisions to meet emerging issues. There is now an opportunity for management to look at the evidence retained in support of decision making.

Financial governance was maintained, with no changes made to Standing Financial Instructions or the Scheme of Reservation and Delegation. Covid-19 related expenditure is separately identified and reviewed by the Chief Finance Officers for appropriateness.

The Acting Executive Director of Finance established a Financial Governance Cell to retrospectively review the efficacy of COVID-19 controls and identify lessons learnt for the future. There is now an opportunity to build on this 'self-critique' approach and broaden the scope of the Cell to other service areas of the Health Board.

Partnership working and engagement with the Community Health Council, Local Authorities and other partners was effective and undertaken as required.

Whilst the Health Board has stood down its emergency planning arrangements and reverted to its business as usual approach to service delivery, albeit within the confines of COVID-19 restrictions, we recognise that it is undertaking a 'lessons learnt' exercise. There are opportunities to build and harness benefits from the temporary arrangements including working in an agile way and building on the clinical engagement that revised clinical pathways at pace, pan Health Board. Our meetings noted there is a real appetite to secure the learning from the experience and realise the opportunities afforded through this pandemic.

Priority Considerations for the Future

We have not assigned priority ratings to considerations for the future, but we would highlight the following to be key areas of focus for the Health Board to take into account as it reviews its processes:

- Developing a robust emergency plan pack for any future peaks of the pandemic, to allow a swift enacting of measures required;
- All of the Executive Team undergo 'Gold' training which is refreshed in accordance with their personal development requirements;
- The Health Board Chair should not be required to Chair any operational groups;
- Establishing a clear Scheme of Reservation and Delegation and decision making framework, with approved Terms of Reference, that sets out which decisions (operational and strategic) require approval by which forum (e.g. Silver/Gold/Executive Team/Health Board) thus ensuring documentation is complete and maintained for each respective decision;

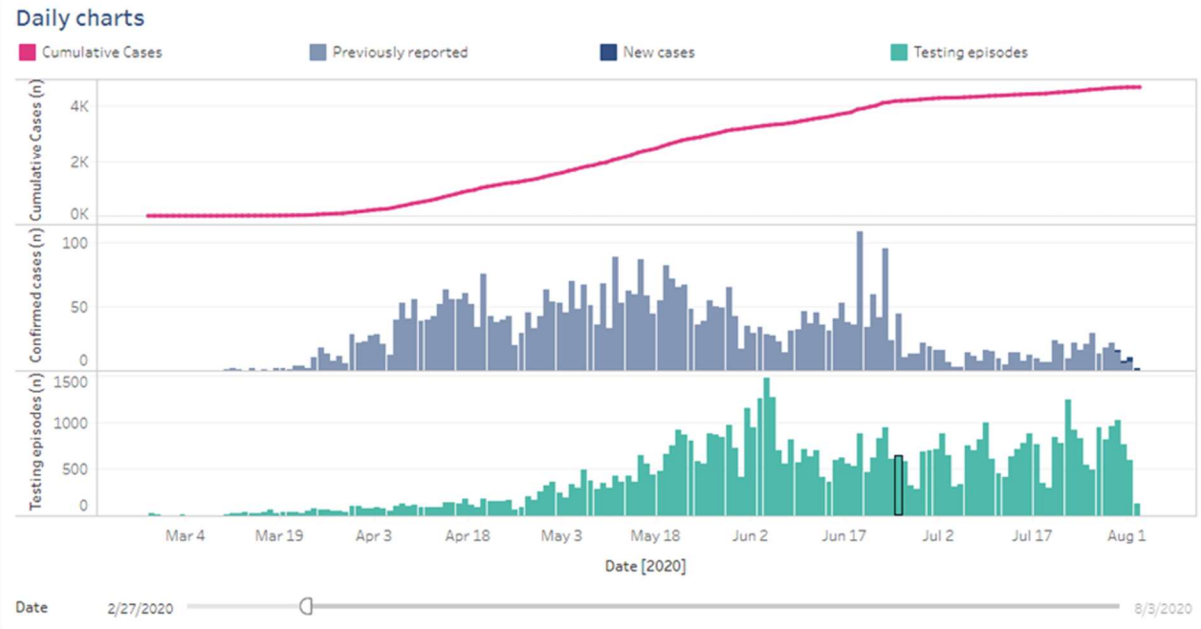
- Documenting all decisions taken in accordance with published guidance, with a clear audit trail;
- Updating all business continuity plans throughout the Health Board, to reflect changes required as a result of the pandemic;
- Ensure all COVID-19 risks are recorded in accordance with the Risk Management Strategy and migrate into day to day management now the Health Board has moved to business as usual;
- Reviewing insurance and indemnity arrangements to ensure adequate cover is in place for all additional sites established within the Health Board, e.g. Test, Trace, Protect testing sites;
- Continue to ensure GDPR requirements are maintained, with the continued and increase of home working arrangements, including the use of personal equipment for work related activities (e.g. mobile phone to access Office 365 Teams and Outlook); and
- Consider the continued use of virtual meetings and supporting arrangements, within the Committee structure.

3. Background and Context

Overview of the Impact of the Pandemic on the Health Board

In the period 3rd April to 28th June 2020 the Health Board has experienced prolonged exposure to the pandemic. The graphs below (Image 1) illustrate the acceleration of the cases of Covid-19 within the Health Board's region.

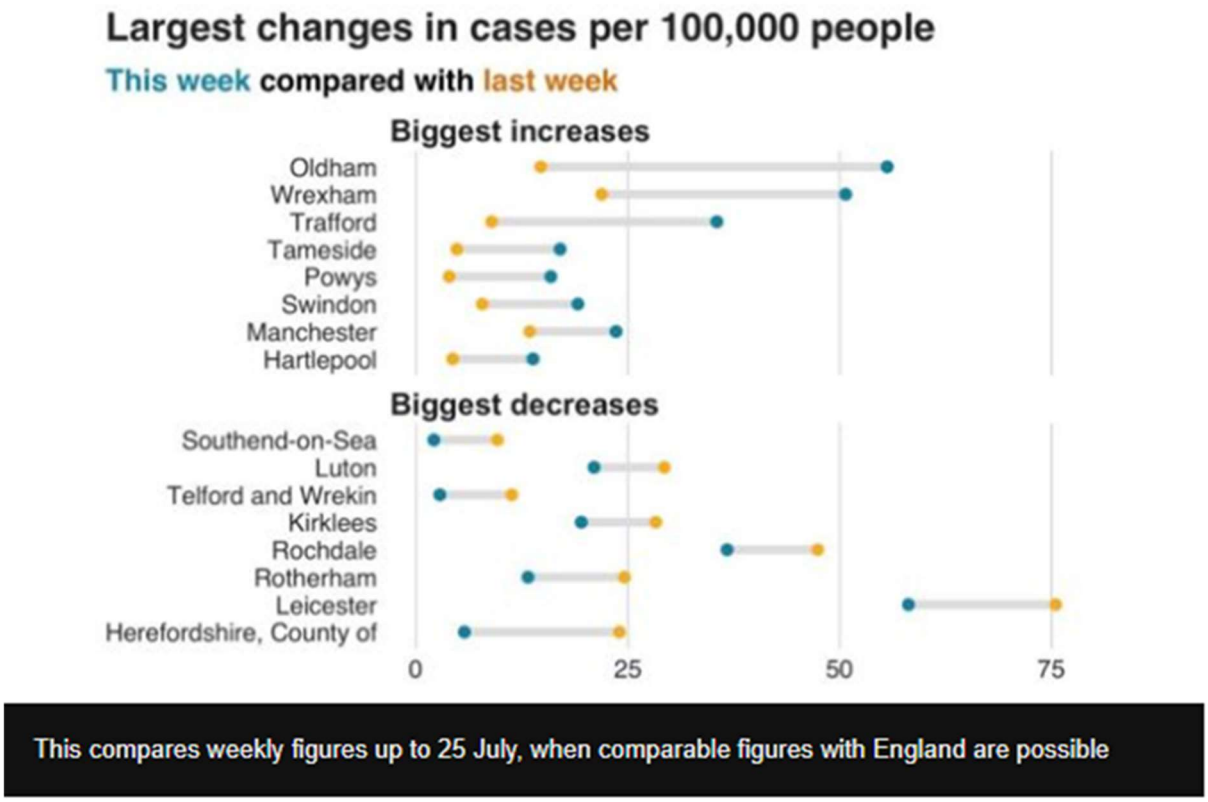
Image 1: Betsi Cadwaladr University Health Board Daily Reports



Source: https://public.tableau.com/profile/public.health.wales.health.protection#!/vizhome/RapidCOVID-19virology-Public/Headlinesummary 3rd August 2020 at 13:00

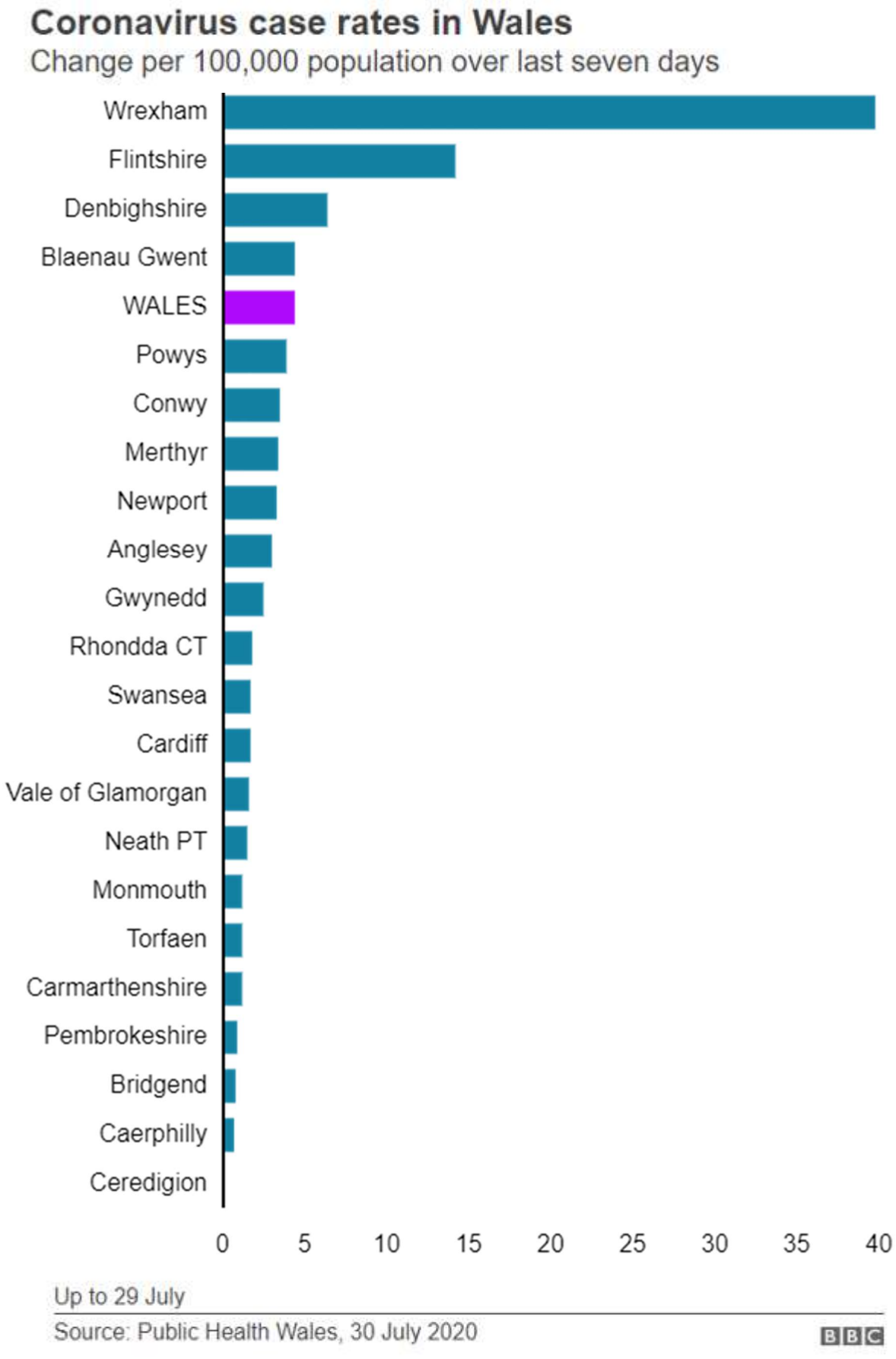
Following the onset of the pandemic across Wales, the Health Board continues to experience high levels of the virus in comparison to England (image 2) and above the Wales average (image 3).

Image 2: Changes in cases per 100,000 people Wales and England (as at 25th July 2020)



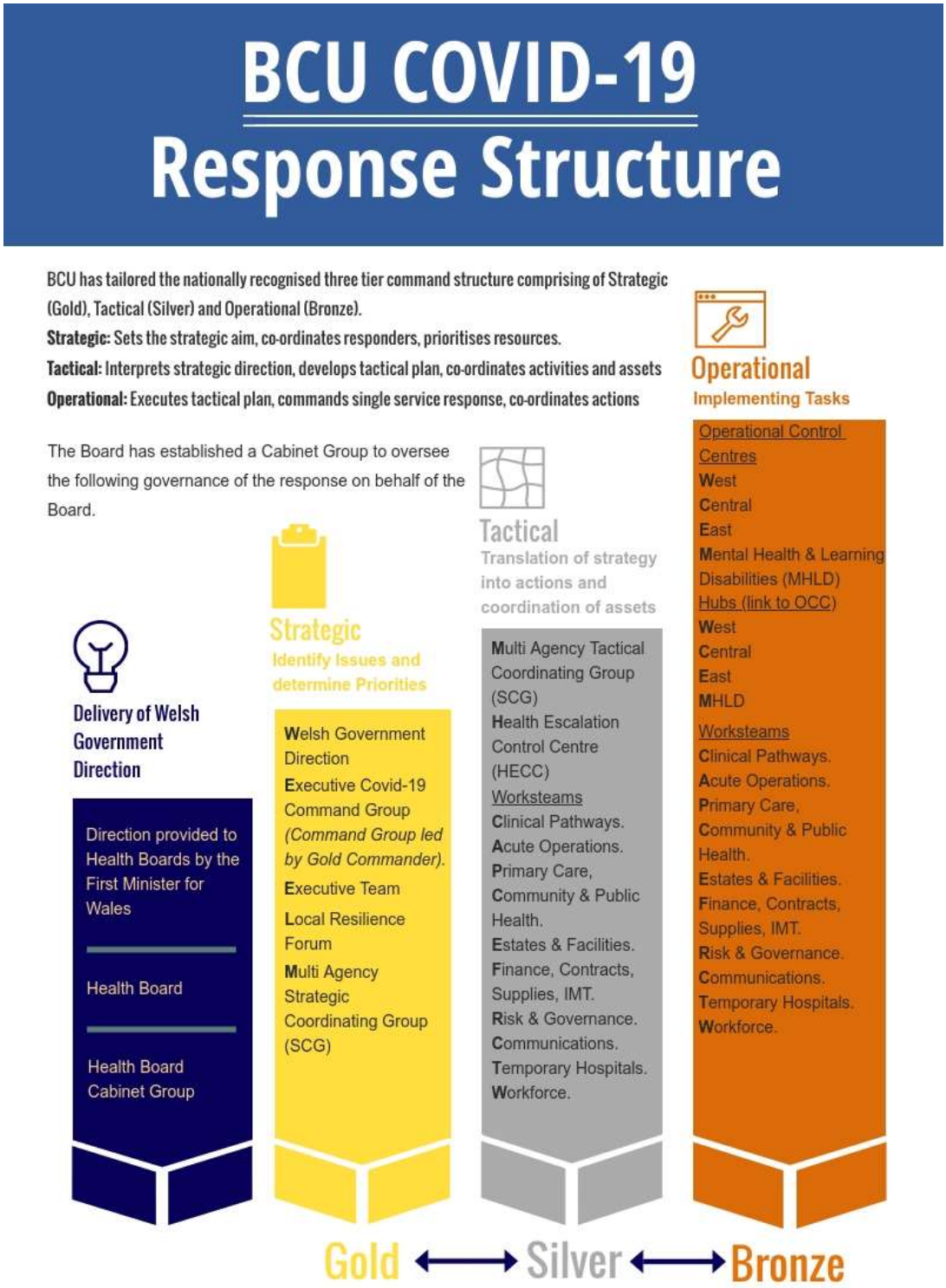
Source: https://www.bbc.co.uk/news/uk-wales-53592767 (Image 2 & 3)

Image 3: COVID-19 case rates in Wales per 100,000 population as at 29th July 2020



Command and Control Structure

The Health Board established a Pandemic Command and Control structure to progress actions/decisions during the outbreak:



Within each level of the pandemic command and control structure, it is expected that the Governance Principles (the 'Principles') set out by the Welsh Government and detailed within Appendix One, are embedded.

Adjusted Governance Arrangements

In addition to the Command and Control structure, the Health Board implemented a range of temporary measures to facilitate new ways of working including:

- Streamlining the Board and Committee structure including the suspension of Committees of the Board, excepting the Audit and Quality, Safety and Experience Committees;
- Introduction of virtual meetings with the available telephone and video conferencing facilities and changes to the public's access to meetings and records; and
- Created a Cabinet, where the Board considered and approved its Terms of Reference, which detailed its purpose *"..to be responsible for oversight of key high-level strategic matters relating to the Health Board's response to the health emergency presented by the Covid-19 pandemic. This will involve consideration of the outputs of Gold Command and other levels within the Command Structure as necessary - providing scrutiny, challenge and seeking assurance - and also decision-making on those matters requiring escalation to the full Board."*

The conclusions and considerations for the future in this report take into account the onset of the pandemic at the beginning of its spread through Wales and the consequent impact on the Health Board and the whole of North Wales. Considered in this context, the Health Board quickly established governance arrangements and continued to strengthen measures to manage the pandemic as more guidance became available.

4. Detailed Findings

This section sets out the detailed findings of the review, under the headings of Strategic Governance, Financial Governance and Other Areas of Governance.

The findings within this advisory review should be seen in the context of management dealing with a pandemic and needing to react quickly to changing risks and demands.

Strategic Governance

1. Board and Committee Meetings
2. Scheme of Reservation and Delegation (SoRD) and Decision Making Arrangements
3. Risk Management

Financial Governance

4. Annual Accounts and Reporting
5. Authorised Signatories/ Electronic Approval Hierarchy / Delegated limits
6. Financial Systems and Processes
7. Covid-19 Expenditure (Revenue and Capital)
8. Workforce
9. Budget and Savings

Other Governance Areas

10. Partnership Arrangements
11. Cross-Border Flows and Long Term Agreements
12. Charitable Funds
13. Counter Fraud Arrangements
14. Information Governance

Each section provides commentary on the adjusted governance arrangements put in place and considerations for the Health Board to take into account as it plans for potential further Covid-19 peaks in the future.

Where we consider it appropriate, we have suggested areas which should be given greater priority.

Strategic Governance

Board and Committee Meetings

What we found

Our review identified the following:

- The Health Board moved quickly to ensure that Board and Committee meetings could continue to be held virtually in order to comply with social distancing and other Welsh Government guidance, with Executive Directors and Independent Members showing a great deal of flexibility. Members of the public were unable to observe Board meetings until the Board meeting of the 21st May 2020, intended for live streaming via Webex and Youtube, but despite two successful dry runs, the live stream failed due to technical issues. Subsequently the Board has successfully streamed live on Youtube on the 23rd July 2020.
- The Board, Audit Committee and Quality, Safety and Experience Committee (QSE) continued to operate, with all other Committees stood down. This was formalised through the Board meeting of the 15th April 2020 and detailed within the 'Maintaining Good Governance COVID-19' paper.
- Inevitably there were some challenges, as with all NHS Wales organisations concerning the availability of suitable conferencing technology throughout NHS Wales. These have been resolved and we were advised that meetings have flowed well, are focused and shorter in duration, with Members adapting to the media used. The default medium is Webex although we understand the Health Board is looking to utilise Microsoft Teams. We have seen guidance issued to Members setting out meeting etiquette for live streaming, but we recognise the value that face-to-face meetings bring.
- Meetings have been streamlined to focus on Covid-19 and an assessment was made by both Chair and Lead Executive Director for both Committees against Welsh Government guidance to ensure compliance. Members of the Board and Committees have, on occasion experienced variable levels of connectivity and we note that the Health Board is equipping Independent Members with a laptop to supplement their iPad to improve connectivity and access.
- We were informed that in addition to the April and May 2020 Board meetings, Cabinet meetings and Board Briefings were held fortnightly (alternate weeks). Cabinet met on seven occasions between 1st April and 28th June 2020 and recorded opportunities to enhance and support the Executive in managing the COVID-19 pandemic.

  Whilst recognising the importance to keep all Members informed and provide the opportunity to ask questions, the general feedback from our interviews regarding this process was positive however we did note that there was a duplication of information on occasions with some seeing the presentations at least twice.

- Agendas and papers of the Board were streamlined from the 15th April 2020 onwards following approval of the 'Maintaining Good Governance COVID-19' paper. Cabinet was also meeting regularly with a focused agenda and Board briefings supplemented this.
- Standing Orders were amended for administrative purposes, e.g. excluding members of the public from attending meetings. We did note that the publication of this notice on the Health Board web site was only visible once you had clicked into the relevant Board/Committee meetings and agenda page.
- A revised Chair's Action process was adopted by the Board at its meeting of the 15th April 2020.
- Quoracy requirements remained unchanged although we noted that both Committee Chairs reduced officer attendance to that of the Lead Executive Director and all Independent Members, with invitations for officers to attend as and when relevant papers were being received.
- Relevant risks were still presented to the Board/Cabinet.
- Whilst Board and Committee papers were published in accordance with Standing Orders, we were advised that for QSE, on two separate occasions, the agenda/draft minutes respectively were not published within the timescale (by 1 day). We note that papers have been made available to the public in a timely manner.
- The Audit Committee meeting on the 28th July 2020 received a paper 'Re-setting Governance' to formally reset the temporary governance arrangements and associated Standing Order amendments.

<u>What could be done differently in the future</u>

- Develop and formalise a protocol pack for future events that require similar arrangements, to swiftly implement the required measures. For example, formally establish meeting etiquette, membership, platform to use, meeting arrangements etc.
- Continue to use and develop suitable technology (whilst maintaining robust privacy and security requirements) that is user friendly and available to all Members and readily available for members of the public e.g. members of the public submitting questions in advance for Members to respond to.
- Consider the needs of all members of the public who may not be able to or have ready access to suitable technology e.g. British Sign Language.
- Restrictions in attending, in person, Health Board and Committee meetings is made clearer at the outset on the main Board and Committee meeting web page, stipulating how to observe the meeting(s). The current narrative may require refreshing.
- Whilst the Health Board currently streams the Board meetings live, consideration should be given to recording other Committee meetings. This may be used to retain a public video record of such meetings or to assist with documenting the minutes subsequently.

- Consider whether all Board and Associate Board Members require media training.
- Continue to ensure that all Members/Officers are suitably trained/offered training to use the conference software available and that the recently published etiquette is included as an aide memoire on all relevant agendas.

Scheme of Reservation and Delegation (SoRD) and Decision Making Arrangements

What we found

Our review identified the following:

- The Health Board did not amend the SORD and continued to work within existing delegation – this was confirmed in reviewing both documentation and meetings held.
- Executive Gold Command paper recorded *"….Gold command is the collective decision-making unit for Covid-19 on behalf of the Executive Team (within the scope of agreed delegation from CEO), and provides a daily 'HECC Commander' to support 'hot decisions' in HECC and operational control centres"*. There was no formally agreed delegation to Gold and therefore it is unclear what decisions they were authorised to undertake.
- There is no documented decision making process that sets out exactly what should be reserved and reported to the Board/Cabinet/Committee for approval or indeed Gold/HECC Command.
- HECC, Workstreams and OCC did not have Terms of Reference detailing the extent of their powers.
- The Health Board Chair, due to necessity, was required to Chair the Temporary Hospital Capacity Silver Group. This is an operational group and should have been led by an Executive Director.
- We found Chair's Action were reported into Cabinet and noted at full Board; the three Actions we identified as part of COVID-19 concerned the three temporary hospitals (Ysbyty Enfys) but these typically pick up key financial decisions.
- Gold/HECC Decision Log was submitted to the Cabinet for review but it remains unclear that all key decisions taken were formally logged and recorded. This is supported by the reports from Gold/HECC command to the Cabinet.
- We requested, for a sample of three Gold Command decision log entries, the formal risk assessment, but have not received a copy of the assessment at time of this review, we acknowledge however that risks may still have been considered.
- Decisions are recorded in decision logs at both Gold/HECC (Silver)/Workstreams/OCC (Bronze), however we have noted that not all decisions may have been formally recorded. Clear guidance was published detailing, the process for loggists to document decisions that follow a prescribed format.
- From a sample of expenditure reviewed, we noted some decisions were not formally recorded and this is supported in reports submitted to Cabinet by Gold and HECC Command that detailed *"Reviews of work stream decision logs have been undertaken….whilst improvements have been made, there is still a need for improvement…in relation to consistency of recording;*

detail included and available e.g. evidence of consideration given to options/risks etc.".

What could be done differently in the future

We advise that priority should be given to considering the following:

- The Health Board Chair should not be required to Chair any operational group.
- Guidance, approved by the Board, detailing what and when the Board (and its Committees) is required to be involved with decision making. This can be used for future mobilisation of the process, in event of potential future peaks.
- Review emergency planning arrangements and reporting structures to ensure reporting arrangements do not become burdensome to Members.
- Whether an approved SORD is established for Emergency Planning for any future situations of such magnitude and over a prolonged period necessitating governance changes. Consideration to include within Business Continuity/Emergency Planning documentation.
- Reviewing the decisions and supporting justification/information in order to ensure that they are sufficiently logged and reported to the Board, as required. Whilst there is a balance between expedience and justification, it is important that all elements of this process are sufficiently documented. This may vary between different types, values and levels of decisions, but this decision should be justifiable post-event.
- Within the Emergency Plan, a suite of actions, setting out the steps to take immediately, through to ongoing requirements (e.g. records required, meeting groups, Decision Log requirements) should be established in preparation for future events.

Risk Management

What we found

Our review identified the following:

- Risk Management Strategy remained extant throughout although we noted observations from the Vice Chair concerning how risks were being managed in Cabinet.
- We noted that Datix and Workstream risks were reported separately and not through one overarching register, with action being taken to remedy this.
- The Board continued to receive the Corporate Risk Register throughout the pandemic.
- A specific Covid risk register was developed and included regular reporting to the Cabinet.
- We also found that risks were being considered by Workstreams and reported to Gold/HECC through the COVID Command Group.
- Whilst risks may have been considered as part of decision making, and the pace needed to keep the process as simple as possible, we have been unable to confirm that decisions were supported by a formal risk assessment process. The Guidance on Decision Making for Command – Gold, Tactical – Silver and Operational - Bronze did not provide the criteria for rating High/Medium/Low.
- COVID Command Group recorded the importance of not losing sight of risks and moving these across for business as usual – it is unclear if/how this has been progressed.
- We were provided with a first draft Finance Directorate business continuity plan having been developed on 18th March 2020 that requires completion and adopting.

What could be done differently in the future

We advise that priority should be given to considering the following:

- Refreshing all continuity plans throughout the Health Board to ensure lessons learnt/experiences can be incorporated.
- COVID Command Group risks are migrated and form part of operational management risks.
- Consider the likelihood of other non-Covid risks increasing during the pandemic, e.g. cyber-attacks.

Furthermore, we suggest the following considerations as the organisation looks forward:

- Updating the Emergency Response Plan for any changes arising from this review and the lessons learnt review being undertaken.

- Any future decision making framework should incorporate a more formal risk assessment process over decisions completed.

Financial Governance

Annual Accounts and Reporting

What we found

Our review identified the following:

- Audit Wales presented the ISA 260 report on the 29th June 2020 to the Audit Committee and noted that the draft accounts had been prepared by the 7th May 2020 despite a longer timeline permitted of the 22nd May 2020. This is a notable achievement by the Finance Directorate with the accounts being produced by the team working remotely.
- Audit Wales did not observe any significant issues in the audit of the draft accounts.
- The Annual Governance Statement was produced within the required timescales and complied with Welsh Government guidance.

What could be done differently in the future

We suggest the following consideration as the Health Board looks forward:

- The benefits of preparing the final accounts and completing the accompanying statutory audit remotely should be reviewed and retained for future financial years. Any efficiencies implemented to assist in the delivery should be retained / expanded upon by the Finance Directorate.

Authorised Signatories/ Electronic Approval Hierarchy / Delegated limits

What we found

At the outset we were advised that no changes were made to delegated limits throughout the Health Board as all delegation remained extant.

As part of our review we did note that the Mental Health and Learning Disabilities Division did update their Scheme of Delegation for administrative reasons and not directly for the Pandemic.

What could be done differently in the future

We suggest the Division submits the revised Scheme of Delegation to the Board Secretary and Audit Committee for ratification.

Financial Systems and Processes

What we found

Our review identified the following:

- Financial procedures (FCPs) were not updated as a result of the pandemic, as whilst it was considered, there were no changes to incorporate.
- We were advised that there are some assets on loan from Welsh Government that will be returned when no longer required. As these assets are not owned by the Health Board, it is unclear which asset register is tracking these centrally procured assets.
- We were provided with details of an indemnity document provided by NHS Wales Shared Services Partnership (NWSSP) but are unclear whether these arrangements/insurances have been updated to capture all locations created for Test, Trace, Protect (TTP), particularly within the Wrexham County area.
- Chief Finance Officers told us additional stock controls were implemented to focus on the pressures concerning Personal Protective Equipment (PPE) during the pandemic. We were advised that regular reporting of levels operated. Whilst there was a focus on maintaining sufficient stock and security of stock, were advised of a theft at Ysbyty Gwynedd where North Wales Police have been informed.
- There have been no Health Board losses or write offs relating to COVID-19 recorded during the pandemic.

What could be done differently in the future

We advise that priority should be given to considering the following:

- Liaise with the Welsh Risk Pool team to establish what the insurance requirements are for operating all additional sites e.g. TTP.

Furthermore, we suggest the following considerations as the organisation looks forward:

- Assets on loan from Welsh Government and other NHS Wales organisations, if any, are tracked via a suitable asset register.
- Controls over desirable stock (for example, hand gel, face masks and gloves) continue to be secured appropriately to reduce the risk of theft.

Covid-19 Expenditure (Revenue and Capital)

What we found

Our review identified the following:

- The Scheme of Reservation and Delegation and delegated financial limits were not changed and therefore all expenditure control limits remained as business as usual.
- Chair's Actions were utilised to ensure a swift authorisation of expenditure for the three Ysbyty Enfys sites and were recorded at Cabinet and subsequently reported to the Board in summary. Whilst the process ensures scrutiny from relevant officers and limited Board Members, it is not apparent what steps could be taken if concerns arose over the expenditure when reviewed in the wider Committee/Board setting.
- The Acting Director of Finance has created the Finance Governance Cell that is scrutinising all levels of expenditure attributed to the pandemic. Further, the Cell is scheduled to provide a report to the Acting Director imminently detailing lessons learnt (Internal Audit are supporting the Cell in a consultancy capacity).
- Agency spend is captured and included within the wider finance reports presented to the Board. At month 3, total agency costs amounted to £1.152m with administrative and clerical accounting for 46% of the cost (£527k). It is unclear whether specific COVID-19 costs have been routinely reported to Cabinet/Board.
- The Acting Director of Finance wrote to Directors and senior staff on the 3rd April 2020 advising of the process to be followed when completing pandemic specific expenditure and required the completion of a capital / revenue fund request form template. From our limited review, these forms were not routinely completed for all expenditure or included as an attachment with the relevant e-financial requisition.
- Revised planning assumptions have been completed within quarter 1 and 2 plans respectively, incorporating the impact of Covid-19, but there is a lack of explanation provided for extra funding sought for some items and why these cannot be met from the existing funding allocation.
- At the time of reporting, additional funding required has yet to be agreed by the Welsh Government, representing a significant financial risk for the Health Board. This has been formally reported to the Board which we recognise as good practice.
- We reviewed expenditure and sought to reconcile a sample of commitments back to decision making logs. We found that this was not easily possible.
- Specific Covid cost centres have been established, with specific linkage to the existing Oracle hierarchy approval limits.
- Expenditure posted to Covid cost centre codes was actively reviewed by Finance to ensure requisitions were appropriate. We were advised that

scrutiny of expenditure has resulted in at least £200,000 being re-classified as non-COVID-19 expenditure and coded back into business as usual costs.

- Using the data compiled by the Finance Governance Cell, it has identified some expenditure has not progressed in accordance with seeking competitive quotation/tender. Further, business cases for investment through revenue or capital had been completed in accordance with relevant procedures – we have been advised these procedures were not stood down.
- During meetings we were advised that no specific payments were made in advance, per classification within the Standing Financial Instructions. However, the Health Board has continued to make payments to third sector providers despite not receiving their service. Similarly, maintenance services may not have been received due to the statutory restrictions placed upon service providers.
- We could not confirm the regular reporting of capital expenditure or that some expenditure received appropriate authorisation in accordance with the Scheme of Reservation and Delegation that remained extant and had not been amended to delegate approval to Gold.

What could be done differently in the future

We advise that priority should be given to considering the following:

- Ensuring that a clear audit trail of decisions made is retained for each decision.
- Implementing a decision-making framework to set out what decisions require which tier of authorisation and the level of documentation required to support it.
- Formally report to the Audit Committee, through the existing conformance report, all items of expenditure that have not followed the requirements of the Standing Financial Instructions and/or Scheme of Reservation and Delegation.
- Business cases for both revenue and capital continue to be adhered to/abridged version developed to meet the pressures in dealing with a pandemic.

Workforce

What we found

Our review identified the following:

- An integrated workforce surge model plan was reported to Cabinet on the 30th April 2020.
- We reviewed a sample of new starters and for those posts that required approval through establishment control, confirmed that this had been undertaken.
- We then sought to confirm the completion of the required pre-employment checks for the sample. However, at the time of producing this advisory paper we have not received the relevant supporting documentation from the recruitment team at NWSSP employment services, with which to verify this.
- Sickness rates reported for the period to May 2020 note a rate of 5.65% overall in the Health Board.
- Overtime payments to Band 8a and above was approved by the Workforce Workstream however the paper shared with us notes only in relation to HECC. In accordance with the Scheme of Delegation, overtime approval is controlled through the divisional SORD which requires the Director to approve. This decision was not escalated Gold or Board with officers paid at time and a half.

  We have been advised that at month 3, total overtime paid to Band 8a 9 inclusive was £253,952. We have not reviewed authorisation or control over requesting overtime to be undertaken as the Governance Cell is undertaking a detailed review.
- A redeployment process was established, with a central log maintained of staff redeployed and those that could be redeployed.
- The Health Board agreed a number of welfare initiatives throughout the pandemic and arranged accommodation for staff isolating from their home to ensure continuity of care.
- A recruitment campaign was implemented to redeploy and recruit additional staff for wards, with healthcare support workers and estates and ancillary staff recruited, with the pre-employment process remaining in place. The number of volunteers was significantly increased to support the Health Board.

What could be done differently in the future

We suggest the following considerations as the organisation looks forward:

- Build on current testing arrangements and arrange regular staff Covid testing throughout the Health Board to reduce the instance/duration of medical exclusion absence.

- Consult and agree in advance pay rates that will apply during any future period of pandemic induced surge, ensuring changes to terms and conditions are appropriately escalated and approved through the Board governance structure.
- The Health Board should seek assurance from NWSSP Employment Services that agreed pre-employment checks are completed in line with requirements.

Budget and Savings

What we found

Our review identified the following:

- Financial Plan for 2020/21 was considered at the Board meeting 15th April 2020. The plan does not include COVID-19 expenditure and this is noted at the outset but reference made to the risks. The Board endorsed and approved the recommendations made.
- The Health Board received the month 1 and 2 finance reports at its meeting of the 23rd July 2020. Month end processes, despite the impact of the pandemic, have not been amended and continue to operate as before. The impact of COVID-19 on the financial position has been highlighted as a significant financial risk.
- The savings position is reported in monthly finance reports, which are subsequently reported to the Welsh Government but many schemes have been paused as the Health Board responded to the pandemic.
- The Health Board did not achieve its savings target in 2019/20 and has set itself a challenging target of £45m in 2020/21.

What could be done differently in the future

We suggest the following consideration as the organisation looks forward:

- With the additional expenditure incurred as a result of Covid-19, the Health Board should refocus efforts onto savings and efficiency plans. This will become even more pertinent if the request to the Welsh Government for additional funding is not fully granted.

Other Areas of Governance

Partnership Arrangements

What we found

Our review identified the following:

- The Health Board established three temporary hospitals 'Ysbyty Enfys' through partnership agreements utilising two local authorities and a University location pan North Wales.
- The Regional Partnership Board met on the 18th May 2020 with some focus on using the Integrated Care Fund to support organisations with the impact of COVID-19.

What could be done differently in the future

We suggest the following considerations as the organisation looks forward:

- Continue the positive engagement with partners to ensure arrangements are confirmed and in place, in preparation for future outbreaks.
- Continually review the capacity situation to ensure sufficient capacity is available in the event of surge demand for beds if there are further peaks.

Cross-Border Flows and Long Term Agreements

What we found

Our review identified the following:

- The Acting Director of Finance provides regular monthly reports to the Board, within the finance report, on the status of cross border activity where the Health Board purchases services from a number of providers.
- The month 2 finance report clearly notes the totality of payments the Health Board continues to make, in line with national guidance, despite those organisations not undertaking work on behalf of the Health Board.

  The Health Board continues to make payments totalling £22.7m per month without any recourse.

Future consideration

The Health Board is exposed to the likelihood it will pay for services it has already paid for within a timeframe that increases delays in treatment for North Wales patients. An opportunity now exists to start planning and develop, with other NHS Wales organisations, opportunities to increase capacity and develop the expertise within Wales, thus reducing the reliance on other providers.

Charitable Funds

What we found

Our review identified the following:

- We were informed that charitable donations are continuing to be processed in accordance with the charitable objectives of the Charity.
- Guidance issued titled 'COVID-19 Voluntary Support Plan' was shared across the Health Board that covered a number of areas including fund raising appeal, response grants and volunteers.

  We have been unable to confirm that the Charitable Funds Committee approved the support plan in advance of publication, through Chair's Action as the meeting was on the 10th March 2020.
- The Charitable Funds Committee, per the support plan, agreed funding of £50,000 for mental health support for frontline staff during and post the COVID-19 response period. Additionally, the COVID-19 Units in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor were allocated £2,000 from this fund initially for staff expenditure refunds.
- A JustGiving page was established as well as donating via Text number to "Awyr Las C19" to give £5 towards the COVID-19 Response Funds.
- Guidance notes that expenditure must be additional to what the NHS provides.
- A report on the amount of donations and expenditure was presented to the Charitable Funds Committee meeting on the 25th June 2020.

What could be done differently in the future

We suggest the following consideration as the organisation looks forward:

- Charitable Funds Committee formally records approval of any future support plans and that the guidance is sought to ensure internal controls are sound when approving expenditure outside the established E-Financials hierarchy.

Counter Fraud arrangements

What we found

Our review identified the following:

- The Audit Committee meeting of the 29th June 2020 received the annual counter fraud report that highlighted the impact COVID-19 had had on delivering its service but also the pro-active status of some fraud-proofing procedures.
- Counter Fraud remained operational throughout and fraud updates were included in the weekly bulletins.
- We were advised that both Health Board staff and Primary Contractors have kept contacting the team for advice throughout.
- Although the Counter Fraud Team were working remotely in common with most non-clinical staff, they have been contactable via dedicated mobile phones, email and Skype.
- The Team have used technology to their advantage and advised that they delivered Fraud Awareness presentations to GP Trainees using MS Teams.
- Of note however, the Counter Fraud team confirmed that overall fraud referrals were down during the period of the pandemic. However they believe this could be down to a number of reasons including:
    - arrangements in place nationally for instance PPV is stood down until October,
    - some on-going LCFS cases were hindered as they cannot progress for instance Interviews Under Caution in person.

What could be done differently in the future

We have no suggestions as the organisation looks forward.

Information Governance

What we found

Our review identified the following:

- The Senior Information Risk Owner (SIRO) is HECC Silver Commander involved in the Strategic Group meetings.
- There is a strong link and involvement of the Information Governance Team around the procurement of IT and homeworking processes.
- A consistent approach across Wales has been established via the National Information Governance Managers' Group (IGMAG), which helps set processes and guidance for the use of technology at home.
- There has been a focus around Covid information governance risks, with a specific document on the Health Board's website developed to provide guidance (COVID-19 NHS Wales Information Governance Joint Statement).
- Information governance advice and guidance has been provided as and when required throughout the pandemic.
- Face to face training has been suspended.
- The Data Protection Impact Assessment (DPIA) process has been streamlined to remove redundant elements. A log is kept to ensure full review once returned to business as usual.
- Freedom of information request are managed with publications available on internet, in some instances, information requests were withdrawn.
- Preparations in place for a predicted surge in subject access requests (SARs).
- Operational processes for cyber security have not changed during the pandemic.
- Encryption and other security measures were maintained during the increased numbers of laptops (and other IT equipment) issued.
- Existing security arrangements have continued (for example, monitoring mail for viruses / malware etc.).
- NHS Wales Operational Security Service Management Board (OSSMB) meetings took place on a weekly basis, with the Cyber Security and Compliance Officer attending, however we cannot corroborate attendance at all meetings.
- Closure document of Governance workstream identifies all changes actioned within this remit.

What could be done differently in the future

We advise that guidance is developed setting out:

- The need to maintain privacy in the household when using video conference/telephone call or other applicable work from other household members.

- Ensuring that laptops are locked when not in use/away from the desk. This is even more important in a public environment if agile working is to be promoted, for example, coffee shops. Consideration could be given to reducing the screen lock functionality within Windows.
- How physical copies of information are held and how they should be securely stored away from other household members/visitors.
- The risk that staff using their own devices at home are potentially more susceptible to malware/phishing attacks, as they may have insufficient security on their phones/home computers etc. This is likely to be more relevant with people able to access the OneDrive/Office 365 with just an internet connection from any device.

Appendix One – Guidance, Principles and Scope

Guidance and Principles

In its response (dated 26 March 2020) to a letter received on behalf of the Board Secretaries Group, Welsh Government agreed the Governance Principles that are designed to help focus consideration of governance matters.

The Principles are:

- public interest and patient safety;
- staff wellbeing and deployment;
- governance and risk management;
- delegation and escalation;
- departures from existing policies and processes;
- one Wales (acting in the best interest of the whole of Wales); and
- communication and transparency.

In particular, the Welsh Government reiterated the importance of continuing the role of both the Audit Committee and the Quality, Safety and Experience Committee during the Covid-19 outbreak, in supporting the Board with discharging its responsibilities.

Further detailed guidance was issued regarding financial governance in Covid-19 Financial Guidance to all NHS Wales' Organisations and the Covid-19 Decision Making and Financial Governance Letter from the Director General Health and Social Services/NHS Wales Chief Executive Welsh Government dated 30th March 2020.

Scope of this Advisory Review

The advisory review assessed the adequacy and effectiveness of internal controls in operation during the Covid-19 outbreak, with particular regard to the Principles set out by the Welsh Government regarding maintaining financial governance.

This review focused on the following Principles:

- governance and risk management;
- delegation and escalation; and
- departures from existing policies and processes.

In particular, we undertook interviews and review of documentation:

- to ensure that appropriate key decisions are made through the revised management arrangements, with risk, impact and value for money adequately assessed;
- to confirm that the Scheme of Delegation and escalation requirements are adhered to;
- to ensure appropriate oversight and scrutiny remains by the Board over applicable matters – for example, the risk appetite level set;

- to ensure that departures from existing standards, frameworks, policies and procedures are appropriately documented and reviewed regularly, but still in accordance with the Principles; and
- to determine if the command structure established (i.e. Gold, Silver and Bronze) is appropriate – for example, achieving the Principles set out by the Welsh Government.

In our interviews with Board Members we discussed the remaining Principles and where appropriate commentary on those is include in the detail of this report.

The potential risks considered in this review are as follows:

- decisions are not completed in the best interest of the public;
- statutory requirements are not met;
- inappropriate expenditure and financial commitments;
- insufficient scrutiny of the risks associated with each key decision;
- the Welsh Government Principles are not adhered to; and
- inappropriate governance arrangements.

As this is an advisory review, the assignment is not allocated an assurance rating, but we have suggested some considerations for the future, should temporary governance arrangements be required in response to further peaks in the future.

Appendix Two – What we did

We undertook the following review activity:

- Interviewed the following Members and Officers, some in partnership with the Audit Lead, Audit Wales:
  - Chair of the Strategy, Partnerships and Population Health Committee;
  - Acting Director of Finance & HECC Silver Commander;
  - Director of Workforce and Organisational Development & HECC Silver Commander;
  - Chair of the Health Board;
  - Acting Board Secretary;
  - Vice Chair and Chair of the Quality, Safety and Experience Committee;
  - Director of Planning & Performance;
  - Deputy Chief Executive & Director of Nursing and Midwifery;
  - Chair of the Audit Committee;
  - Medical Director;
  - Acting Director of Mental Health and Learning Disabilities;
  - Director of Primary and Community Care & Gold Commander;
  - Interim Chief Executive;
  - Associate Director, Workforce and Organisational Development;
  - Associate Director of Health, Safety & Equality;
  - Area Director, West;
  - Area Director, Central;
  - Interim Managing Director – Ysbyty Glan Clwyd;
  - Chief Finance Officer, Central Area;
  - Chief Finance Officer, Mental Health and Learning Disabilities Division;
  - Chief Finance Officer, Ysbyty Wrexham Maelor;
  - Assistant Director of Information Governance & Risk (Acting Board Secretary March to May 2020); and
  - Assistant Director, Corporate Governance.
- Reviewed notices, agendas and minutes of the Board, Cabinet, Audit Committee and Quality, Safety and Experience Committees from March 2020 onwards.

- Reviewed the public availability of the respective committee papers and in particular the hosting of them onto the Health Board's webpage (www.bcuhb.nhs.wales).
- Reviewed the risk register(s) for Covid and non-Covid risks.
- Reviewed consideration of Committee business.
- Reviewed the Standing Orders, SoRD and Standing Financial Instructions and any associated changes to the documents.
- Reviewed the Chair Actions relating to COVID-19.
- Reviewed the Executive Team minutes/notes.
- Reviewed the papers/documentation/logs from Gold; HECC (Silver) and Workstreams.
- Reviewed evidence of any business cases presented to the respective groups.
- Selected a sample of three key decisions from Gold Decision Log and sought evidence of the risk assessment.
- Reviewed the response plans and business continuity arrangements within Finance.
- Reviewed the revised timetable for reporting of annual accounts.
- Obtained and reviewed saving plans Covid-19 staff and non-staff recorded costs.
- Reviewed the command structure for managing Covid arrangements.
- Reviewed the assets directly linked to the pandemic.
- Reviewed indemnity arrangements within the Health Board.
- Received and identified a sample of new starters.
- Reviewed summary overtime information.
- Identified additional capacity procured.
- Obtained discretionary capital project information, including expenditure incurred.
- Reviewed charitable funds arrangements and any changes to policies.
- Shared information and emerging findings with Audit Wales for consistency.

Cyfarfod a dyddiad: Meeting and date:	**17th September 2020**
Cyhoeddus neu Breifat: Public or Private:	All Audit Wales papers will be in the public agenda of the committee
Teitl yr Adroddiad Report Title:	• Audit Wales programme update • Effectiveness of counter fraud arrangements at the Health Board. • 'raising our game' tackling fraud in Wales – national report
Cyfarwyddwr Cyfrifol: Responsible Director:	Acting Board Secretray, on behalf of the executive team
Awdur yr Adroddiad Report Author:	Andrew Doughton and Amanda Hughes
Craffu blaenorol: Prior Scrutiny:	All final Wales Audit Office reports on Betsi Cadwaladr University Health have passed through a clearance process with the lead Executive Director.
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Audit Committee is requested to:

- Receive the programme update
- Receive and discuss the reports on Counter Fraud services.

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

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

Sefyllfa / Situation:

The documents for audit committee include an update on the delivery of the external audit programme at the Health Board, references to new national publications and novel practice work which is led and coordinated as part of the approach to collecting and sharing good practice. Covid 19 has impacted the delivery of the performance audit programme and is under a process of regular review, with the latest position set out in the update.

The counter fraud reports provide both local and national findings from our recent review.

Cefndir / Background:

Asesiad / Assessment & Analysis

Strategy Implications

Financial Implications

Effectiveness of counter-fraud arrangements is a key element for safeguarding the proper use of public funds, through prevention and awareness raising, detection, and investigation.

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

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Impact Assessment

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

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: September 2020

Document reference: 2021A2020-21

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

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Contents

Audit Committee Update

About this document

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

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2020-21.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2019-20 Accountability Report and Financial Statements	Completed. Certified by the Auditor General on 2 July 2020 and laid by the Senedd on 3 July 2020.
Audit of the 2019-20 Funds Held on Trust Accounts	The audit will be commencing in late September and is scheduled to be completed (and the accounts certified) in December 2020, ahead of the Charity Commission's deadline of 31 January 2021.
Audit of the 2020-21 Accountability Report and Financial Statements	Audit planning is scheduled to start in December.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- completed work since the last Audit Committee update (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Review of interim director appointment arrangements	March 2020
The Refurbishment of Ysbyty Glan Clwyd	Received final draft 'in committee' July 2020, prior to publication in September
Effectiveness of Counter-Fraud Arrangements	September 2020

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Continuing Healthcare management arrangements Executive Lead: Chris Stockport	This review considers the extent to which the corporate CHC function is able to maintain strategic oversight and monitor compliance and performance of continuing healthcare services.	Draft report issued for clearance 3 September 2020

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Structured Assessment 2020	Our annual structured assessment is one of the main ways in which the AGW discharges his statutory requirement to examine the arrangements NHS bodies have in place to secure efficiency, effectiveness and economy in the use of their resources. In the context of Covid-19, this work will examine governance arrangements, managing financial resources and operational planning.	Drafting report December 2020
Review of Welsh Health Specialist Services Commissioning Committee	This work will focus on the governance and assurance arrangements of WHSSC. Fieldwork was well-progressed prior to the pandemic, but we revised the methodology for capturing views of health board Chairs and CEOs. We are seeking to complete fieldwork in September.	Fieldwork ongoing December 2020
Orthopaedic services – follow up Executive Lead – Chief Operating Officer	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Report being drafted December 2020
Test, Track and Protect	In response to the Covid-19 pandemic, this work will take the form of an overview of the whole system governance arrangements	Fieldwork underway TBC

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Director of Public Health	for Test, Track and Protect, and of the Local Covid-19 Prevention and Response Plans for each part of Wales.	
A cross-cutting review focussed on North Wales partnerships Executive Lead: Chris Stockport	The exact nature of this work will be discussed with the Health Board and other partners, including local government bodies. The scoping meeting is scheduled for September 2020	Scoping

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Ophthalmology services Executive Lead: Gill Harris and Chris Stockport	Our review will assess the economy, efficiency and effectiveness of ophthalmology services alongside wider service modernisation plans.	In light of the demands cause by COVID-19, we are considering options to postpone or replace this work

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead TBC	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Data analysis currently being completed Further work postponed to 2021 and replaced with work on Test, Track and Protect TBC
Quality Governance Executive Lead TBC	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Fieldwork on hold TBC

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 **Exhibit 5** outlines the upcoming and recent Good Practice Exchange (GPX) events which have been held in the last 12 months. Materials are available via the links below. Details of future events are available on the GPX website.

Exhibit 5 – Good practice events and products

Event	Details
Cyber Resilience in Wales Wednesday 23 September 2020 15:00 – 16:30.	Delegates will get a preview of the emerging findings from our national study on cyber resilience in Welsh public sector bodies. To register for the seminar please complete our online booking form [opens in new window].
Unearth the value in your data (January 2020)	This webinar was for organisations that want to transform the way they collect, analyse and use data, at all levels. There are no materials available following the webinar.
Working together to identify and reduce vulnerability (February 2020)	This seminar focussed on how to achieve effective governance and accountability in partnership working to deliver efficient public services. There are no materials available following the seminar.

6 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

NHS-related national studies and related products

7 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh

Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

8 **Exhibit 6** provides information on the NHS-related or relevant national studies published in the last 12 months. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 6 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
'Raising Our Game' - Tackling Fraud in Wales	July 2020
Rough Sleeping in Wales – Everyone's Problem; No One's Responsibility	July 2020
NHS Wales Finances Data Tool - up to March 2020	July 2020
Findings from the Auditor General's Sustainable Development Principle Examinations	May 2020
Progress in implementing the Violence Against Women, Domestic Abuse and Sexual Violence Act	November 2019
Primary care services in Wales	October 2019
Review of Public Services Boards	October 2019
Fuel Poverty	October 2019
Public Spending Trends in Wales 1999-00 to 2017-18	September 2019
Preparations in Wales for a 'no-deal' Brexit - follow-up letter	September 2019

Title	Publication Date
The well-being of young people	September 2019
The ‘front door’ to adult social care	September 2019

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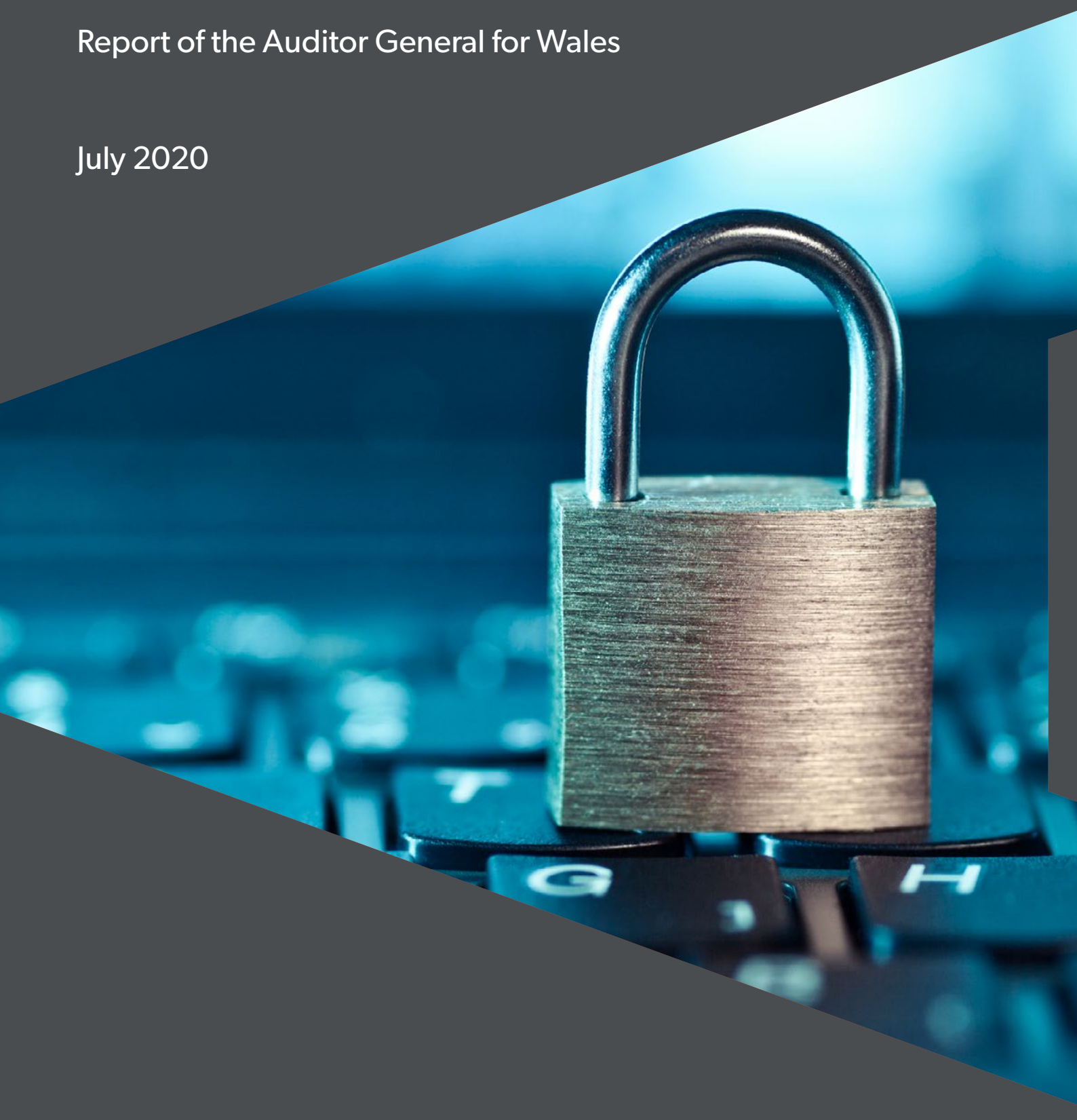
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

‘Raising Our Game’
Tackling Fraud in Wales

Report of the Auditor General for Wales

July 2020



This report has been prepared for presentation to the Senedd under the Government of Wales Acts 1998 and 2006 and the Public Audit (Wales) Act 2004.

The Audit Wales study team comprised Rachel Davies, Christine Nash and Ian Hughes, under the direction of Mike Usher.

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

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

For further information, or if you require any of our publications in an alternative format and/ or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Foreword by the Auditor General

1 In June 2019, I published a report giving an overview of the scale of fraud in the Welsh public sector, together with a description of counter-fraud arrangements across the Welsh Government, the NHS and Local Government. I noted that the sums lost annually in Wales to fraud and error are significant – and could be anywhere between £100 million and £1 billion. The Crime Survey for England and Wales recognises fraud as being one of the most prevalent crimes in society today.

2 However, some senior public sector leaders are sceptical about the levels of fraud within their organisations. As a result, they are reluctant to invest in counter-fraud arrangements and assign a low priority to investigating cases of potential fraud identified to them by the National Fraud Initiative, even though there are many examples of a good return on investment in this area. Their stance runs contrary to all the research being done by recognised leaders in the field such as CIPFA and the UK Government's Counter Fraud Function. This latest report, which examines the effectiveness of counter-fraud arrangements at over 40 public-sector bodies in Wales, has found that where such scepticism arises, it is not based on any significant local counter-fraud work or robust fraud risk assessments.

3 But we also know that fraudsters appear the very instant that an opportunity presents itself. Fifteen individuals have to date been jailed for fraud in the light of the Grenfell fire tragedy. Fraudsters and scammers were quickly on the scene earlier this year whilst the flooding in South Wales was ruining the homes and lives of local people. There has been an explosion in fraudulent activity, and especially in cyber crime, during the current COVID-19 pandemic. I welcome the proactive steps which the Welsh Government has taken to raise awareness across the public sector in Wales about this risk.

4 Public sector bodies can mitigate these risks by having the right organisational culture supported by strong counter-fraud arrangements. Many local authorities have invested so little in counter-fraud arrangements that they have only a few of the key components in place. Whilst the position is generally much more robust across the NHS in Wales, there is still a challenging agenda to make counter-fraud fit for the next decade where globalisation and the advent of digital technology have created new risks, and opportunities, for the fraudsters.

5 I was heartened to see the Welsh Government's positive response to my 2019 report and, following the one-day conference organised by the Public Accounts Committee in July 2019, the Permanent Secretary's commitment (see **Appendix 2**) to provide Wales-wide leadership in raising the profile of counter-fraud activity.

6 In this latest report, based on a more extensive programme of field work, we identify a significant range of further opportunities to improve on the current national position, including:

a strengthening strategic leadership, coordination and oversight for counter-fraud across the Welsh public sector;

b increasing counter-fraud capacity and capabilities, especially across local government, and exploring the potential for sharing resources and expertise across public bodies;

c getting the right balance between proactive and reactive counter-fraud activities;

d improving awareness-raising and staff training in counter-fraud; and

e better evaluation of fraud risks and sharing of fraud information, both within and across sectors.

7 There is also significant potential for Wales to take advantage, where appropriate, of many of the counter-fraud initiatives underway across the wider UK public sector. These include the recent establishment of a recognised government counter-fraud profession, with defined competencies and career paths, and the increasing focus on tackling fraud by smarter use of data analytics.

8 As I publish this report, Wales continues to grapple with the effects of the COVID-19 pandemic. This report contains a timely illustration of some of the ways in which fraudsters have moved rapidly in recent months to exploit the pandemic for criminal gain. I have already taken steps to extend the scope of our National Fraud Initiative (NFI) to enable local authorities in Wales to undertake eligibility checks on applications for COVID-19 support grants. I am also proposing to mandate that all local authorities, together with the Welsh Government, should submit COVID-19 grant and payment data to the NFI, to help identify fraudulent applications.

Adrian Crompton
Auditor General for Wales

4 Summary and recommendations

Ensuring that the arrangements for preventing and detecting fraud in the Welsh public sector are effective

This report examines seven **'key themes'** that all public bodies need to focus on in raising their game to tackle fraud more effectively:

- leadership and culture;
- risk management and control frameworks;
- policies and training;
- capacity and expertise;
- tools and data;
- collaboration; and
- reporting and scrutiny.

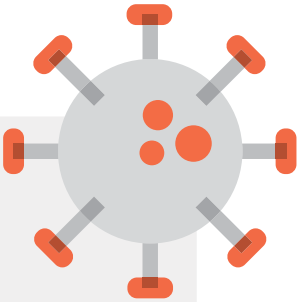
For each theme in turn, the report examines:

- why it is important;
- what our audit fieldwork identified in terms of current working practices and their effectiveness across the 40 Welsh public sector bodies that we examined (listed in **Appendix 1**); and
- what needs to happen next to generate improvement.

Our **recommendations for improvement** which are addressed to all public bodies in Wales within the Auditor General's remit, are as follows:

Theme	What needs to happen next?
Leadership and Culture 	**R1** The Welsh Government should enhance its strategic leadership of counter-fraud across the public service in Wales, playing a coordinating role where it can, while recognising that individual bodies remain responsible for their own counter-fraud activities. **R2** All public bodies should champion the importance of a good anti-fraud culture and actively promote its importance to give confidence to staff and members of the public that fraud is not tolerated.
Risk management and Control framework 	**R3** All public bodies should undertake comprehensive fraud risk assessments, using appropriately skilled staff and considering national intelligence as well as organisation-specific intelligence. **R4** Fraud risk assessments should be used as a live resource and integrated within the general risk management framework to ensure that these risks are appropriately managed and escalated as necessary.
Policies and Training 	**R5** All public bodies need to have a comprehensive and up-to-date set of policies and procedures which together represent a cohesive strategy for identifying, managing and responding to fraud risks. **R6** Staff working across the Welsh public sector should receive fraud awareness training as appropriate to their role in order to increase organisational effectiveness in preventing, detecting and responding to fraud. **R7** Cases where fraud is identified and successfully addressed should be publicised to re-enforce a robust message from the top that fraud will not be tolerated.

Theme	What needs to happen next?
Capacity and Expertise 	**R8** All public bodies need to build sufficient capacity to ensure that counter-fraud work is resourced effectively, so that investigations are undertaken professionally and in a manner that results in successful sanctions against the perpetrators and the recovery of losses. **R9** All public bodies should have access to trained counter-fraud staff that meet recognised professional standards. **R10** All public bodies should consider models adopted elsewhere in the UK relating to the pooling /sharing of resources in order to maximise the availability of appropriately skilled staff.
Tools and Data 	**R11** All public bodies need to develop and maintain dynamic and agile counter-fraud responses which maximise the likelihood of a successful enforcement action and re-enforces the tone from the top that the organisation does not tolerate fraud. **R12** All public bodies should explore and embrace opportunities to innovate with data analytics in order to strengt hen both the prevention and detection of fraud.
Collaboration 	**R13** Public bodies should work together, under the Digital Economy Act and using developments in data analytics, to share data and information to help find and fight fraud.
Reporting and Scrutiny 	**R14** Public bodies need to collate information about losses and recoveries and share fraud intelligence with each other to establish a more accurate national picture, strengthen controls, and enhance monitoring and support targeted action. **R15** Audit committees must become fully engaged with counter-fraud, providing support and direction, monitoring and holding officials to account.



The COVID-19 pandemic: a case study in how scammers and fraudsters are ready to exploit a crisis

We know from experience that fraudsters appear the very instant that an opportunity presents itself. Fifteen individuals have to date been jailed for fraud in the light of the Grenfell fire tragedy. Fraudsters and scammers were quickly on the scene earlier this year whilst the flooding in South Wales was ruining the homes and lives of local people.

Predictably, there has been an explosion in fraudulent activity, and especially in cyber crime, during the current COVID-19 pandemic.

The first reported positive cases of COVID-19 were reported in the UK on 31 January 2020. By this time the fraudsters and scammers had mobilised and were already hard at work.

The first fraud report relating to COVID-19 was received on February 9 by Action Fraud, the UK's fraud reporting centre. Since that time, the number of reports has increased significantly across the UK – the media reporting an unprecedented number of scams linked to the virus.

We have seen examples of good practice by some public bodies and organisations in Wales in identifying the fraud risks and sharing them with other bodies and citizens. The Welsh Government is liaising with the UK Cabinet Office and is sharing its guidance and learning on counter-fraud with the rest of the public service in Wales, including Local Authority Counter Fraud leads. Welsh Government officials have agreed to maintain and develop this group post-COVID. The intelligence obtained from these meetings has also assisted the Head of Counter Fraud with fraud intelligence sharing with Cabinet Office and the three other devolved administration fraud leads.

But has the Welsh public sector response been more reactive than proactive? What can we do better? Whilst globalisation has benefited the fraudsters it can also be to the advantage of counter-fraud specialists; we had early notice of scams from thousands of miles away a few weeks before the first case of COVID-19 was identified in the UK.

The COVID-19 pandemic: a case study in how scammers and fraudsters are ready to exploit a crisis

We believe that the COVID-19 pandemic provides an important opportunity for the Welsh counter-fraud community to come together (by appropriate means) and reflect on the speed and effectiveness of its response to the scammers and fraudsters.

The key issues and recommendations set out in this report could help set an agenda or framework for such an event. There has never been a timelier opportunity for Welsh public sector leaders and counter-fraud specialists to consider how to:

- create stronger strategic leadership, coordination and oversight for counter-fraud across the Welsh public sector;
- make best use of counter-fraud capacity and capabilities and explore the potential for shared arrangements, resources and expertise;
- get a better balance between proactive and reactive counter-fraud activities;
- raise awareness amongst employees and provide the necessary training to those most likely to come across a fraud; and
- evaluate fraud risks more effectively and share fraud information both within and across sectors.

So, what do we already know about the fraudsters' response to the pandemic?

The mobilisation of fraudsters has benefited from a number of factors, for example:

- more people are spending time online to shop and socially interact. Elderly people are seen as particularly vulnerable, being generally less computer literate and more susceptible to scams such as phishing emails and ordering fake products such as face masks and sanitisers.
- working patterns have changed at short notice which can leave weaknesses in processes and procedures.
- an unprecedented amount of public money has been put into a range of new and innovative financial support schemes to businesses and individuals.

The COVID-19 pandemic: a case study in how scammers and fraudsters are ready to exploit a crisis

Fraudsters and scammers mobilised quickly for a number of reasons:

- they are very good at evaluating risks and exploiting vulnerabilities which can be at a process or at an individual level;
- they have well-established tools and methodologies and can adapt them at short notice to a new opportunity; and
- they do not recognise geographical boundaries and can be effective individually and by collaborating with like-minded individuals.

There are more examples of COVID-19 frauds and scams coming to light than can be mentioned here. There are, however, a number of themes emerging:

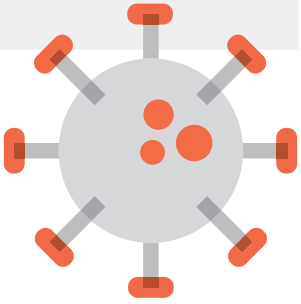
- the early reports related to the sale of Personal Protective Equipment such as face masks and hand sanitiser and testing kits. Typically, the items were fake or often failed to arrive after payment had been made[1].
- the next to emerge were phishing emails. For example, one claiming to be from the Department for Work and Pensions (DWP) asking the individual for debit or credit card details by saying that they are entitled to a council tax refund.
- as the attentions and resources of organisations were diverted to new ways of working and many staff were laid off, the incidence of cyber security attacks to steal business-sensitive and personal data increased.
- with more people working from home following the UK-wide lockdown, phishing campaigns then targeted applications that are being relied upon during remote working, in particular popular conference calling applications and parcel delivery firms.

1 NHS in Wales introduced arrangements to mitigate against this fraud risk and it did not become an issue.

The COVID-19 pandemic: a case study in how scammers and fraudsters are ready to exploit a crisis

- as the national focus turned to test and track, the fraudster's net became wide and indiscriminate, as shown by a fake text message attempting to dupe people into believing they have been in contact with someone who has tested positive for the virus, directing recipients to a website for more information. The link is then used to harvest personal and financial data.

A world-leading counter-fraud response would mean that counter-fraud specialists had identified the risks at least at the same pace as the fraudsters, if not sooner. It would also mean they had the right tools to prevent and detect fraudsters exploiting any new opportunities; and that the counter-fraud response was mobilised rapidly through effective collaboration and information sharing.



Culture and leadership across the Welsh public sector

01

Why is it important?

1.1 The Crime Survey for England and Wales recognises fraud as one of the most prevalent crimes in society today. Every pound stolen from the public sector means that there is less to spend on key services such as health, education and social services. Public sector bodies can mitigate the risks from fraud by having the right organisational culture supported by effective counter-fraud arrangements.

1.2 Strong leadership sets the appropriate tone from the top of an organisation and plays a crucial part in fostering a culture of high ethical standards. It is important that senior management leads by example and sends a clear message that fraud will not be tolerated either from inside or outside of the organisation. A strong tone at the top can raise the profile of fraud risks and promote the best standards and approaches in counter-fraud work.

What did we find?

1.3 Other than in the NHS there is an absence of any overarching strategic approach, guidance, coordination and oversight.

1.4 In NHS Wales, the NHS Counter Fraud Service[2] provides leadership, specialist investigation skills, support and guidance to the sector and a Counter Fraud Steering Group[3] provides strategic direction and oversight. This leadership model delivers a coordinated approach to counter-fraud across the NHS in Wales and a good counter-fraud culture complemented by inbuilt scrutiny of the arrangements. The legal framework specific to the NHS Wales and the levels of investment give counter-fraud a high profile and robust enforcement and recovery mechanisms. At a local level, strategic leadership was evident within Health Boards through the dissemination of a consistent message, both internally and externally, that fraud is not tolerated.

2 Which is hosted by the NHS Wales Shared Services Partnership

3 A sub-group of the All Wales Directors of Finance Forum

1.5 Across local authorities there is an absence of sector-wide strategic leadership, guidance, coordination and oversight of counter fraud. Within the individual authorities we found statements espousing a zero tolerance of fraud in policies and strategic documents. But there is much more that can be done to re-enforce the tone from the top at a practical level. We found examples where the leadership team actively promotes the importance of a good anti-fraud culture through awareness campaigns, newsletters to staff and active engagement with counter-fraud teams. But we also found in many authorities that there was little evidence that the message is driven down from the top and little priority is given to counter-fraud work. There were often competing priorities and, as a result, little time was given to counter-fraud and it often had a low profile.

1.6 In Central Government, the position is mixed. Within Welsh Government, we found evidence that counter-fraud is taken seriously, and a small team has achieved many successful outcomes, albeit its emphasis leans towards reactive rather than proactive work. We have been encouraged to see that the Welsh Government has accepted both of the recommendations made by the Public Accounts Committee following our first report. However, there remains a leadership gap that still needs to be addressed.

1.7 Across the other central government bodies that we examined, counter-fraud is not always given such a high priority. One reason for this appears to be the very low incidence of fraud being identified and reported; this poses the difficult question of whether this is due to a lack of investment in counter-fraud or a genuine low incidence of crime taking place. However, this latter explanation runs contrary to all the research being done by recognised leaders in the field such as CIPFA and the National Crime Agency.

1.8 The threat posed by fraud is also getting greater recognition within the UK. The UK government, for example, is working to make central government, and the public sector more widely, a place where fraud is actively found and robustly dealt with. It is transforming its whole approach to counter-fraud by:

a establishing a counter-fraud function;

b developing and launching a Government Functional Standard (GovS013);

c establishing a 'Government Counter Fraud Profession' to develop people and increase capability;

d providing expert advice to the rest of government on how to deal with fraud;

e delivering specialist services to assist public bodies; and

f collaborating with overseas governments to bring further expertise to the UK.

What can the Welsh public sector do to improve?

Recommendations

R1 The Welsh Government should enhance its strategic leadership of counter-fraud across the public service in Wales, playing a co-ordinating role where it can, while recognising that individual bodies remain responsible for their own counter-fraud activities. In doing so it could consider:

- forming strategic partnerships with the key players nationally and internationally;
- developing and delivering an all Wales counter-fraud strategy and vision;
- advocating/promoting minimum standards in terms of public sector counter-fraud arrangements similar to those established by the UK Government;
- elevating the status of counter-fraud staff by recognising counter fraud as a profession with essential competencies;
- supporting the other sectors by, for example, providing invest-to-save funding opportunities, and supporting the development of professional competencies across the Welsh public sector; and
- providing timely advice and guidance on 'hot' issues by gathering and disseminating important information and analysing trends.

R2 All public bodies should champion the importance of a good anti-fraud culture and actively promote its importance to give confidence to staff and members of the public that fraud is not tolerated.

Risk management and control frameworks

02

Why is it important?

2.1 Fraudsters are becoming more sophisticated and are evaluating opportunities and risks on a real-time basis. The management and mitigation of risk in public bodies often fails to keep up with changes in the nature and impact of potential fraud. The recent flooding in South Wales created opportunities for scams within days of the floods. Security experts have reported an explosion in fraudulent activity during the COVID-19 outbreak as the pandemic has created a myriad of opportunities for fraudsters (see **Case Study on page 10**).

2.2 A fraud risk assessment should be an honest appraisal of risks using a range of sources such as national intelligence, local intelligence, audit reports, brainstorming exercises and data-matching results. Risk assessments should be live documents and kept under constant review. Having identified the risks, bodies can then evaluate them, assessing their likelihood and the impact if the fraud were to occur. It is only when risks are properly identified and evaluated that public bodies can tackle the risks in a prioritised and proportionate way and put appropriate actions and controls in place to manage or mitigate these risks.

2.3 It is important that organisations have an effective control framework to help mitigate the risks identified. A strong internal control environment can help to prevent fraud from happening in the first place and detect fraud if an instance has occurred. Fraudsters will try to circumvent established controls and it is important that controls are regularly reviewed. A strong control programme whereby fraudsters are faced with a real prospect of detection helps mitigate the risk. When frauds are discovered, controls should be reviewed to identify weaknesses and introduce improvements. Internal Audit have expertise in designing and testing controls and they should undertake work on key systems on a risk-based approach.

What did we find?

2.4 The quality of counter-fraud risk assessment and mitigation varies significantly in the Welsh public sector and there is generally scope to improve their quality and timeliness.

2.5 In the NHS, National Fraud Risk Alerts are produced by the NHS Counter Fraud Authority. These are routinely circulated to all Local Counter Fraud Specialists (LCFS) and Directors of Finance across NHS Wales. The LCFS are also required to conduct their own local risk assessments. This is a relatively new requirement and we found that these assessments are still being developed and embedded. The NHS Fighting Fraud Strategy recognises that a key challenge for the sector is the need to develop a comprehensive analysis of specific fraud risks to ensure counter-fraud resources are being directed to the most appropriate areas within the sector. The Counter Fraud Steering group has undertaken an overall risk assessment and produced assurance maps in respect of each main area of fraud. These maps will be used to target area of proactive work.

2.6 Our work identified that while some local authorities and central government bodies have undertaken fraud risk assessments, there were many who had not prepared a fraud risk assessment for several years. Some bodies in these sectors did not have a fraud risk assessment and therefore had not properly assessed the likelihood or impact of the risk. Without this key component, bodies cannot direct resources appropriately or adequately mitigate the risks of losses due to fraud. As a result, fraud strategies and work programmes are not particularly useful or relevant as they are not targeting the key areas of risk.

2.7 Our work also identified that, even where risk assessments were undertaken, they may not be integrated within the wider risk management framework. Fraud is not commonly reflected in corporate risk registers. We did not find many coordinated mechanisms for ensuring that fraud risks are appropriately communicated, owned and monitored within the audited body. Instead, fraud risk assessments are often held as standalone documents without any corporate ownership or active management of the risk. As a result of this approach, fraud risks are not adequately shared across departments.

2.8 We did identify some good practice in the sharing of fraud risks. In response to the Coronavirus pandemic, the Welsh Government issued a fraud risk bulletin early in April 2020, highlighting the emerging risks to the Welsh public sector. Ahead of the Welsh Government's bulletin, the UK Government Counter Fraud Function published its own guide: Fraud Control in Emergency Management – COVID-19 UK Government Guidance. The guide highlights the importance of risk assessment, effective payment verification and due diligence arrangements and the need for robust claw-back arrangements to recover funds that are paid out incorrectly. There were also good examples in local authorities of raising awareness of scams with local residents.

2.9 We found that, in general, public bodies across all sectors have internal control frameworks that are well established and internal audit teams test controls as part of their annual programmes of assurance work. However, we found that internal audit teams do not always consider the fraud risks associated with systems as part of their work programmes. Furthermore, where new systems and processes are established, we found that organisations are not always using counter-fraud contacts and internal audit teams to try to design fraud out of systems.

What can the Welsh public sector do to improve?

Recommendations

R3 All public bodies should undertake comprehensive fraud risk assessments, using appropriately skilled staff and considering national intelligence as well as organisation-specific intelligence.

R4 Fraud risk assessments should be used as a live resource and integrated within the general risk management framework to ensure that these risks are appropriately managed and escalated as necessary.

Policies and training

03

Why is it important?

3.1 A sound policy framework enables organisations to direct their approach to counter-fraud and to promote good ethical behaviour. There should be a suite of policies and procedures in place that set out what is expected and what the consequences are for breaking the rules. Codes of conduct should set out the standards expected of employees and highlight the importance of declaring conflicts of interest and establish rules around gifts and hospitality.

3.2 Publicising frauds and the recovery action undertaken, helps to re-enforce the message from the top that fraud will not be tolerated. Publicity can help to discourage wrongdoing by others as it can highlight the damaging repercussions of their actions.

3.3 Staff are often the first to notice something irregular or potentially fraudulent and are the often the first line of defence in the fight against fraud. These staff need easy access to a good counter-fraud policy and whistleblowing policy so they can be clear about their roles and responsibilities and the process they must follow if they suspect a fraud.

3.4 Effective training helps staff interpret policies and codes of conduct, giving them the confidence and skills to report suspected fraud. However, training and awareness-raising campaigns should be kept under continual review and must be linked to the live risk assessments so that new frauds or risks facing public bodies are quickly shared amongst staff and contractors if appropriate.

What did we find?

3.5 Generally, we found that public bodies have prepared and approved a range of policies setting out the processes to follow if staff suspect that they have uncovered a fraud. However, we identified that some policies were outdated, some were still in draft form and some were not easily accessible to staff.

3.6 Whilst NHS bodies have each developed comprehensive counter-fraud strategies (informed by an over-arching national strategy), we found that only a few other public sector bodies had done so. Such strategies set out clear approaches to managing fraud risks along with responses and actions, they define roles and responsibilities and are cross-referenced to other policies so that they can be readily understood by staff.

3.7 The NHS has a policy of proactively publicising successful fraud cases. The NHS Counter Fraud Service does this by issuing press releases and engaging with local media for interviews and promotional opportunities. Publicity helps raise awareness of fraud risks and also deters staff and contractors from committing fraud. By publicising counter-fraud work and raising awareness of the effects of fraud, the NHS involves staff, key stakeholders and the public in the fight against fraud.

3.8 We did not identify the same level of proactive publicity work in other sectors. Some local authorities take the view that publicising cases can be reputationally damaging and are therefore reluctant to publish such information. The Welsh Government recognises that more can be done to publicise fraud cases. The very low levels of fraud identified at central government bodies also means there is little publicity that can act as a further deterrent.

3.9 Our audit work also identified wide variation in levels of training and awareness-raising specifically relating to counter-fraud across the Welsh public sector. We found that a few public bodies provide fraud awareness training to all their staff. Some others provide training as part of the induction of new staff but do not provide this training for longstanding staff. We found some examples of refresher training sessions and e-learning modules provided for staff, but these are not widespread. There are many bodies that do not provide any counter-fraud training or awareness-raising events.

3.10 These findings suggest that there could be a significant proportion of the public sector workforce in Wales who have either received no fraud-awareness training at all or have not received training for several years.

3.11 There are good examples of awareness-raising in the NHS where the LCFS has an ongoing work programme to develop and maintain an anti-fraud culture within their health board. These programmes include the preparation of presentations and publications to raise awareness of fraud. There are also examples of LCFS undertaking staff surveys to capture the levels of staff awareness of fraud in order to act if necessary. In addition, the NHS has developed a fraud awareness e learning package for all staff and levels of compliance across organisations is reported the Directors of Finance on a quarterly basis. However, even in the NHS sector, counter-fraud training for new staff is generally not a mandatory requirement.

What can the Welsh public sector do to improve?

Recommendations

R5 All public bodies need to have a comprehensive and up-to-date set of policies and procedures which together represent a cohesive strategy for identifying, managing and responding to fraud risks.

R6 Staff working across the Welsh public sector should receive fraud-awareness training as appropriate to their role in order to increase organisational effectiveness in preventing, detecting and responding to fraud.

R7 Cases where fraud is identified and successfully addressed should be publicised to re-enforce a robust message from the top that fraud will not be tolerated.

Capacity and expertise

04

Why is it important?

4.1 It is important that public bodies each designate a counter-fraud champion who understands fraud and leads the organisation's approach and response. Public bodies need access to sufficient appropriately skilled counter-fraud specialists to prevent, detect and investigate suspected fraud and protect their assets. As fraud risks change, public bodies should have resources available to provide a response that is appropriate to the threat.

4.2 Skilled and experienced staff will also help to ensure investigations are undertaken properly with evidence being obtained and handled lawfully in order to secure successful sanctions and the recovery of losses.

4.3 Investigations, whilst crucial, can be time consuming and costly and the low numbers of successful prosecutions mean that public bodies cannot rely on investigations alone to combat fraud. Public bodies need to have the capacity to undertake both proactive counter-fraud work and reactive investigation work. Proactive work includes fraud awareness campaigns, training, designing policies and strategies and strengthening controls to prevent attacks.

What did we find?

4.4 Insufficient capacity arose frequently as a key challenge faced by public bodies in their efforts to combat fraud. On the ground, capacity and skills in counter-fraud vary widely across and within public sector bodies in Wales. Most of the capacity is allocated to responsive work and investigations with any spare capacity being used in preventative counter-fraud work.

4.5 In local government, some officers are sceptical about the levels of fraud within their organisations and question the need for additional resources. However, these same local authorities allocate little resource to counter-fraud arrangements, do not have robust fraud risk assessments and the following up of matches from the National Fraud Initiative is assigned a low priority. Their assumptions about low levels of fraud run contrary to all the research being done by recognised leaders in the field such as CIPFA and the National Crime Agency.

4.6 Local authorities suffered a significant loss in counter-fraud capacity when the independent Single Fraud Investigation Service (SFIS) was created in 2014. SFIS is a partnership between the Department for Work and Pensions, HMRC and local authorities and which covers welfare benefit fraud. Most of the counter-fraud specialists left the sector to work for this new organisation. A small number of authorities have retained experienced and skilled counter-fraud staff, but the workload has mostly fallen on Internal Audit teams.

4.7 Our work found that the counter-fraud arrangements were generally more advanced in the local authorities that retained a dedicated and specialist counter-fraud resource. Where Internal Audit teams carry out the counter-fraud work we found a trade-off between counter-fraud work and the general programme of assurance work due to limited resources and competing priorities.

4.8 We also found that, within some local authorities, several teams play a role in counter-fraud work; for example, Internal Audit, Council Tax, and Human Resources teams all contribute. Whilst helpful in terms of adding capacity, we found that this can result in a lack of coordination and integration between these teams and a lack of clarity in the overall picture of counter-fraud activity.

4.9 Counter-fraud is generally better resourced in the NHS than other public sector bodies and there has been an increase in LCFS resource over recent years. There is a central team within the NHS Counter Fraud Service Wales which investigates complex, large scale frauds and provides a financial investigation resource. The team also provides guidance, intelligence and investigative support to the network of finance directors and LCFS at health bodies in Wales. In addition, Welsh Government Directions require that each health body should appoint at least one LCFS who is an accredited counter-fraud professional. These LCFS are the primary points of contact for counter-fraud work at their respective health bodies and have a key role in fraud prevention and detection. Increasing staffing levels above the minimum number is a matter of local discretion.

4.10 The mixture of LCFS and support and guidance from the NHS Counter Fraud Service and the Counter Fraud Steering Group has resulted in improved counter-fraud arrangements within the NHS sector in comparison to the other sectors. However, whilst LCFS staff are often shared between individual health boards, they are not pooled across the entire sector. As a result, the relatively low counter-fraud staff numbers in some health boards can cause issues if staff members are absent from work. Even within the NHS Wales, there is a general recognition that more proactive work should be undertaken.

4.11 The Counter Fraud Team at the Welsh Government is skilled and experienced and has secured a number of high-profile prosecutions over recent years. However, a recent Government Internal Audit Agency review of the Welsh Government in 2017 concluded that the counter-fraud function could achieve more with increased resources. The Counter Fraud Team is able to draw on resources from within the Welsh Government to assist with investigations where appropriate and there are plans to increase the resource in the team in the near future.

4.12 Our audit also found that public bodies in Wales bodies are generally following traditional counter-fraud approaches with a focus on detection and investigation rather than prevention. Most public bodies recognise that more proactive and preventative work should be done, but they acknowledge that the lack of time, resources and expertise are barriers to making this shift of focus.

4.13 We did not find many examples of public bodies in Wales outside the NHS pooling resources to help reduce duplication of effort and improve the efficiency and effectiveness of counter-fraud arrangements across sectors. Pooled resources could also help to improve continuity and add flexibility to adapt to changing needs going forward.

4.14 In 2018 the UK government launched the Counter-Fraud Profession to enhance overall counter-fraud capability across government. The profession develops the skills of specialist staff and moves beyond the traditional focus of investigations, placing greater emphasis on fraud prevention and the use of data analytics. Membership across UK Government Departments has been steadily increasing, and the Welsh Government is engaged with this initiative. Organisations joining the profession are required to have learning environments that support their staff to develop and maintain professional standards.

What can the Welsh public sector do to improve?

Recommendations

R8 All public bodies need to build sufficient capacity to ensure that counter-fraud work is resourced effectively, so that investigations are undertaken professionally and in a manner that results in successful sanctions against the perpetrators and the recovery of losses.

R9 All public bodies should have access to trained counter-fraud staff that meet recognised professional standards.

R10 All public bodies should consider models adopted elsewhere in the UK relating to the pooling and/or sharing of resources in order to maximise the availability of appropriately skilled staff.

Tools and data

05

Why is it important?

5.1 An effective counter-fraud function will ensure that those responsible for it are equipped with up-to-date methodologies and the right tools for the job. Counter-fraud staff must make best use of data and intelligence in order to:

a prevent fraud by 'fraud-proofing' systems and processes; and

b mounting an effective response to suspicions of fraud.

5.2 New fraud threats are continually emerging, both globally and nationally. It is important that public bodies have flexible, cutting-edge counter-fraud approaches that are fit for a digital age and agile enough to keep up with, or better still, ahead of the fraudsters.

5.3 Cyber-attacks are an alternative means of committing traditional frauds such as the theft of assets, cash or intellectual property. PricewaterhouseCoopers' most recent global economic crime survey found that cyber crime is now the most common fraud facing UK businesses, overtaking asset misappropriation for the first time since the survey began. We can see this in the explosion in number of cyber scams linked to the COVID-19 pandemic.

5.4 Preventing fraud is always preferable to responding to an instance. Many organisations are now looking to 'fraud-proof' systems at the point of entry using the latest developments in data analytics. For example:

a the Cabinet Office has developed on-line tools that can look at 10,000 records in seven seconds to provide due diligence checks on grant applications; and

b the Department of Work and Pensions have been trialling an Artificial Intelligence system that detects fraudulent claims by searching for certain behaviour patterns, such as benefit applications that use the same phone number or are written in a similar style. Any suspicious activity is then passed on to specialist investigators.

5.5 Data analytics provide an increasingly important tool in preventing fraud as well as in its detection. We look at how public bodies can share data to help find fraud in the next section of this report.

5.6 Sophisticated technology and data analytics are of little use if they are not used effectively and this requires adequately trained resource to understand it. Therefore, it is important that public bodies have access to staff adept in data analytics in order to achieve better counter-fraud results.

5.7 Knowing what to do in the event of a suspected fraud improves the chances of a successful enforcement action. It also re-enforces the tone from the top that the organisation does not tolerate fraud. Fraud response plans need to provide a clear direction to relevant parties so that bodies are able to respond to allegations quickly and appropriately. A response plan should be reviewed regularly to ensure that responses to fraud keep abreast with changing times and emerging risks. They should outline:

a the fraud investigation process from receipt of allegation to outcome report;

b roles and procedures for securing evidence and undertaking interviews;

c details of how and when to contact the police;

d a commitment to pursuing a range of sanctions;

e reporting arrangements; and

f how lessons learned will be used to strengthen system and process controls.

What did we find?

5.8 Generally speaking, we found that more work is needed to bring counter-fraud tools and methodologies up to date to reflect the new world of cyber attacks and digitally-facilitated crimes. Many local authorities and central government bodies we looked at as part of our fieldwork did not have information security policies that reflected the risks associated with cyber crime. The situation was more positive in NHS Wales bodies.

5.9 Our review identified only a few examples of data analytics being used as a means of preventing fraud. Data analytics are used more widely to detect fraud, in following up on NFI data matches, for example, but our previous audit work[4] has shown that the level of engagement with the NFI varies considerably across Welsh public bodies.

5.10 We found that some local authorities and central government bodies did not have a fraud response plan that was communicated to all staff and which made it clear that all allegations of fraud would be investigated. The Welsh Government had a fraud response plan, but this was in draft form at the time of our audit work and was not, therefore, available to staff. Again, the position was much more positive in NHS Wales.

4 **Our October 2018 NFI report** stated that 'most Welsh public sector bodies participating in the NFI were proactive in reviewing the data matches, but a small number of participants did not review the matches in a timely or effective manner'.

5.11 NHS bodies all use the same case management system to record and monitor the progress of potential fraud cases. In other sectors, few bodies have a case management system although some do have a spreadsheet log that records information. The variation in the information collected makes it very difficult to report an all-Wales position on the level of fraud taking place. The reasons that many local authorities and central government bodies do not have a case management system or detailed records was the very low numbers of fraud cases that were being identified and handled.

5.12 Most of the public bodies we looked at consider the full range of possible sanctions (disciplinary, regulatory, civil and criminal) against fraudsters and will seek redress including the recovery of assets and money where possible. However, many bodies report such low levels of fraud that it is impossible to substantiate their claims. For any internal frauds identified, most bodies tend to deal with the perpetrators through internal disciplinary procedures.

5.13 Most of the public bodies we looked at reflected on the weaknesses revealed by instances of proven fraud and corruption and fed back to departments and teams so that they might fraud-proof their systems. The arrangements at local NHS bodies were particularly robust because fraud cases in their case management system cannot be closed down without providing assurance that any system weaknesses have been considered and remedied if necessary.

What can the Welsh public sector do to improve?

Recommendations

R11 All public bodies need to develop and maintain dynamic and agile counter-fraud responses which maximise the likelihood of a successful enforcement action and re-enforce the tone from the top that the organisation does not tolerate fraud.

R12 All public bodies should explore and embrace opportunities to innovate with data analytics in order to strengthen both the prevention and detection of fraud.

Collaboration

06

Why is it important?

6.1 Fraudsters do not respect geographical or other boundaries. This means that individual public sector bodies cannot establish effective counter-fraud arrangements by themselves. They must work collaboratively to maximise the effectiveness of their response to fraud.

6.2 Collaboration is an increasingly important aspect of public service, particularly in the context of reduced funding and the need to do more with less. Collaboration is also one of the 'five ways of working' as defined in the Welsh Government's 'Well-being of Future Generations (Wales) Act 2015: the essentials'[5] document. It is therefore essential that collaboration and the sharing of intelligence and good practice take place between public, private and third-sector bodies across the UK and internationally.

6.3 Collaboration can mean sharing people or pooling resources and, more commonly these days, in the sharing of information. This information can be shared between departments, between bodies, across different elements of the public sector and with other key stakeholders such as law enforcement authorities and the private sector. The information shared can be about the nature of a fraud or information about the identities of the perpetrators.

6.4 The sharing of data to help find fraud is a rapidly evolving area and is being facilitated by changes in the law. In 2017, the Digital Economy Act became law, enabling public authorities to share personal data to prevent, detect, investigate and prosecute public sector fraud. The Act recognises that the wider use of data-sharing could improve the prevention, detection and investigation of fraud in a number of ways, including:

a improved targeting and risk-profiling of potentially fraudulent individuals;

b streamlining processes, enabling the government to act more quickly; and

c simplifying the legislative landscape.

5 Well-being of Future Generations (Wales) Act 2015: the essentials', Welsh Government (2015)

What did we find?

6.5 Our field work across forty public sector bodies in Wales found that collaboration was insufficiently developed, reinforcing the findings of our 2019 review.

6.6 Within local authorities and central government bodies there are some good examples of bodies working jointly and some regional networks, but these tend to be informal arrangements and there is no consistency in approach. Formalising arrangements can help improve accountability and governance and can influence commitment and results.

6.7 The picture is generally more positive across local NHS bodies and the Welsh Government than in local authorities and central government bodies. However, there is scope for all public bodies to work more closely with each other and with other stakeholders to tackle fraud.

6.8 Because of the tiered approach to counter-fraud within NHS Wales and established formal partnerships with the NHS Counter Fraud Authority, there is good access to specialist fraud investigation teams such as surveillance, computer forensics, asset recovery and financial investigations. The NHS Counter Fraud Service Wales provide the surveillance, asset recovery and financial investigations services to NHS Wales, while the NHS Counter Fraud Authority provides forensic computing services and other specialist support services to NHS Wales under the terms of their annual agreement with Welsh Government.

6.9 The existence of these formal access arrangements is less well established within other sectors, but most organisations told us that they could access specialist services if required. The low level of fraud being identified was one of the reasons given for the absence of formal partnerships between public sector bodies.

6.10 We also found wide variations in the amounts of data that are shared. In most bodies, the sharing of data was typically limited to the National Fraud Initiative (NFI), although not all central government bodies currently take part in NFI. We found that some local authorities do not invest much resource into following up NFI matches and these are often the same authorities in which counter-fraud arrangements were limited.

6.11 There were very few examples of organisations working frequently across internal and external boundaries and sharing information. Common reasons for this lack of collaboration was lack of time and resources, and concerns about the sharing of data.

What can the Welsh public sector do to improve?

Recommendations

R13 Public bodies should work together, under the Digital Economy Act and using developments in data analytics, to share data and information to help find and fight fraud.

Reporting and scrutiny

07

Why is it important?

7.1 Arriving at a reliable estimate for the cost of fraud is a difficult task. This is particularly so for the Welsh public sector as our 2019 report highlighted. Whilst the UK Government produces annual estimates, there is no breakdown of this estimate to each of the devolved administrations in the UK. CIPFA's most recent analysis estimates that fraud costs the UK public sector £40.3 billion annually. The Cabinet Office[6] estimates losses due to fraud and error at between 0.5% and 5% of budget. Applying this range to annual public expenditure in Wales of around £20 billion gives a possible estimated value of losses to fraud and error between £100 million and £1 billion per annum. The losses are therefore significant and take valuable funding away from our public services.

7.2 Fraud is often under-reported as some suspicious activity identified through NFI matches, for example, is not classified as fraudulent and therefore not reported. Also, some public bodies fail to report fraud as it can attract unwanted publicity and perceived reputational damage. This situation leads to an incomplete national intelligence picture.

7.3 The International Public Sector Fraud Forum[7] has recognised that 'finding fraud is a good thing' and this is one of their 'Key Fraud and Corruption Principles'. The Forum noted that, if bodies do not find fraud, then they are unable to fight it, and that a change of perspective is needed so that the identification of fraud is seen as a positive and proactive achievement.

7.4 Reporting fraud to those charged with the governance of public sector organisations is important as it provides managers and audit committees, for example, with the information and intelligence they need to challenge and scrutinise. To facilitate accountability, public bodies should provide copies of counter-fraud reports detailing numbers of cases and outcomes to audit committees so that they are fully informed of any issues of concern and can hold management and counter-fraud teams to account. Audit committees can also promote the message that fraud will not be tolerated, supporting the efforts of counter-fraud teams.

6 Cabinet Office Cross Government Fraud Landscape Report 2018

7 International Public Sector Fraud Forum A Guide to Managing Fraud for Public Bodies in Feb 2019

What did we find?

7.5 The arrangements in NHS Wales to record, collate and share information about fraud losses and recoveries are well established. The NHS Counter Fraud Service collates information on the number of fraud cases and recoveries from each health body as a matter of course. There are quarterly and annual Operational Performance Reports which summarise information about resources, referrals and the work of the Counter-Fraud Service and LCFS based at each health body. These reports are reviewed by the Counter Fraud Steering Group and shared with Directors of Finance and the audit committees of each health body, helping to facilitate meaningful comparisons within the sector. The NHS Counter Fraud Authority also reports to the Welsh Government on a quarterly basis.

7.6 In other sectors, audit committees are not generally provided with as much information:

a in the Welsh Government, the Audit and Risk Assurance Committee is not provided with, nor does it request, detailed information about fraud cases, although information about major cases and anti-fraud activity is included in the regular report from the Head of Internal Audit;

b in the local government sector, fewer than half the authorities report information about fraud cases, losses and recoveries to their audit committees on a regular basis; and

c even fewer central government bodies report on cases of fraud, reflecting a very low incidence of fraud being identified and managed.

7.7 The absence of both the reporting of information and arrangements to collate and share this information across the Welsh public sector is troubling for a number of reasons. It does little to help re-enforce a zero-tolerance message from the top of an organisation to both staff and external stakeholders. It may also send the wrong message to fraudsters that Wales does not see fraud as a priority and makes it difficult to assess the level of risk and how best to respond to it by senior public sector officials and politicians.

7.8 When frauds are identified, Internal Audit (or, where they exist, counter-fraud specialists) provide audit committees with reports and updates. On balance, however, audit committees outside of the NHS Wales have not been sufficiently proactive in recognising the increasing risk of fraud and in asking the searching questions necessary about the matching of resources to risk or about the lack of information being supplied about fraud risk.

What can the Welsh public sector do to improve?

Recommendations

R14 Public bodies need to collate information about losses and recoveries and share fraud intelligence with each other to establish a more accurate national picture, strengthen controls, and enhance monitoring and support targeted action.

R15 Audit committees must become fully engaged with counter-fraud, providing demonstrable support and direction, monitoring and holding officials to account if insufficient information is being provided about counter-fraud activity.

Appendices

1 Audit methods

Our audit was structured around seven key lines of enquiry to help us answer the overall question: 'Are the arrangements for preventing and detecting fraud in the Welsh public sector effective?':

- Does the top tier demonstrate a commitment to counter-fraud and provide the necessary leadership to fight fraud?
- Does the organisation have a suitable structure and sufficient skilled resources to prevent and detect fraud?
- Does the organisation have a sound policy framework to support effective counter-fraud arrangements?
- Does the organisation have an effective fraud risk assessment together with appropriate responses to emerging issues?
- Does the organisation's internal control environment support effective arrangements for preventing and detecting fraud?
- Does the organisation have an appropriate response to fraud?
- Does the organisation have proper reporting and scrutiny in place to ensure its counter-fraud culture and framework is operating effectively?

The audit fieldwork was carried out by our local audit teams between November 2019 and February 2020. Their fieldwork included:

- structured interviews – interviews with key individuals in order to understand the counter-fraud arrangements in place at each audited body; and
- document reviews – where these existed, they typically included the counter-fraud strategy, risk assessment, work plans, corporate risk register, fraud response plan, Codes of Conduct, whistleblowing policy, guidelines and procedures for local fraud investigators and counter-fraud reports/updates provided to Audit Committee.

Teams also issued a core information request in order to gather some information directly from audited bodies.

The project team collated and reviewed the local findings to distil the key messages for inclusion in this report. Our audit teams have been providing tailored feedback on their local findings to relevant staff at each audited body.

The audited bodies included in this study are:

Local Government bodies:

- Blaenau Gwent County Borough Council
- Bridgend County Borough Council
- Caerphilly County Borough Council
- Cardiff Council
- Carmarthenshire County Council
- Ceredigion County Council
- Conwy County Borough Council
- Denbighshire County Council
- Flintshire County Council
- Gwynedd Council
- Isle of Anglesey County Council
- Merthyr Tydfil County Borough Council
- Monmouthshire County Council
- Neath Port Talbot County Borough Council
- Newport City Council
- Pembrokeshire County Council
- Powys County Council
- Rhondda Cynon Taf County Borough Council
- City and County of Swansea
- The Vale of Glamorgan Council
- Torfaen County Borough Council
- Wrexham County Borough Council

NHS Wales bodies:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board
- Swansea Bay University Health Board
- Health Education and Improvement Wales
- Velindre NHS Trust
- Public Health Wales Trust
- Welsh Ambulance Service NHS Trust

Central Government bodies:

- Welsh Government
- Welsh Revenue Authority
- Arts Council for Wales
- Higher Education Funding Council for Wales
- National Museums and Galleries Wales
- Natural Resources Wales
- National Library of Wales
- Sport Wales
- Senedd Commission

2 The Welsh Government's response to the July 2019 recommendations of the Public Accounts Committee

PAC Recommendation	Response from the Welsh Government's Permanent Secretary
We ask that the Welsh Government consider whether there is scope and potential to support a national counter fraud team to work across Wales to ensure that at least a basic level of counter fraud work is undertaken in each local authority area by suitably trained staff.	The Welsh Government recognises and fully supports local authorities addressing fraud within the £8 billion of their general revenue expenditure. As independent democratically led organisations, the prime responsibility for the detection and prevention of fraud is for each of the 22 councils themselves. As such, we would expect all to be fully engaged in this work and for local politicians to understand and provide leadership. To make sure that the recommendation is understood and given priority, officials will raise the matter with Ministers to secure an item on the Partnership Council agenda as well as its Finance Sub Committee. Subject to Ministers' agreement, we will agenda an item for the next possible meeting.
We ask that the Welsh Government consider whether there is scope and potential to support a national counter fraud team to work across Wales to ensure that at least a basic level of counter fraud work is undertaken in each local authority area by suitably trained staff.	I am supportive of any move to increase the understanding of fraud and the consistent application of best practice techniques across the Welsh Public Sector and there exists already a vehicle to bring together counter-fraud practitioners and other interested parties and drive forward a common understanding of this important area. The Welsh Government's Head of Counter-Fraud is Deputy Chair of the Wales Fraud Forum (WFF), which is a not-for-profit company run by a strategic board of volunteers. Its aims are to help prevent fraud in Wales by raising awareness in the public and private sectors and amongst individuals. In particular, its stated objectives include to: • bring the public and private sectors together to fight fraud and financial crime and to protect the economy of Wales;

PAC Recommendation

Response from the Welsh Government's Permanent Secretary

- promote fraud awareness amongst its membership, organisations and individuals throughout the region;
- create good practice cultures by encouraging and developing anti-fraud strategies for its membership to utilise;
- establish a best practice between its members for fraud prevention, investigation and detection; and
- promote an open and co-operative environment between the membership in both the public and private sectors.

The Forum is held in high regard; in 2017 the current First Minister gave the keynote address at its annual conference and outlined his support for effective counter-fraud arrangements across Wales. Forum membership includes the Audit Wales as well as a number of public and private sector organisations.

Therefore, I believe the Welsh Government can achieve the outcome desired by identifying strategies to support the work of the Forum, raising its profile within the Welsh Public Sector and seek a high level of commitment to support it. I will ask Officials to engage with the Forum to discuss strategies for strengthening its effectiveness by the end of the calendar year.

We agree there is potential in the use of data sharing between Welsh public bodies to improve the impact of counter-fraud activities. The introduction of the Digital Economy Act gives the Welsh Government and certain scheduled Welsh public bodies useful new powers to share data with each other compliantly to identify potential fraud. Officials are working on setting up the appropriate governance for taking forward the use of these new powers in Wales, and are aiming for a panel to be in place by the end of the financial year to consider potential uses of the powers.

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Effectiveness of Counter-Fraud Arrangements – **Betsi Cadwaladr University Health Board**

Audit year: 2020

Date issued: September 2020

Document reference: 1992A2020-21

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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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.

Mae’r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

The Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs.

Summary report

Background

1 On 11 June 2019, the Auditor General published Counter-Fraud Arrangements in the Welsh Public Sector: An Overview for the Public Accounts Committee. The report was a high-level, descriptive review of the arrangements in place within the Welsh Government, the NHS and local government (unitary authorities only). It highlighted some important messages:

- losses caused by fraud in the public sector are significant and could be anywhere between £100 million and £1 billion. In a time of austerity, every pound lost to fraud is a pound that could be spent on public services.
- fraud in all its forms is constantly evolving, so counter-fraud measures need to keep pace with the fraudsters.
- resources devoted to counter-fraud activity vary widely across the public sector in Wales.

2 Following publication of the report, the Public Accounts Committee endorsed the Auditor General's proposal to undertake further work across 40 Welsh public sector bodies to examine how effective counter-fraud arrangements are in practice and to make recommendations for improvement. This work was undertaken during December 2019 – February 2020.

3 On 30 July 2020, the Auditor General published a national report called Raising our game – Tackling Fraud in Wales which summarises the key finding from our review across Wales. It does not describe in detail the arrangements in place in individual bodies, but it identifies a range of opportunities to improve counter-fraud arrangements across Wales.

4 Whilst the national report identified that NHS counter-fraud arrangements are the most developed across the public sector, it identified that there is still a challenging agenda to make counter-fraud fit for the next decade where globalisation and the advent of digital technology have created new risks, and opportunities for the fraudsters.

5 The report calls on NHS bodies to satisfy themselves that:

- counter-fraud resources are determined based on an assessment of local risk factors;
- counter-fraud risk assessments are integrated with corporate risk management arrangements;
- strategies are in place to make greater use of data analytics to both prevent and detect fraud; and
- strategies are in place to improve collaboration within the sector and more widely across sector boundaries.

6 This summary report sets out our assessment of Betsi Cadwaladr University Health Board's (the Health Board's) arrangements for preventing and detecting fraud. Our

assessment is based on document reviews, including board and committee papers, and interviews with a small number of staff.

Main findings and areas for improvement

7 Our assessment identified that the Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs. Our key findings from the work are set out in more detail in the following section of this report.

8 In undertaking this work, we identified some areas for improvement (**Exhibit 1**), they should be considered alongside the themes identified in the national report. The Health Board's management response to the areas for improvement is available in **Appendix 2**.

Exhibit 1: areas for improvement

Training and awareness raising

I1 Although training is part of the induction training and progress is monitored at Audit Committee, the Counter Fraud e-learning module could be included in the Health Board's Mandatory Training for Staff and staff are not trained on an annual basis.

Resources and skills

I2 The number of LCFS staff in the establishment is not explicitly linked to an evaluation of the increased fraud risk facing the Health Board. There is an opportunity to reflect on whether counter-fraud resources and balance between proactive and reactive work match the fraud risks the Health Board is exposed to.

Fraud risk assessment

I3 Fraud risk assessments should be used as a live resource and integrated within the general risk management framework to ensure that these risks are appropriately managed and escalated as necessary. The case study on the COVID-19 pandemic provides an important opportunity for the Welsh counter-fraud community to come together and reflect on the speed and effectiveness of its response to the scammers and fraudsters. However, this reflection could also be undertaken at a local level by the Health Board.

Internal control environment

I4	Our national review identified only a few examples of data analytics being used as a means of preventing fraud, predominantly the National Fraud Initiative data matching exercise. The Health Board should reflect on how it could make greater use of data analytics to both prevent and detect fraud.

Response to fraud

I5	The Health Board should explore avenues to improve collaboration more widely across sector boundaries on common risks and challenges.

Exhibit source: Audit Wales

Detailed report

Our findings

9 The following table sets out the areas of focus within our work and our findings.

Exhibit 2: areas of work and findings

Areas of work	Findings
We considered whether the top tier demonstrates a commitment to counter-fraud and provides the necessary leadership to fight fraud. We expected to see: • the Board/Executive team promoting a clear commitment to zero tolerance of fraud and championing counter-fraud work; • senior leadership actively promoting and cascading an anti-fraud culture; • an organisation-wide understanding of responsibilities for preventing fraud and reporting suspected fraud; and • an organisational commitment to counter-fraud and ethics awareness training, with appropriate and targeted mandatory counter-fraud training for all staff.	We found the following good practice: • the Executive Director of Finance is the Board Level Executive with responsibility for Counter Fraud – responsibility is delegated to the Finance Director: Operational Finance; • all fraud related issues are treated as a priority by the organisation, and there is a clear commitment from the Executive Director of Finance and the Chair of the Audit Committee; • policies and strategies send out a consistent message that fraud will not be tolerated, and that all steps will be taken to take criminal or disciplinary sanctions against perpetrators; • the Health Board ensures that there are effective lines of communication between those responsible for counter-fraud, bribery and corruption work and other key staff groups and managers within the organisation; and • the Health Board publicises proven frauds and the action taken. We identified the following areas for improvement: • although training is part of the induction training and progress is monitored at Audit Committee, the Counter Fraud e-learning module has not been included

Areas of work	Findings
	in the Health Board's Mandatory Training for Staff and staff are not trained on an annual basis. For quarter one of 2020-21, just nine staff undertook the e-learning module.
We considered whether the organisation has a suitable structure and sufficient skilled resources to prevent and detect fraud. We expected to see: • a designated Local Counter Fraud Specialist (LCFS) with designated responsibility for counter-fraud and the ability to influence the level of counter-fraud resources; • an appropriate level of experienced, trained and accredited counter-fraud staff to undertake investigations and counter-fraud work; • clarity in respect of counter-fraud roles, responsibilities and lines of accountability; • investment in counter-fraud based on informed decisions derived from a fraud risk assessment which highlights risks and determines the resources needed to address them; and • an annual programme of proactive counter-fraud work (fraud prevention work) which covers	We found the following good practice: • the Health Board has a dedicated LCFS, with the ability to influence the level of counter-fraud resources designated by the Executive Director of Finance. • the Health Board employs accredited and trained counter-fraud staff, who attend training and professional development courses as required. • the level of counter-fraud resources within the Health Board is the highest of the six big health boards, however when compared to the total workforce, the rate of LCFS per 1,000 staff is one of the lowest (**Appendix 1**). The number of LCFS has remained at three full-time LCFS since 2010 with a part-time Administration Support Officer since 2015. Prior to 2010 the number was higher at five whole-time equivalent LCFS. • the Health Board has a clear structure where the roles and responsibility in relation to counter-fraud are clearly set out. • the LCFS and counter-fraud staff have access to all systems, records and premises required to do their work. • the LCFS completes the NHS Counter-Fraud Authority Self-Review Tool (SRT) on an annual basis. Where issues (risks) are identified, they are incorporated into the counter-fraud work plan, together with any issues/risks identified through general counter-fraud work. The SRT identifies proactive work priorities for the year.

Areas of work	Findings
the risks identified in the risk assessment with ring fenced time allocated to proactive work.	• the Health Board has an annual programme of proactive counter-fraud work (i.e. fraud prevention work) which covers the risks identified in the risk assessment with ring fenced days for proactive work to be undertaken. We identified the following areas for improvement: • the number of LCFS staff in the establishment is not explicitly linked to an evaluation of the increased fraud risk facing the Health Board. There is an opportunity to reflect on whether counter-fraud resources and balance between proactive and reactive work match the fraud risks the Health Board is exposed to.
We considered whether the organisation has a sound policy framework to support effective counter-fraud arrangements. We expected to see: • a counter-fraud strategy/policy which sets out the organisation's approach to managing fraud risks and defines specific counter-fraud responsibilities; • a Code of Conduct setting out acceptable behaviours and how to report and manage conflicts of interest; • sound whistleblowing arrangements which set out mechanisms for reporting fraud;	We found the following good practice: • the Health Board has a current anti-fraud, bribery and corruption policy (the policy), which is reviewed, evaluated and updated regularly. The policy includes a counter-fraud response plan. • the policy was scrutinised and signed off by the Health Board's LCFS, senior management and Audit Committee. • staff awareness of the policy is raised in counter-fraud awareness sessions. • the Health Board has an appropriate Code of Conduct, and whistleblowing and cyber security policies with review and renewal processes in place. • the Health Board has appropriate arrangements to maintain and review registers of interests, gifts and hospitality. • the Health Board has arrangements in place to ensure that all new staff are subject to the pre-employment checks before commencing employment within

Areas of work	Findings
• maintained registers of gifts and hospitalities; and • pre-employment screening.	the organisation. Further clarification should be sought as to whether this includes staff employed via employment agencies. We did not identify any areas for improvement.
We considered whether the organisation has an effective fraud risk assessment together with appropriate responses to emerging issues. We expected to see: • regular and comprehensive fraud risk assessments discussed and agreed with senior leaders and the Audit Committee; • fraud risk assessments featuring as part of the organisation's overall risk management framework; and • fraud risk built into system design to minimise opportunities for fraud.	We found the following good practice: • the Health Board completes the NHS Counter-Fraud Authority's SRT on an annual basis. • annual work plans are based upon intelligence received and identified, a review of ongoing cases, referrals and proactive work priorities identified across Wales. Counter-fraud resource levels are proportionate to the risk level identified. Measures to mitigate identified risks are included in the workplan, which is approved by the Audit Committee. • policies and paper-based procedures are fraud proofed using guidance issued by the NHS Counter-Fraud Authority. The LCFS reviews policies and proposes changes where it is deemed necessary. We identified the following areas for improvement: • fraud risk assessments should be used as a live resource and integrated within the general risk management framework to ensure that these risks are appropriately managed and escalated as necessary.

Areas of work	Findings
We considered whether the organisation's internal control environment supports effective arrangements for preventing and detecting fraud. We expected to see: • internal controls designed and tested to address identified fraud risks and help prevent fraud occurring; • internal audit reviews of fraud risks and testing of controls designed to prevent and detect fraud; • the organisation acting on recommendations to strengthen controls if internal controls are found to be not operating as well as intended and lessons learned from fraud incidents; and • the organisation uses data matching to validate data and detect potentially fraudulent activity.	We found the following good practice: • the Health Board's Internal Audit team reviews fraud risks and tests controls designed to prevent and detect fraud as part of its annual programme of work. Information and intelligence are shared with local counter-fraud services in line with the agreed information sharing protocol. • the Health Board acts upon recommendations to strengthen controls if internal controls are found to be not operating as well as intended and learns lessons from fraud incidents. • the Health Board participates in the National Fraud Initiative data matching exercise, primary care post-payment verification checks and other local checks (such as payroll). • the Health Board uses case management software to record all system weaknesses as identified as a result of investigations and/or proactive prevention and detection exercises. An important aspect of this software is recording lessons learned. • there is information sharing between the LCFS and the Post Payment Verification team but some concerns about the robustness of recovery arrangements as a result of recoveries not being based on extrapolated data. We identified the following areas for improvement: • our national review identified only a few examples of data analytics being used as a means of preventing fraud, predominantly the National Fraud Initiative data matching exercise. The Health Board should reflect on how it could make greater use of data analytics to both prevent and detect fraud.

Areas of work	Findings
We considered whether the organisation has an appropriate response to fraud. We expected to see: • a comprehensive fraud response plan which sets out clear arrangements for reporting and investigating allegations of fraud; • action to ensure that all allegations of fraud are assessed; • documented procedures for conducting fraud investigations which follow proper professional practice and in line with the fraud response plan; • consideration of the full range of sanctions available, and redress sought (for example, the recovery of money and assets) where appropriate; • an appropriate case management system to record and monitor the progress of potential fraud cases; and • collaboration with external partners to tackle fraud.	We found the following good practice: • the Health Board's Fraud Response Plan follows best practice as advised by the NHS Counter-Fraud Authority. • qualified staff investigate all cases of suspected fraud, and in line with the Fraud Response Plan. Outcomes of investigations are reported to the Audit Committee and to the NHS Counter-Fraud Authority. • the Health Board utilises the full range of sanctions available (staff disciplinary action, civil action and criminal action) and seeks to recover monies where appropriate and cost effective to do so. • all investigations are documented on case management software. Learning from fraud is shared with appropriate staff to action and implement changes to systems and procedures where appropriate. • the Health Board liaises proactively and on a regular basis with other organisations and agencies such as NHS Legal and Risk Services, the police, Home Office Immigration Services, local authorities, and regulatory and professional bodies to assist in countering fraud, bribery and corruption. Specialist services can be purchased from the NHS Counter-Fraud Authority where necessary. We found the following areas for improvement: • The Health Board should explore avenues to improve collaboration more widely across sector boundaries on common risks and challenges.

Areas of work	Findings
We considered whether the organisation has proper reporting and scrutiny in place to ensure its counter-fraud culture and framework are operating effectively. We expected to see: • a record kept of fraud losses and recoveries; • the Audit Committee taking a proactive approach to prevent fraud and promote an effective anti-fraud culture; and • the Audit Committee challenging and reviewing counter-fraud work, and ensuring it discharges its duties in relation to counter-fraud.	We found the following good practice: • the Health Board maintains a record of fraud losses and recoveries; • counter-fraud is a standing item on the Audit Committee agenda; • the annual plan is presented to the Audit Committee along with regular progress reports on delivering the annual programme of work, along with identified fraud risks and actions to minimise them; and • case updates are produced for the private session of Audit Committee outlining the case, status, and recoveries of money/assets. We did not identify any areas for improvement.

Appendix 1

Counter-fraud resources

The following exhibit sets out the number of LCFS resources per 1,000 staff.

Exhibit 3: Number of LCFS resources per 1,000 staff (in order of highest to lowest)

	LCFS WTE	Total number of staff within the organisation	LCFS WTE per 1,000 staff (headcount)
Health Education and Improvement Wales[1]	0.2	280	0.71
Welsh Ambulance Services NHS Trust	2.0	3,535	0.57
Powys Teaching Health Board[2]	1.2	2,286	0.52
Cwm Taf Morgannwg University Health Board[2]	2.6	11,944	0.22
Hywel Dda University Health Board	2.0	10,032	0.20
Aneurin Bevan University Health Board	2.6	13,659	0.19
NHS Wales (average)	**18.17**	**94,614**	**0.19**
Swansea Bay University Health Board[2]	2.16	12,962	0.17
Betsi Cadwaladr University Health Board	2.91	18,491	0.16
Public Health Wales NHS Trust[1]	0.3	1,903	0.16
Velindre University NHS Trust[1]	0.4	4,411	0.16
Cardiff & Vale University Health Board[1]	1.8	15,111	0.12

[1] The Cardiff & Vale University Health Board LCFS Team also provides services to Health Education and Improvement Wales, Public Health Wales NHS Trust and Velindre University NHS Trust via an annual Service Level Agreement.

[2] The Swansea Bay University Health Board LCFS Team also provide services to Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board via an annual Service Level Agreement.

Source: Counter Fraud Services in NHS Wales, Operational Performance Report 2019-20 (Quarter 3), and Stats Wales Headcount as at 30 September 2019 (extracted from the NHS Electronic Staff Record system).

Appendix 2

Management response

Exhibit 4: management response

Ref	Area for improvement	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
I1	**Training and awareness raising** Although training is part of the induction training and progress is monitored at Audit Committee, the Counter Fraud e-learning module could be included in the Health Board's Mandatory Training for Staff and staff are not trained on an annual basis.	Greater uptake of counter-fraud staff training leading to greater awareness of associated issues and responsibilities.	No	Yes	The Health Board will explore if it is viable to include Counter Fraud e-learning as part of its mandatory training.	31 December 2020	Sue Hill

Ref	Area for improvement	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
I2	**Resources and skills** The number of LCFS staff in the establishment is not explicitly linked to an evaluation of the increased fraud risk facing the Health Board. There is an opportunity to reflect on whether counter-fraud resources and balance between proactive and reactive work match the fraud risks the Health Board is exposed to.	Maximise the potential of the service.	No	Yes	A review of resources employed will be undertaken, taking into account current workload, benchmarking with comparative organisations and the current fraud risk.	31 December 2020	Sue Hill

Ref	Area for improvement	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
I3	**Fraud risk assessments** Fraud risk assessments should be used as a live resource and integrated within the general risk management framework to ensure that these risks are appropriately managed and escalated as necessary. The case study on the COVID-19 pandemic provides an important opportunity for the Welsh counter-fraud community to come together and reflect on the speed and effectiveness of its response to the scammers and fraudsters. However, this reflection could also be undertaken at a local level by the Health Board.	Improved management of risk and minimised opportunities for fraud to occur	Yes	Yes	The Health Board will use fraud risk assessments as a live resource and fraud will be integrated within the general risk management framework, to ensure that these risks are appropriately managed and escalated as necessary. This process has already started. The Welsh NHS counter-fraud community both nationally and at a local level share fraud alerts, (especially in relation to scams and fraud relating to the COVID-19 pandemic) in real time. The fraud alerts are shared with the relevant stakeholders. The Health Board will establish a monitoring programme to measure the speed and effectiveness of the fraud alerts, which are issued at a local level.	31 December 2020	Sue Hill

Ref	Area for improvement	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
I4	**Internal control environment** Our national review identified only a few examples of data analytics being used as a means of preventing fraud, predominantly the National Fraud Initiative data matching exercise. The Health Board should reflect on how it could make greater use of data analytics to both prevent and detect fraud.	Maximised impact through the use of data analytics.	Yes	Yes	The Health Board will undertake the appropriate research on how to make greater use of data analytics to both prevent and detect fraud.	31 December 2020	Sue Hill
I5	**Responses to fraud** The Health Board should explore avenues to improve collaboration more widely across sector boundaries on common risks and challenges.	Mutual benefit from increased information sharing leading to a further strengthening of the service.	Yes	Yes	The Health Board will explore avenues to improve collaboration more widely across sector boundaries on common risks and challenges.	31 December 2020	Sue Hill

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 17th September 2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Primary Care Dental Services Assurance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director for Primary Care and Community Services
Awdur yr Adroddiad Report Author:	Assistant Director for North Wales Dental Services
Craffu blaenorol: Prior Scrutiny:	Executive Director for Primary Care and Community Services / Area Director Central
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Audit Committee is asked to note the contents of this paper and the actions implemented to provide assurance of the maintenance of an effective dental service during the Covid-19 pandemic and other processes to protect the public purse expenditure the management and commissioning of General Dental Services.

Please tick as appropriate

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

Sefyllfa / Situation:

The purpose of the paper is to provide Members with an overview of the risks and assurance processes that are applied by the Dental Directorate of the Health Board (HB) in its management of primary care dental service contractors during the Red and Amber phases of the current Covid-19 pandemic.

Cefndir / Background:

The previous report to the Audit Committee (12 December 2019) outlined how dental contracts were performance monitored and managed via a system of Units of Dental Activity (UDA) and the mechanisms in please to manage risk and provides assurance

The Welsh Government issued notification 23 March 2020 that dental services had entered Red Alert phase and that all face to face treatment in dental practices, with the exception of limited treatment in absolute urgent circumstances, was suspended.
The Chief Dental Officer Wales (CDO) subsequently wrote to all Health Boards and Dental Contractors 26 March 2020 suspending the monitoring of UDA and setting out the conditions and

expectations for continued contract payments at 80% of full contract value initially for the 3 month period to end June 2020.

The conditions and expectations were:

- all staff in post in March 2020 will be retained and their pay will be protected at previous levels to reflect their NHS work, with no redundancies being made.
- Practices will remain ‘open for contact’ and will commit to providing Health Boards with details of activity every fortnight.
- Practices are required to ensure a dentist is available, during normal practice opening hours, to give telephone advice and direction to patients including remote prescriptions.
- Practices may need to undertake certain urgent treatments for patients that do not have any symptoms of COVID-19 and that cannot be delayed
- Practice staff may be asked by their Health Board to assist in the provision of services at the Urgent/Emergency dental care centres or to undertake other tasks to assist the wider NHS.
- Practices will cooperate to ensure sufficient cover for emergency work is provided to Health Boards. This will include staff and resources being shared between practices.
- Practices are advised to consider paying a stipend or retainer is paid to labs based in Wales that is proportionate to their level of supply of NHS lab work to the practice.

The conditions and expectations effectively replaced the UDA system and meant that previously described mechanism for UDA performance monitoring practices became unavailable.

This paper describes the actions taken by the Dental Directorate to maintain adequate levels assurance and risk management regarding dental services following the suspension of the UDA system and further processes that have been put in place to improve the engagement and management of contractor activity.

Asesiad / Assessment & Analysis

Strategy Implications

General Dental Services is a key primary care service commissioned by the Health board for its residents. This supports Care Closer to Home, a key area of the HBs strategy by delivering preventative oral healthcare to both adults and children at convenient and appropriate locations.

Financial Implications

The assessment is that there are no financial implications to this report. The report is intended to provide Members with a background to actions implemented during the Covid pandemic to provide assurance that contract payments are being utilised for continued effective delivery of dental services.

Risk Analysis

The assessment of risk is that, following the suspension of UDA, there is limited NHS/BSA or BCUHB oversight of the risk management processes. This risk is not currently registered on the Risk Register

Actions to manage risk and provide assurance are:

Assurance Action 1 - Telephone contact
Each and every General Dental Services (GDS) practice was contacted phone by the dental contracting team during the first fortnight of April in order to:

- Establish personal contact with the practice following “lockdown”
- Confirm that the practice was “open for contact” during normal working hours
- Ensure there was an understanding of the conditions and expectations of continued contract payment and that the practice was complying with them
- Identify any queries and provide/offer guidance and/or support as appropriate

Assurance Action 2 – Weekly Activity Data Reporting
All GDS dental contractors were required to complete and submit a weekly activity data report detailing the numbers of:

- Patients assessed/treated in the practice
- Referrals made to the Urgent Dental Centres
- Prescriptions issued
- Patients provided with remote advice by a dentist
- Telephone calls received from patients

The submissions were checked by the dental contracting team to ensure a return had been received and that a level of activity was being reported. If either were missing the practice was contacted by a member of the team to query why and establish and agree what action was required

Assurance Action 3 – Contractor Declaration

Contractors were requested to complete, sign and return a declaration indicating their compliance with the conditions and expectations of continued payments.
All contractors signed and returned their declaration. Declarations that included comments from the contractor were followed up to provide support and guidance to help ensure maintenance of a dental

services to patients. Practices were encouraged to work together where they found difficulties maintaining a service as a single practice – this was particularly the case with some of the smaller practices.

Assurance Action 4 – Third Party Feedback

Feedback from patients and practice staff on aspects of compliance with the conditions and expectations of continue payments were monitored and followed up as appropriate. Feedback from patients often related to the practice not being open for contact. Feedback from practice staff often related to their understanding of the requirement of the contractor to continue to pay staff at pre-COVID levels.

Most issues raised have been resolved with a phone call to the practice, however, the dental contracting team have taken advice from the Local Counter Fraud Team regarding claims from staff regarding continued salary payments. Subsequently, a small number of cases are under consideration for referral to the local Audit team.

In June 2020 Welsh Government announced that dental services would move to Amber Alert phase from 22 June. The CDO subsequently set out an adjusted set of conditions and expectations for continued payments during the Amber phase for continued payments at 90% of full contract value during the 3 months to end September 2020

In addition to the Assurance actions listed above the following additional ones have been implemented

Assurance Action 5 – Practice Standard Operating Procedure & Staff Risk Assessment

Amber phase requires the re-instatement of Aerosol Generating Treatments (AGPs) within practice. The dental contracting team have requested a copy of the practice Standard Operating Procedure (SOP) for the safe delivery of AGPs and for confirmation that a Covid-19 risk assessment has been completed for each member of the practice team along with their risk rating. SOPs submitted by each practice are reviewed by one of the Health Board's Dental Practice Advisers and, if assessed as satisfactory, approval to provide AGP treatments provided to the practice

Assurance Action 6 – Contractor Declaration

A second declaration, relevant to the Amber phase conditions and expectations had been issued and was in progress at the time of writing this report

Non-Compliance

In circumstances that the contractor is unable or unwilling to provide satisfactory assurance of compliance with the conditions and expectations of continued payment the contracting team engage with the contractor to discuss the issue and agree a resolution (e.g. cooperate with nearby practices). If serious non-compliance by the contractor persists the Welsh Government have confirmed the option to revert the management of the contract back to UDA monitoring. Such a reversion has potentially serious consequences for the payment levels to the Contractor so would not be triggered lightly by either party.

Advice has been sought from the Local Counter Fraud Service for consideration of non-compliance with Welsh Government guidelines. Their recommendation is that in such cases where the contracting team is unable to resolve the issue, a paper is brought to Audit committee for their consideration.

Further Assurance with Contract Management

The Assistant Director has developed an additional process to further aid performers and practices who may be experiencing lower levels of performance or issues with processes, governance or reporting of activity which the contracting team have been unable to resolve through discussion.

The process is known as the Support and Assurance process. The ideology behind the approach is to invite individuals into a formal meeting to discuss and asking them to present their cases for not achieving compliance.

The panel is made up of the Assistant Director and the interim North Wales Dental Clinical Director where they consider presentations from the contracting team and the provider. A solution is actively sought, hopefully without have to formerly escalate concerns to Quality and Safety or Performance Concerns Group.

The process is yet to be formerly adopted through our normal governance routes but this will take place in this month. Please note, the draft has been shared with the Local Dental Committee and it has their approval.

Legal and Compliance

GDS services are covered by the NHS GDS (Wales) Regulations 2006. Since the declaration of Red Alert 23 March 2020 and the subsequent progression to Amber Alert 22 June 2020 services are covered by a number of specific guidance documents issued by the CDO:

- Red Phase Guidance (23/3/20)
- Covid-19 Business Continuity and Financial Support (26/3/20)
- Red Alert Escalation (3/4/20)
- De-escalation SOP (21/5/20)
- Restoration of Dental Services (22/5/20)
- SOP for AGPs for non-COVID patients (10/6/20)
- Expectation Document – Amber Phase (13/7/20)

Impact Assessment

No impact assessment has been completed as the paper describes the assurance processes in place for an existing service.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 17/09/20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	End of Year Reporting Documentation / Committee Annual Reports
Cyfarwyddwr Cyfrifol: Responsible Director:	Acting Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Acting Board Secretary Committee Members for respective Committee Annual Reports
Atodiadau Appendices:	Appendix 1:

Argymhelliad / Recommendation:

The Audit Committee is asked to receive the following annual reports:

1. Finance & Performance Committee
2. Remuneration & Terms of Service Committee
3. Strategy, Partnership & Population Health Committee
4. Stakeholder Reference Annual Report
5. Healthcare Professionals Forum and;

to note/approve that the Digital & Information Governance Committee, the Mental Health Act Committee / Power of Discharge Sub Committee and the Local Partnerships Forum be approved via Chair's Action.

Please tick as appropriate

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

Sefyllfa / Situation:

Under normal circumstances, Members will be aware that all Committees, in accordance with Standing Orders are required to produce Annual Reports, however in the light of Covid-19, the Board agreed to step down that requirement in respect of all Committees with the exception of Audit and QSE (which were presented at the June Audit Committee meeting). The Committee Business Management Group at its meeting on 18th June 2020 agreed to request all other Committees to commence completion of their Annual Reports and for these to be submitted to the September Audit Committee.

Cefndir / Background:

Annual Committee Reports
Draft Annual Committee reports have been reviewed by the respective Committee Members in advance of submission.

Asesiad / Assessment & Analysis

Strategy Implications

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

Financial Implications

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

Risk Analysis

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

Legal and Compliance

Compliance with Health Board Standing Orders.

Impact Assessment

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

Remuneration & Terms of Service Committee Annual Report 2019-20

1. Title of Committee

Remuneration & Terms of Service Committee (R&TS)

2. Name and role of person submitting this report:

Sue Green, Executive Director of Workforce & Organisational Development

3. Dates covered by this report:

01.4.19 – 31.3.20

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

The R&TS Committee was routinely scheduled to meet five times and otherwise as the Chair deemed necessary. During the reporting period, it met formally on seven occasions including two extraordinary meetings (17.1.20 and 23.1.20, at which other Independent Members were also present). Attendance by Committee members at formal meetings is detailed within the table below. All formal meetings were quorate.

Independent Members of the Committee	9.4.19	13.5.19	29.8.19	4.11.19	17.1.20	21.1.20	23.1.20
Mark Polin, Chair	P*	P	P	P*	P	P	P
Jackie Hughes	P	P	P	P	P	P	P
Medwyn Hughes	P	P	P	P	P	P	P
Marian Wyn Jones	P	A	P	P	◆	◆	◆
Directors and Officers - formally In attendance (as per Terms of Reference)							
Gary Doherty, Chief Executive	P*	P	P	P	X	X	X

Sue Green, Executive Director of Workforce & Organisational Development	P	P*	P	P	P	P	P

Key:

P - Present
P* - Present for part meeting
A - Apologies submitted
X - Not present
◆ Not a member of the Committee at this time.

In addition to the above core membership, other directors and officers from the Health Board may attend meetings of the Committee for certain items. Other independent members may also attend on a co-opted basis. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Committee is designed to provide:

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

- Advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;

- Assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales;

- To perform certain, specific functions as delegated by the Board (as set out in the Delegated Powers and Authority section of the terms of reference)

During the period that this annual report covers, the Committee operated in accordance with its terms of reference. Version 4.0 was operative from April 2019, Version 5.0 from July 2019 and Version 6.0 from November 2019. Copies are provided at Appendices 1, 2 and 3.

The work programmes, cycles of business and overall performance of the Committee are reviewed by the Committee Business Management Group (CBMG) which meets quarterly. The CBMG oversees effective communication between committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's governance framework.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a log is maintained by the Office of the Board Secretary to record any breaches of compliance with this requirement. During the reporting period there was one breach of this nature in terms of an individual paper not being available 7 days before the meeting.

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

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

Objective as set out in Terms of Reference	**Assurance Status (RAG)***	**Supporting narrative** *(Please provide narrative against all red and amber including the rationale for the assurance status)*
1. Advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;	Green	Reports including Executive Director pay and terms of service were considered on 9.4.19, 13.5.19, 29.8.19, 17.1.20 and 23.1.20.
2. Assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales;	Green	Rates of pay for GPs in managed practices and out of hours were considered on 9.4.19 and 21.1.20. A pay protection report was considered on 9.4.19. A paper on pay and terms of service for non-clinical staff in managed practices was considered on 13.5.19. A paper relating to re-banding of a group of staff was considered on 29.8.19. A paper on a secondment was considered on 21.1.20.
3. To perform certain, specific functions as delegated by the Board: 3.1 To comment on the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;	Green	VSM pay and terms of service were considered as part of reports received on 9.4.19, 13.5.19, 29.8.19 and 4.11.19.
3.2 Be sighted on the objectives set by the Chief Executive for his immediate team, confirm that Directors have had objectives set, and that appropriate and timely performance reviews have taken place	Green	A report on this matter was considered on 4.11.19.

3.3 To comment on proposals to make additional payments to consultants;	-	No business to discuss during the reporting period.
3.4 To comment on proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.	Green	Termination arrangements relating to an Executive Director were considered as part of a report received on 9.4.19
3.5 To comment on removal and relocation expenses	-	No business to discuss during the reporting period in question – no exceptions to report.
3.6 Consider and approve Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.	-	No individual VERS applications to consider during the reporting period in question. A wider paper on pay protection which referenced VERS was considered 0n 9.4.19. Severance payments were discussed as part of a paper considered on 17.1.20.
3.7 To monitor compliance with issues of professional registration, including the revalidation processes for medical and dental staff and registered nurses, midwives and health visitors and Allied professionals.	Green	Reports were considered on 29.8.19.
3.8 Monitor and review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;	-	No business to discuss during the reporting period in question as there are no corporate risks currently allocated to the R&TS Committee.
3.9 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	Green	A report on the management of Human Resources processes in respect of an investigation was considered on 9.4.19.

• other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.		
3.10 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;	Green	The use of external legal advisers was referred to in a paper considered by the Committee on 17.1.20.
3.11 Consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business including approval of Workforce policies.	Green	A new policy approval mechanism was approved on 9.4.19.
3.12 Consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.	Green	Reports on Upholding Professional Standards in Wales (UPSW) cases were considered on 9.4.19, 29.8.19, 4.11.19 and 21.1.20. A paper on an UPSW process review was considered on 21.1.20.

Key:

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

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

- Revised approval process for Workforce & Organisational Development Policies.
- The Committee's annual report for 2018-19 was approved for submission to the Audit Committee.
- Review of terms of reference
- Current Upholding Professional Standards in Wales cases.
- Health Care Professions Council and General Pharmaceutical Council Wales Professional Registration Report 18/19
- General Medical Council (GMC) Revalidation Update 2019
- Review Body on Doctors' & Dentists Remuneration Report
- Pay protection progress reports.
- Matters pertaining to Executive portfolios and acting/interim arrangements including remuneration.
- Matters pertaining to senior leadership structures

- National pay rates for Single Integrated Clinical Assessment and Triage Service.
- A collective grievance matter.
- Executive team objectives and performance assessment.
- Matters pertaining to the post of Chief Executive

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages
https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

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

Meeting Date	Key risks including mitigating actions and milestones
29.8.19	Information was provided on mitigating actions in respect of risks relating to a collective employment grievance.

Other risks and mitigating actions were covered during private session discussions.

9. Focus for the year ahead:

The primary focus of the R&TS Committee over the next twelve months will be to oversee the arrangements for the recruitment of a Chief Executive, to review objectives and performance managements in place for Executive Directors and their immediate reports, and to oversee re-structuring in respect of senior posts.

Appendix 1 – April to June 2019:

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the Remuneration and Terms of Service Committee **(R&TS)**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to provide:

- advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;

- assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales; and

- to perform certain, specific functions as delegated by the Board and listed below.

3. DELEGATED POWERS AND AUTHORITY

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

3.1.1 comment specifically upon

- the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;
- objectives for Executive Directors and other VSMs and their performance assessment;

- performance management system in place for those in the positions mentioned above and its application;
- proposals to make additional payments to consultants;
- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
- removal and relocation expenses

3.1.2 consider and approve Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.

3.1.3 to monitor compliance with issues of professional registration.

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

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

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

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

3.1.7 consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business including approval of Workforce policies.

3.1.8 Consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.

4. SUB-COMMITTEES

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

5. MEMBERSHIP

5.1 Members

- Four Independent Members of the Board
- The Chair of the Audit Committee will be appointed to this Committee either as Vice-Chair or a member.

5.2 In attendance

- Chief Executive Officer
- Executive Director of Workforce and Organisational Development (Lead Director)

Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. A Staff Side Chair of the Local Partnership Forum will be in attendance at meetings held in public as an ex-officio member.

5.3 Member Appointments

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

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

5.4 Secretariat

5.4.1 Secretary: as determined by the Board Secretary.

5.5 Support to Committee Members

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

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

6. COMMITTEE MEETINGS

6.1 Quorum

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

6.2 Frequency of Meetings

6.2.1 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings, as deemed necessary. It is expected that the Committee shall meet at least once a year, consistent with the Health Board's annual plan of Board Business.

6.3 Withdrawal of individuals in attendance

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

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

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

7.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

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

7.3.2 sharing of information

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

7.4 The Committee shall embed the corporate goals and priorities through the conduct of its business and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable

development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Committee Chair shall:

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

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

8.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

• Quorum

10. REVIEW

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

Date of approval

Health Board 6.9.18

Reported to RATS 26.11.19

Appendix 2 – July to October 2019:

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the Remuneration and Terms of Service Committee **(R&TS)**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to provide:

- advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;

- assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales; and

- to perform certain, specific functions as delegated by the Board and listed below.

3. DELEGATED POWERS AND AUTHORITY

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

3.1.1 comment specifically upon

- the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;
- objectives for Executive Directors and other VSMs and their performance assessment;
- performance management system in place for those in the positions mentioned above and its application;

- proposals to make additional payments to consultants;
- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
- removal and relocation expenses

3.1.2 consider and approve Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.

3.1.3 to monitor compliance with issues of professional registration, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and Allied professionals.

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

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

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

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

3.1.7 consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business including approval of Workforce policies.

3.1.8 Consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.

4. SUB-COMMITTEES

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

5. MEMBERSHIP

5.1 Members

- Four Independent Members of the Board
- The Chair of the Audit Committee will be appointed to this Committee either as Vice-Chair or a member.

5.2 In attendance

- Chief Executive Officer
- Executive Director of Workforce and Organisational Development (Lead Director)

Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. A Trade Union Partner Chair of the Local Partnership Forum will be in attendance at meetings held in public as an ex-officio member.

5.3 Member Appointments

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

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

5.4 Secretariat

5.4.1 Secretary: as determined by the Board Secretary.

5.5 Support to Committee Members

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

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

6. COMMITTEE MEETINGS

6.1 Quorum

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

6.2 Frequency of Meetings

6.2.1 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings, as deemed necessary. It is expected that the Committee shall meet at least once a year, consistent with the Health Board's annual plan of Board Business.

6.3 Withdrawal of individuals in attendance

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

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

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

7.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

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

7.3.2 sharing of information

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

7.4 The Committee shall embed the corporate goals and priorities through the conduct of its business and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable

development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Committee Chair shall:

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

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

8.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

• Quorum

10. REVIEW

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

Date of approval

Audit Committee 30.5.19

Health Board 25.7.19

Appendix 3 – November 2019 to present:

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the Remuneration and Terms of Service Committee **(R&TS)**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to provide:

- advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;

- assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales; and

- to perform certain, specific functions as delegated by the Board and listed below.

3. DELEGATED POWERS AND AUTHORITY

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

3.1.1 comment specifically upon

- the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;

- and to be sighted on the objectives set by the Chief Executive for his immediate team, confirm that Directors have had objectives set, and that appropriate and timely performance reviews have taken place
- proposals to make additional payments to consultants;
- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
- removal and relocation expenses

3.1.2 consider and approve Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.

3.1.3 to monitor compliance with issues of professional registration, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and Allied professionals.

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

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

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

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

3.1.7 consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business including approval of Workforce policies.

3.1.8 Consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.

4. SUB-COMMITTEES

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

5. MEMBERSHIP

5.1 Members

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- The Chair of the Audit Committee will be appointed to this Committee either as Vice-Chair or a member.

5.2 In attendance

- Chief Executive Officer
- Executive Director of Workforce and Organisational Development (Lead Director)

Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. A Trade Union Partner Chair of the Local Partnership Forum will be in attendance at meetings held in public as an ex-officio member.

5.3 Member Appointments

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

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

5.4 Secretariat

5.4.1 Secretary: as determined by the Board Secretary.

5.5 Support to Committee Members

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

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

6. COMMITTEE MEETINGS

6.1 Quorum

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

6.2 Frequency of Meetings

6.2.1 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings, as deemed necessary. It is expected that the Committee shall meet at least once a year, consistent with the Health Board's annual plan of Board Business.

6.3 Withdrawal of individuals in attendance

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

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

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

7.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

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

7.3.2 sharing of information

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

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

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Committee Chair shall:

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

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

8.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

• Quorum

10. REVIEW

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

Date of approval

Audit Committee

Health Board – November 2019.

V6.0 Approved

Stakeholder Reference Group Annual Report 2019/20

1. Title of Group: Stakeholder Reference Group (SRG)

2. Name and role of person submitting this report:

Ffrancon Williams, Chair
Mark Wilkinson, Lead Director and BCU Executive Director of Planning & Performance

3. Dates covered by this report:

1st April 2019 to 31st March 2020

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

The Advisory Group was routinely scheduled to meet four times and otherwise as the Chair of the Group deemed necessary. During the reporting period, it met on four occasions. Attendance at meetings is detailed within the table below:

Members of the Group	Organisation	4/6/2019	10/9/2019	17/12/2019	3/3/2020
Ffrancon Williams (Chair)	Housing Association	✓	✓	✓	✓
Gwilym Elllis Evans (Vice Chair)	Mantell Gwynedd	✓	✓	✓	✓
Mark Wilkinson	BCU Exec Director of Planning & Performance (Lead Director)	✓	✓	✓	✓
Cllr Christine Marston	Denbighshire County Council	A	A	A	✓
Mr Mark Thornton	NW CHC Chair	✓	A	A	A
Dr Garth Higginbotham	Vice Chair, NW CHC	A	✓	✓	✓
Fran Hughes	Flintshire VSC	✓	✓	♦	♦
Mrs Sherry Weedall / Mrs Jackie Allen from Oct '19	Wrexham AVOW	♦	✓	✓	A
Mrs Ann Woods	Flintshire VSC (Part)	A	A	✓	✓
Mrs Mary Wimbury	Care Forum Wales	✓	A	A	✓

■Julie Pierce / Mair Davies/ Debbie Thompson	Denbighshire Voluntary Services	A	✓	A	✓
Sian Purcell	Medrwn Mon VSC	A	✓	A	A
Mrs Fiona Evans	Conwy VSC	A	A	✓	✓
Prof Robert Moore	North Wales Regional Equality Network	A	✓	✓	A
Cllr Llinos Medi Huws	Ynys Mon LA	A	A	A	A
Cllr Joan Lowe	Wrexham LA	A	A	A	✓
Llinos M Roberts	Carer's Outreach Service	✓	A	✓	A
Cllr Penny Andow / Cllr Louise Emery from Dec 2019	Conwy LA	A	A	✓	A
Mrs Claire Sullivan	NEWCIS	A	A	A	A
Cllr Christine Jones	Flintshire LA	A	A	A	A
Cllr Dafydd Meurig	Gwynedd LA	A	A	A	A
Mr Mike Harriman	One Voice Wales	✓	♦	♦	♦
Cllr Mike Parry	One Voice Wales	♦	✓	✓	✓
Mrs G Winter	Carers Trust	A	A	A	A
Mr Trystan Pritchard	North Wales Hospices	♦	✓	A	✓
■WAST Nominee (Alternating Attendance – Andy Long / Wayne Davies)	WAST	A	A	A	A
Sally Baxter	BCU Acting Director of Strategy (Lead Director)	✓	✓	A	A
Katie Sargent	BCU Asst Director Comms & Engagement (Lead Officer)	✓	✓	A	A
Suzanne Didcote	BCU PA – Admin Support (Minutes)	✓	✓	✓	✓

Key:

✓ Present A Apologies/Absent ♦ Not a member of the Group at this time
■ Where there are multiple nominees for one organisation, attendance is based on the organisation rather than the individual.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee/Group/Forum. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

From the above table it is suggested that:

- There has been strong support from relevant directors and officers to the work of the SRG
- Those members who have attended have found it relevant enough to justify their continued participation.
- Attendance from some members and in particular Local Authority representation continues to be a challenge where some representatives have not attended / hardly at all.

5. Assurances the Group is designed to provide:

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

- Continuous engagement and involvement in the determination of the LHB overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the UHB operations on the communities it serves

During the period that this Annual Report covers, the Group operated in accordance with its terms of reference which were operative for the whole of the term this Annual Report covers. The terms of reference are appended at **Appendix 1**.

The work programmes, cycles of business and overall performance of each Committee/Group/Forum are reviewed by the Committee Business Management Group (CBMG) which meets quarterly. The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

The Group is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were no breaches of this nature in terms of either individual papers / whole agenda not being available 7 days before the meeting.

6. Overall *RAG status against Group's annual objectives / plan: GREEN

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

Objective as set out in Terms of Reference	Was sufficient advice provided? RAG	**Supporting narrative**
Continuous engagement and involvement in the determination of the LHB overall strategic direction		A variety of Reports & presentations on the specific service areas and the overall strategic direction to each meeting, as can be seen from the additional information presented in Section 7.0 below.
Provision of advice on specific service proposals prior to formal consultation		The SRG has Strategic Planning as a regular agenda item. Feedback has been given on several occasions, including via the Chair's regular report to the health Board. Examples include: Stroke, Orthopaedics, Ophthalmology and Urology
Feedback on the impact of the LHB operations on the communities it serves		A significant focus has been on SRG influencing the organisation's strategic direction and ensuring impacts on communities are recognised and reflected as the strategy develops. Individual members have had opportunity to describe impacts on their constituents across a range of strategies and activities of the Board through the agenda items considered by the Group.

**Key:*

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

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

The Group has re-focussed its agenda and meetings to enable concentration on a limited number of key issues at each meeting. The topics covered are as follows:

June 2019:

- Corporate Planning update, incorporating Estate Strategy
- Update on Workforce Strategy
- Reducing reliance on temporary staff
- Engagement Strategy update
- Third Sector Strategy update
- Services Strategy update
- Stroke Services
- Orthopaedics Services
- Eye Care Services

September 2019:

- Mental Health Update to include Financial Position
- Clinical Services Strategy
- Development of Strategic Equality Plan
- Third Sector Strategy update
- Well-Being of Future Generations Act update

December 2019:

- Primary Care update
- Orthopaedic Business Case – Consultation and Engagement
- Planning Update – Annual Plan and Digitally Enabled Clinical Strategy
- Update on Well North Wales Programme

March 2020:

- Planning update
- Ophthalmology Business Case
- Urology Services Business Case

Full details of the issues considered and discussed by the Group are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

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

Meeting Date	Key Advice and Feedback to the Board
June 2019	The Group raised concerns about the time it will take to implement the changes to Stroke Services. It was recognised that progress has been made, but it has taken a long time from the Stakeholder Sessions held two years ago to get to this stage with some Hyper Acute Services not planned for delivery for a further 4 years. The Group's concerns were around patient outcomes not improving at the pace required. The Group noted that some strategies would benefit from improved alignment; the example which presented difficulty at the meeting was continued investment in for example, Eye Care Services at the Abergele Hospital site whilst moving Orthopaedics from that site at a time when the Estate Strategy has identified continued investment in Abergele Hospital does not align with the Health Board's aspirations. The Group noted that engagement activity had improved greatly compared to the inception of Special Measures Attendance at the last SRG meeting was low. The Chairman and the Director of Planning and Performance are to prioritise agenda items coming to the Stakeholder Reference Group to ensure they align with the Health Board's work programme.
Sep 2019	The work in Mental Health is encouraging, with the Pathway approach and the projection of savings to break even. It was pleasing to hear of the effectiveness of the referral process and the Community Care Hub. The Group was encouraged to hear about the use of Mental Health Practitioners working with the Police before S136 Powers were implemented. Relating to the Clinical Services Strategy, the Group emphasised the importance of public engagement that will be needed around the changes to services. Transport links, travel times to services and WAST performance (Welsh Ambulance Services Trust) needs to be taken into account and prioritised in some way. The Chair noted the on-going lack of attendance by Local Authorities and the Group agreed that the matter should be raised with them so that attendance at the SRG meeting would be prioritised.

Dec 2019	From the Primary Care (General practice) update, the Board should note the issues around workforce implications, the Multi-Disciplinary Team working model that is being developed, work that needs to be undertaken in shaping public expectations and emphasis on the third sector working relationships From the Orthopaedics Programme update, the Board should note that whilst there is a want to support the initiative, there is a clear message from the Group that the outcomes need to be delivered. From the Well North Wales Programme update the Board should note that the Stakeholder Reference Group value and support the work that is being done, but have concern about increased deprivation and poverty, and addressing health inequalities.
March 2020	From the Planning update the Board should note that the challenges with funding mechanisms were raised. The financial support package plans are welcomed and the Group endorsed that. In addressing financial issues, value for money is key especially in the Care sector. The focus on sharpening accountability is also welcomed. Collaborative working is key and any opportunities to strengthen this should be undertaken. From the Ophthalmology Business Case update the Board should note that the Group positively received the work been undertaken in terms of patient experience. There is a need to monitor outcomes to ensure benefits are delivered and cost pressures are addressed. It was noted that this also fits with the Care Closer to Home work of the Health Board. From the Urology Services Business Case update the Board should note that the work undergoing has the support of this Group. The need to address recruitment, cost and patient experience is welcomed. Disappointment was expressed on the time it has taken to get this far and that there should be no further delay. The Group also wanted to express that due consideration be given to address politics around engagement and how we might do it to greater effect

9. Focus for the year ahead:

The primary focus of the Group over the next twelve months will be to continue to remain relevant by focussing on the items under discussion at Board and improve the timing of SRG discussion so that it becomes more useful to the Board in its service change related and strategic decision making.

The Group has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached at **Appendix 2**.

APPENDIX 1

Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

The Stakeholder Reference Group (SRG)

INTRODUCTION

The Board has a statutory duty to take account of representations made by persons who represent the interests of the communities it serves. To help discharge this duty the Board has appointed Advisory Groups to provide advice to the Board in the exercise of its functions. The Board Advisory Groups includes the Stakeholder Reference Group.

PURPOSE

The purpose of the Stakeholder Reference Group, hereafter referred to as "SRG", is to provide:

- Continuous engagement and involvement in the determination of the LHB overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB operations on the communities it serves.

DELEGATED POWERS AND AUTHORITY

The SRG will, in respect of its provision of advice to the Board:

- Provide a forum to facilitate continuous engagement and activate debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.
- The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. The SRG's role is distinctive from that of Community Health Councils (CHCs), who have a statutory role in representing the interests of patients and the public in their areas.

Authority

The SRG may offer advice specifically requested by the LHB on any aspect of its business, and the SRG may also offer advice and feedback even if not specifically requested by the LHB. The SRG may provide advice to the Board:

- at Board meetings, through the SRG Chair's participation as Associate Member;
- in written advice; and
- in any other form specified by the Board

Sub Committees

The Board may determine that the SRG should be supported by sub groups to assist it in the conduct of its work, or the SRG may itself determine such arrangements, provided that the Board approves such action.

MEMBERSHIP

Chair	nominated from within the membership of the SRG by its members and approved by the Board
Vice Chair	nominated from within the membership of the SRG by its members and approved by the Board.
Members	The membership is drawn from within the area served by the LHB, and ensures involvement from a range of bodies and groups operating within the communities serviced by the LHB. SRG Members can agree 'nominated/named deputies' to attend in exceptional circumstances such as a prolonged period of absence. These nominations must be notified in writing to the Board Secretary and approved by the Health Board. The membership will be made up of representatives from the following sectors:

Sector/organisation	Number of places available
Third sector	6
Independent sector	1
Town/Community Councils	1
Housing Associations	1
Carers	3
Local Authorities	6
Disability equality	1
North Wales Regional Equality Network	1
Hospice	1
Total	**21**

This membership will be reviewed by the Chair and Lead HB Officer on an annual basis

Representatives can be 'co-opted' to advise on specific issues as appropriate by agreement with the Chair.

Lead HB Officer	Executive Director of Planning & Performance
Secretary	As determined by the Board Secretary
In attendance	The Board may determine that designated board members or LHB staff should be in attendance at Advisory Group

meetings. The SRG's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

By invitation — The SRG shall make arrangements to ensure designated CHC members receive the SRGs papers and are invited to attend SRG meetings.

Member Appointments

Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder group where it has determined that formal bodies or groups are not already established or operating within the area who may represent the interests of these stakeholders on the SRG.

The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Assembly Government. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment.

Members shall be appointed for a period of no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively. The Board may, where it considers it appropriate, make interim or short term appointments to the SRG to fulfil a particular purpose or need.

The ***Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the LHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

The ***Chair's*** term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

The ***Vice Chair*** shall be nominated from within the membership of the SRG, by its members by the same process as that adopted for the Chair, subject to the condition that they be appointed from a different sector/organisation from that of the Chair.

The Vice Chair's term of office will be as described for the Chair.

A member's tenure of appointment will cease in the event that they no longer meet any

of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.

Support to SRG Members

The LHB's Board Secretary, on behalf of the Chair, will ensure that the SRG is properly equipped to carry out its role by:

- ensuring the provision of governance advice and support to the SRG Chair on the conduct of its business and its relationship with the LHB and others;
- ensuring that the SRG receives the information it needs on a timely basis;
- ensuring strong links to communities/groups; and
- facilitating effective reporting to the Board
- enabling the Board to gain assurance that the conduct of business within the SRG accords with the governance and operating framework it has set.

SRG MEETINGS

Quorum

At least one third of the members must be present to ensure the quorum of the SRG.

Frequency of Meetings

Meetings shall be held bi-monthly or otherwise as the Chair of the SRG deems necessary – consistent with the LHB's annual plan of Board Business.

Openness and transparency

The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board therefore requires, wherever possible, the Forum to hold meetings in public unless there are specific, valid reasons for not doing so.

REPORTING AND ASSURANCE ARRANGEMENTS

The SRG Chair is responsible for the effective operation of the SRG:

- chairing Group meetings;
- establishing and ensuring adherence to the standards of good governance set for

the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating arrangements; and

- developing positive and professional relationships amongst the Group's membership and between the Group and the LHB's Board and its Chair and Chief Executive.

- The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Group in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

- As Chair of the SRG, they will be appointed as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

The SRG shall embed the Corporate goals and priorities through the conduct of its business and in so doing and transacting its business shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

The Board may determine that designated board members or LHB staff should be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

The Board should determine the arrangements for any joint meetings between the LHB Board and the Stakeholder Reference Group.

The Board's Chair should put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

APPLICABILITY OF STANDING ORDERS TO SRG BUSINESS

The requirements for the conduct of business as set out in the LHB's Standing Orders are equally applicable to the operation of the SRG, except in the following areas:

- Quorum

REVIEW

These terms of reference and operating arrangements shall be reviewed annually by the SRG with reference to the Board.

DATE OF ACCEPTING THE TERMS OF REFERENCE AND APPROVAL

Board 25.7.19

Appendix 2

Agenda Item	Lead Officer	22 Jun	28 Sep	14 Dec	22 Mar
Opening Business (Standing Items)					
Apologies for Absence		x	x	x	x
Previous Minutes and Action Plan		x	x	x	x
Declaration of Interests		x	x	x	x
Chair's Report		x	x	x	x
Members' Reports		x	x	x	x
Key papers submitted to Health Board for information		x	x	x	x
Governance Matters					
Committee annual report (inc annual review of ToR and Cycle of Business)	Mark Wilkinson	x			
Strategic Matters					
BCU Third Sector Strategy Update	Sally Baxter	x			
BCU 3 Year Plan / Corporate Planning update incl Estate Strategy	John Darlington		x	x	x
BCU Services Strategy	Sally Baxter	x	x		
BCU Business Cases / Capital Development	Ian Howard / Neil Bradshaw	x	x	x	x
BCU Primary Care updates	Chris Stockport			x	
Well-being of Future Generations Act	Sally Baxter		x		
Annual Reports – for information					
BCU Annual Quality Statement	Gill Harris				x
BCU Annual Report of the Health Board	Dawn Sharp		x		

BCU Director of Public Health Annual Report	Teresa Owen			x	
BCU Equality & HR Annual Report & Strategic Equality Plan Progress	Sue Green		X Eq/HR	X SEP	
BCU Welsh Language Strategic / Annual Report(s)	Teresa Owen		x		
Closing Business (Standing Items)					
Issues of Significance to Inform Chair's Report to Board		x	x	x	x
Date of Next Meeting		x	x	x	x

Healthcare Professionals Forum Annual Report 2019/20

1. Title of Forum:

Healthcare Professionals Forum (HPF)

2. Name and role of person submitting this report:

Mr Gareth Evans, Chair of the Forum

Mr Adrian Thomas, Executive Director Therapies and Health Sciences

3. Dates covered by this report:

1st April 2019 to 31st March 2020

4. Number of times the <u>Healthcare Professionals Forum</u> met during this period:

The Forum was scheduled to meet four times or otherwise as the Chair of the Forum deemed necessary. During the reporting period, it met on 4 occasions.

Attendance at meetings is detailed within the table below:

Members of the Forum	14th June 2019	13th September 2019	13th December 2019	13th March 2020 ****Meeting Stood Down ****
Mr Gareth Evans – **Chair Therapies Representative**	P	P	P	
Prof Michael Rees – **Vice-chair** Specialist and Tertiary Care medical representative	P	P	P	
Mr Alton Murphy Optometry representative, Deputy – Bryn Jones	P	P	P	

Dr Jay Nankani Primary and Community Care Medical representative	P	P	P	
Mrs Susan Murphy Hospital and Primary Care representative	P	P	P	
Mrs Mandy Jones Nursing representative	P	A	A	
Mrs Fiona Giraud Midwifery representative	A	A	A	
Mrs Jane Wild Scientific representative	P	A	A	
Mr John Speed Community Pharmacy representative	P	A	P	
Mr Ian Douglas Dental Advisory	♦	P	P	
Mr Adrian Thomas Lead Executive Director Therapies and Health Sciences	P	P	P	

**** Due to CoVID 19 escalation – the HPF meeting scheduled for 13th March 2020 was stood down.**

Key:

P - Present
P* **-** Present for part meeting
A - Apologies submitted
X - Not present
◆ Not a member of the Healthcare Professionals Forum at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee/Group/Forum. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Healthcare Professionals Forum is designed to provide:

The Healthcare Professionals Forum is designed to provide advice to the Board on the following key areas as set out in its Terms of Reference as follows:-

- Facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the LHB's decision making.

During the period that this Annual Report covers, the Healthcare Professionals Forum operated in accordance with its terms of reference which were operative for the whole of the term this Annual Report covers. The terms of reference are appended at Appendix 1.

The work programmes, cycles of business and overall performance of each Committee/Group/Forum are reviewed by the Committee Business Management Group (CBMG) which meets quarterly. The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

The Healthcare Professionals Forum is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were 0 breaches of this nature in terms of either individual papers / whole agenda not being available 7 days before the meeting.

6. Overall *RAG status against Healthcare Professionals Forum annual objectives / plan: Green

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

Objective as set out in Terms of Reference	**Assurance Status (RAG)***	**Supporting narrative** *(Please provide narrative against all red and amber including the rationale for the assurance status)*
Facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the LHB's decision making.	Green	Meetings have functioned effectively throughout the year, and the group has fulfilled its advisory role to the Health Board

***Key:**

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

7. Main tasks completed / evidence considered by the Healthcare Professionals Forum during this reporting period:

Regular Items and updates

- Corporate Planning – including updates on AOP/IMTP/3 year plan
- Performance
- Annual Quality Statement
- Public Health
- Quality and Improvement (QI) Hub
- Workforce & Organisational Development update
- Annual discussion with CEO
- Membership

Governance and Standing Items

- Chairs written updates
- Members written updates
- Review of minutes and actions
- Committee Annual Report
- Review and refresh of Forums terms of reference
- Minutes Quality, Safety & Experience Committee meetings
- Minutes of Professional Advisory Group meetings
- Team Briefing Updates

Full details of the issues considered and discussed by the Healthcare Professionals Forum are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

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

Meeting Date	Key risks including mitigating actions and milestones
14th June 2019	**H19/19 Vice Chair appointment** AT formally announced that Professor Michael Rees had been successful in the Election on becoming Vice Chair. The Forum congratulated MR and MR took the opportunity to give thanks and confirmed that he would further encourage and support the development of other members for the future uptake of the role. **H19/22 Corporate Planning Update – BCUHB Planned Care Update** KM presented to the members a range of slides which described the progress of the **BCUHB Planned Care Update**. The slides covered the following information: **Acute Hospitals Programme – Planned Care** • Musculo Skeletal services • Eye Care • Urology

	• Robotic Assisted Surgery (RAS) • Rheumatology The Forum fully acknowledged the positive steps and progress which were underway. In addition, concern was raised in relation to ensuring that planned care programmes are cognisant of unscheduled care pressures and are able to be delivered. With regards to orthopaedics planning, the importance of identifying within the business process the necessary support services was recognised. **H19/22.06 New Eye Care Measures** KW gave an overview of the new eye care measures and confirmed that the regional implementation plan would continue to be developed. **H19/22.09 Urology** The forum welcomed the urology review and supported the testing of the feasibility of the proposed model prior to consultation. **H19/22.10 Robotic assisted Surgery** – It was noted that the Business Case had been developed. It was further noted that this would be a positive aid to recruitment within the region and a welcome step forward. **H19/22.12 North Wales Rheumatology Service Review –** An overview was given and highlighted key drivers regarding workforce issues. The Forum advises supporting the multidisciplinary team solutions focusing on workforce competency. The Forum also supports the use of evidence to determine the best outcome for the review. **H19/23 Public Health update** The Forum welcomed Teresa Owen, Executive Director of Public Health, Teresa gave a brief update in relation to the Health Improvement in Inequalities Team/Health Improvement Reducing Inequalities Group, changes within the Public Health Team and Healthier Wales. The forum noted support in relation to the move towards the preventative agenda and that “a Healthier Wales” does bring prevention to the forefront. **H19/24.01 Member Summary report for HPF – MR - Specialist and Tertiary Medicine.** Key issues for attention of the forum were in relation to the Physician Associate vacancies and the urgent need for extra clinical support. MR also confirmed that slides recently received from the GMC in relation to pressures of medical staffing, pressures and pension issues would be circulated to the Forum for information. **H19/24.02 Member Summary report for HPF – MJ – Nursing representative.** Key issues for attention of the forum were with regards to the pilot for the launch of the electronic Nursing

	documentation, thus highlighting the gateway to progress electronically. **H19/24.03 Member Summary report for HPF – SM – Pharmacy and Medicines Management.** Key issues for attention of the forum were the development of Pharmacist's roles across Wales, which had been launched early April 2019. It was also noted that Pharmacist pre-registration training had been a success and was being rolled out across North Wales. SM confirmed that pharmacy staff had been reassured regarding the media concern about the privatisation of pharmacy services being untrue. The "Sore Throat Test and Treat Service" was recognised as being a successful project trialled in BCUHB over winter. The Forum supports the roll out across North Wales. It was further noted that the BCUHB pharmacy team had been scoping the potential to work in partnership with community pharmacies to provide outpatient prescription dispensing services within our main hospitals. JS also gave a summary in relation to this and confirmed that the system would provide a much needed resource and change. JS also reported upon lots of educational training being undertaken along with innovation and progress being made to date. **H19/24.04 Member Summary report for HPF – AM – Optometry.** Key issues for attention of the forum were raised in relation to Contact Lens Provision, it was confirmed that the pilot would be undertaken. Welsh Language within optometry was also raised and it was confirmed that all wards within BCUHB have a Welsh Language speaker. The items were noted. **H19/24.05 Member Summary report for HPF – JW – Healthcare Science.** Key issues for attention of the forum were that Welsh Government had approved the Welsh Healthcare Science Associate Apprenticeship framework. It was also reported that a series of workshops were being delivered across Wales focusing on the Healthcare Science workforce and Educational needs; which will include, discussions regarding challenges and pressures and how differences can be incorporated. **Work shop time** There was a Workshop following the meeting, the Assistant Director - Health Strategy was in attendance, the workshop discussion was in relation to the Clinical Strategy Programme to date. It was agreed that this would be a future agenda item.
13th Sept 2019	**H19/32** The Vice-Chair wished members and the Health Board to note the importance of Exit Interviews and the feedback that is received.

	H19/33 The Forum received an Overview of Planning and Performance Directorate by the Executive Director, Mr Mark Wilkinson. Members noted the comment Mr Wilkinson made of the importance of the Health Board plans being Specific, Measurable, Achievable, Realistic and Time (SMART) and how important it is that going forward, our plans need to be built up from services and teams. Members also acknowledged the underdeveloped areas of Primary Care and Demand Management. **H19/34** Members received an update from the Assistant Director for Health Strategy on Developing our Clinical Services Strategy. The presentation incorporated the following slides: • Reviewing our strategy • Population Health • Life expectancy at birth – trends 1 and 2 • Review of current strategies and evidence • Living Healthier, Staying Well • A Healthier Wales: actions required to date • Acute hospital care – current position • Other major services – current developments • What else will shape the future clinical services strategy • Where does this take us? • Priorities identified to date • Clinical Leadership • Questions to consider • Next steps It was noted by the Forum that as members of the Health Board attending National Groups, we have a responsibility to disseminate communication across the Health Board. Members also agreed there needs to be more Clinical Involvement and this should be encouraged more. The Forum also recognised the importance to provide time and space for this. H19/35 The Forum received a presentation from the Director of Performance, which incorporated the following slides: • Performance Framework • Key Performance Indicators • RTT – Waiting List All BCU Patients • Diagnostics – unvalidated over 8 week position • Cancer • Unscheduled Care • Ambulance Handover and DTOC • Quality Improvements – reducing Mortality • BCUHB Reducing Harms – Collaborative Approach • The Future of Performance

	Members noted the long-term objective for Performance is delivering a better outcome for the population of Wales. The Key Performance Indicators were also noted by the Forum who welcomed an update that these measures are under review to ensure they are balanced to meet the strategic intent of A Healthier Wales. **H19/36** Members received a presentation on Development of Strategic Equality Draft Objectives by Sally Thomas, Head of Equality and Human Rights. The presentation incorporated the following: • Background to the Plan • Our work to date • Our draft Equality Objectives • Questions to HPF Members The Forum were informed Wales has the strongest equality laws across Great Britain and the Welsh Government are currently working to further strengthen the equality and rights protections afforded to individuals in Wales. Members were also advised that the consultation document will be circulated in October and the forum have been invited to respond. **H19/37** Members received a presentation on BCU Quality & Improvement Hub (QI) from Dr Melanie Maxwell, Senior Associate Medical Director. The presentation incorporated the following: • What is the hub? • Quality Framework • What are the hub aims • The offer • What have we achieved so far? • What next? • How will we judge success? • Why get involved? The forum were informed the function of the Hub is to look at "*How do we work together to improve services*" and it is hoped through the quality framework this will be the way forward, alongside the idea of networking. Members also noted all Health Boards are now required to have a QI Hub. The Forum supported the need for this work to be linked to organisational priorities and that it should be part of peoples jobs as well part of a prevailing culture. **H19/38** The forum noted the written updates received from the following representatives: H19/38.01 Pharmacy and Medicines Management H19/38.02 Nursing

	H19/38.03 Healthcare Science H19/34.04 The member for Optometry raised the concern again around Contact Lenses Service and the information being received by patients. It was agreed that the Lead Executive Director of the Forum who would refer the concerns onto the appropriate Operational Lead.
13th Dec 2019	• **H19/45 Matters arising and summary action log** • **H19/46 Terms of Reference** • **H19/47 Corporate Planning Update –** *Developing our Clinical Services Strategy, BCU Health Board 3 Year Plan 2020/23* The Assistant Director for Health Strategy and Assistant Director, Corporate Planning gave an update to members on Development of the Clinical Strategy - BCU Health Board 3 Year Plan 2020/23. A presentation was distributed to Members within the meeting. • The handout include the following slides: • Current Position • Moving Forward • North Wales Planning Framework 2020/23 • Deliverables • Strengthening our Approach • Strategy & Planning Map • From Board to PADR • Cluster Plans – example Key Themes • Work to Develop our Clinical Strategy • Outlines timetable for our plan • **H19/48 Members' Summary Updates** The forum noted the written updates received from the following representatives: H19/48.01 Midwifery H19/48.02 Pharmacy and Medicines Management H19/48.03 Therapy Services and HPF Associate Board Update H19/48.04 Secondary and Tertiary Care Verbal updates were received from the following representatives: H19/48.05 Dental H19/48.06 Optometry H19/48.07 Community Pharmacy **H19/49 Summary of key advice to be included in Chairs report to the Board:**

	• **H19/47.01** Development of the Clinical Strategy - BCU Health Board 3 Year Plan 2020/23 update. HPF members would like to again advise the Board of the importance of clinical engagement. • Dental Clusters request to the Board for them to be kept separate in the short-term • **H19/48.02** To advise the Board to recognise the need to invest in our staff. The current financial recovery process is stopping and restricting training, at times when it is deemed required training to do the job. • **H19/48.04** HPF Members would like the Board to note its support for the need for appropriate resources for the Occupational Health and Mental Health Support Team • **H19/48.05** Dental Funding: currently have 5 levels of process that the Contracting Team have to go through. HPF advise the Board that this could be reviewed in order to help with improved dental access going forwards.
13th Mar 2020	Due to CoVID 19 situation and the increased level of preparation that the organisation is now engaging, it was agreed to stand down the HPF meeting for the 13th March

9. Focus for the year ahead:

The primary focus of the Healthcare Professionals Forum over the next twelve months will be as stated within the Cycle of Business for the year 2020/21.

The Healthcare Professionals Forum has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 2.

Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

The Healthcare Professionals Forum

INTRODUCTION

The Healthcare Professionals Forum's role is to provide a balanced, multi-disciplinary view of professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of professional terms and conditions of service.

PURPOSE

The purpose of the Healthcare Professionals Forum, hereafter referred to as "the Forum", is to:

- facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the LHB's decision making.

DELEGATED POWERS AND AUTHORITY

The Forum will, in respect of its provision of advice to the Board:

- offer advice to the LHB when specifically requested on any aspect of its business
- offer advice and feedback even if not specifically requested by the LHB.

Authority

The LHB may specifically request advice and feedback from the Forum on any aspect of its business, and the Forum may also offer advice and feedback even if not specifically requested by the LHB. The Forum may provide advice to the Board:

- at Board meetings, through the Forum Chair's participation as Associate Member;
- in written advice; and
- in any other form specified by the Board.

Sub Committees

The Board may determine that the Forum should be supported by a range of sub fora to assist it in the conduct of its work, e.g., special interest groups, or the Forum may itself determine such arrangements, provided that the Board approves such action.

MEMBERSHIP

Chair	nominated from within the membership of the Forum by its members and approved by the Board
Vice Chair	nominated from within the membership of the Forum by its members and approved by the Board
Members	The membership of the Forum reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the Forum shall therefore comprise the following eleven (11) members:

- Welsh Medical Committee
  - Primary and Community Care Medical representative
  - Mental Health Medical representative
  - Specialist and Tertiary Care medical representative
- Welsh Nursing and Midwifery Committee
  - Community Nursing and Midwifery representative
  - Hospital Nursing and Midwifery representative
- Welsh Therapies Advisory Committee
  - Therapies representative
- Welsh Scientific Advisory Committee
  - Scientific representative
- Welsh Optometric Committee
  - Optometry representative
- Welsh Dental Committee
  - Dental representative
- Welsh Pharmaceutical Committee
  - Hospital and Primary Care representative
  - Community Pharmacists representative

Lead Health Board Officer	Executive Director of Therapies and Health Sciences
Secretary	As determined by the Board Secretary

In attendance	The Board may determine that designated Board members or LHB staff should be in attendance at Advisory Group meetings. The Forums Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

Member Appointments

Appointments to the Forum shall be made by the Board, based upon nominations received from the relevant professional group, and in accordance with any specific requirements or directions made by the Welsh Government. Members shall be appointed for a period of no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively.

The ***Chair*** will be nominated from within the membership of the Forum, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Government. The nomination will be subject to consideration by the Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. Their appointment as Chair will be made by the Minister, but it will not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

The Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the Forum. That individual may remain in office for the remainder of their term as a member of the Forum after their term of appointment as Chair has ended.

The ***Vice Chair*** shall be nominated from within the membership of the Forum, by its members by the same process as that adopted for the Chair, subject to the condition that they be appointed from a different clinical discipline from that of the Chair.

The Vice Chair's term of office will be as described for the Chair.

A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the Forum Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Forum Chair will advise the Board in writing of any such cases immediately. The LHB will require Forum members to confirm in writing their continued eligibility on an annual basis. Where a member is unable to attend for 3 consecutive meetings, except in exceptional circumstances, the Chair would request that the member consider their continued membership on the Forum.

Support to Committee Members

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

- ensuring the provision of governance advice and support to the Forum Chair on the conduct of its business and its relationship with the LHB and others;
- ensuring that the Forum receives the information it needs on a timely basis;
- facilitating effective reporting to the Board; and
- enabling the Board to gain assurance that the conduct of business within the Forum accords with the governance and operating framework it has set.

COMMITTEE MEETINGS

Quorum

Quorum agreed as 6 members or more and to include Chair or Vice Chair

Frequency of Meetings

- Meetings to take place each quarter consistent with Betsi Cadwaladr University Health Board annual plan of Board Business.
- Additional meetings can be called at the Chair and 2 other members discretion. The Lead Executive may also request additional meetings via the Chair.
- Meetings to be arranged prior to the Full Board meetings so that effective reporting can take place.

Openness and transparency

The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board therefore requires, wherever possible, the Forum to hold meetings in public unless there are specific, valid reasons for not doing so.

REPORTING AND ASSURANCE ARRANGEMENTS

The Chair is responsible for the effective operation of the Forum:

- chairing meetings;
- establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating arrangements; and
- developing positive and professional relationships amongst the Forum's membership and between the Forum and Betsi Cadwaladr University Health Board, and in particular its Chair, Chief Executive and Directors.

The Chair shall work in close harmony with the Chairs of Betsi Cadwaladr University Health Board other advisory groups, and, supported by the Lead Executive, shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions. Where appropriate and within their area

of responsibility, the Forum may be requested by the Health Board to review and comment on draft documents prior to formal approval by the Board.

As Chair of the Forum, they will be appointed as an Associate Member of the LHB Board on an ex officio basis. The Chair is accountable for the conduct of their role as Associate Member on the Betsi Cadwaladr University Health Board to the Minister, through the Health Board Chair. They are also accountable to the Betsi Cadwaladr University Health Board for the conduct of business in accordance with the governance and operating framework set by the Health Board.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

The Forum's main link with the Board is through the Forum Chair's membership of the Board as an Associate Member.

The Board should determine the arrangements for any joint meetings between the Betsi Cadwaladr University Health Board and the Forum.

The Health Board's Chair should put in place arrangements to meet with the Forum Chair on a regular basis to discuss the Forum's activities and operation.

The forum shall embed the corporate goals and priorities through the conduct of its business and in so doing and transacting its business shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-being of Future Generations Act.

The Health Board Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

- where the Forum recommends that a matter should be presented to the Board by a particular professional grouping, e.g., due to the specialist nature of the issues concerned; or

- where a professional group has demonstrated that the Forum has not afforded it due consideration in the determination of its advice to the Board on a particular issue, or

The Board may itself determine that it wishes to seek the views of a particular professional grouping on a specific matter.

Members of the Forum may be invited to attend other Board Committees / Groups at the discretion of the Health Board Chair.

RELATIONSHIP WITH THE NATIONAL PROFESSIONAL ADVISORY GROUP

The Forum Chair will be a member of the National Professional Advisory Group. The Forum may be asked to provide NJPAC with comments on national documents and the NJPAC meeting minutes will be shared with Forum Members.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

REVIEW

These terms of reference and operating arrangements shall be reviewed annually by the Forum with reference to the Board.

DATE OF ACCEPTING THE TERMS OF REFERENCE AND APPROVAL

Audit Committee 14.9.17

Health Board 21.9.17

Reported to HPF 10.11.17

V5.0 approved - (Version 5 – updated solely to reflect the move to quarterly meetings from bi monthly-agreed by the Board Meeting in September 2018).

Appendix 2

Health Professionals Forum - Cycle of Business 2020/21 – Draft

Item		Jun	Sept	Dec	Mar
Welcome, apologies	Secretariat, HPF	✓	✓	✓	✓
Declarations of Interest	Members declaration - *if applicable*	✓	✓	✓	✓
Corporate Planning – including updates on AOP/IMTP/3 year outlook LHSW Strategy	Assistant Director Planning Assistant Director Health Strategy	✓	✓	✓	✓
Mental Health Strategy - Implementation	Appropriate Executive Director and/or representative				
Primary Care					
Innovation Strategy					
QI Hub					
Others as evolve in year – TBC					
Chief Executive	Annual discussion with CEO	✓			
Executive Director	Workforce & Organisational Development				✓
Executive Director of Planning & Performance	Planning & Performance			✓	
Executive Director of Primary & Community Care	Primary Care	✓			
Executive Director Public Health	HMP Berwyn (NW Prison) – Update				
Executive Director Public Health	Public Health	✓			
Executive Director Nursing, Midwifery & Patient Services	Seasonal Plan				
Director Estates and Facilities	Estates developments				
Director Quality Assurance	Draft Annual Quality Statement (for information)				✓
Performance Director	Performance focus		✓		

Assistant Nurse Director Infection Control	Infection Prevention and Control				
Assistant Director Communications	Engagement				
Head of Quality for CHC & Complex Care	A Place to Call Home – Impact & Analysis				
Head of Equality	Strategic Equality – the year ahead Including annual report and recommendations				
Chairs written update	Chair, HPF	✓	✓	✓	✓
Members written updates	All members HPF	✓	✓	✓	✓
Summary of information to be included in Chair's report to Board		✓	✓	✓	✓
Draft Advisory Group Annual report inc • COB approval • Terms of Reference review				✓	✓
Adhoc items	Executive Director Therapies & Health Sciences	✓	✓	✓	✓
Workforce Transformation Group	Office of the Director of Workforce and Organisational Development				
Minutes Quality, Safety & Experience Committee meetings	Office of the Board Secretary	✓	✓	✓	✓
Minutes of Professional Advisory Group meetings	Office of the Director of Nursing & Midwifery	✓	✓	✓	✓
NJPAC approved minutes (meet 3x per year dates to be sought)	Nigel Champ Directorate for Health Policy Business Unit, Health and Social Services Group, WG	✓	✓	✓	✓
Team Briefing Updates	Communications	✓	✓	✓	✓
Any Other Business	Members to raise with the Chair before meeting	✓	✓	✓	✓
Forward Plan – *next meeting items*	Cycle of Business	✓	✓	✓	✓
Dates of next meetings	Corporate calendar	✓	✓	✓	✓

Finance & Performance Committee
Annual report 2019-20

1. Title of Committee:

Finance and Performance Committee

2. Name and role of person submitting this report:

Ms Sue Hill, Acting Executive Director of Finance

3. Dates covered by this report:

01/04/2019-31/03/2020

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

The Committee was routinely scheduled to meet 12 times and otherwise as the Chair deemed necessary. During the reporting period, it met on 11 occasions. Attendance at meetings is detailed within the table below:

Members of the Committee	24.4.19	23.5.19	25.6.19	29.7.19	22.8.19	30.9.19	24.10.19	4.12.19	19.12.19	23.1.20	27.2.20	24.3.20 CNX
Independent Members												
Mr Mark Polin	P	P	P	P*	P	P*	P	P	P	P	P	
Mr John Cunliffe	P	P	P**	P	P	P	P	P	A	P	P	
Ms Helen Wilkinson	P	P	P	P	P	P	P	A	A	P	P	
Mrs Lyn Meadows	P	P	P**	P	◆	◆P	◆	◆	◆	◆	◆	
Mr Eifion Jones	◆	◆	◆	◆	P	P	A	A	P	P	A	
Mrs Jackie Hughes	◆	◆	◆	◆	◆	◆P	◆P	◆P	◆P	◆	◆	
Cllr Cheryl Carlisle	◆	◆	◆	◆	◆	◆ P*	◆P	◆	◆	◆	◆	

Formally In attendance (as per Terms of Reference)	24.4.19	23.5.19	25.6.19	29.7.19	22.8.19	30.9.19	24.10.19	4.12.19	19.12.19	23.1.20	27.2.20	24.3.20 CNX
Directors												
Mr Russ Favager Executive Director Finance	P	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Ms Sue Hill Acting Executive Director Finance	◆	P	P**	P	A	P	P	P	P	P	A	
Mrs Sue Green Executive Director Workforce &OD	P	P	P**	P	P	P	P	P	P	P	P	
Mr Mark Wilkinson Executive Director Planning & Performance	P	P	P**	P	P	P	A	P*	P*	P	P	
Dr Evan Moore Executive Medical Director	P	P*	P	A	◆	◆	◆	◆	◆	◆	◆	◆
Dr David Fearnley Executive Medical Director	◆	◆	◆	◆	A	P	A	P	P	P*	P	
Mrs Deborah Carter Acting Executive Director Nursing & Midwifery	P	P*	P	P*	P	P*	P*	A	◆P	◆	◆P	◆
Mr Geoff Lang Director of Turnaround	P	P	P**	◆	◆	◆	◆	◆	◆	◆	◆	◆
Mr Phil Burns Interim Recovery Director	◆	◆	◆	P	P	P	P	P	P	P	P*	
Mr Gary Doherty Chief Executive by invitation wef July	◆	◆	◆	A	A	P	P	P	A	A	◆	◆
Mrs Gill Harris Executive Director Nursing & Midwifery	◆	◆	◆	◆	◆	◆	◆	◆	A	P*	A	

Key:

P - Present

P* - Present for part meeting

A - Apologies submitted

X - Not present

◆ Not a member of the Committee at this time.

P** - part attendance due to membership of Savings Programme Group meeting held part concurrently

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Committee is designed to provide:

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

The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance and delivery. This includes the Board's Capital Programme and Workforce activity.

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference which were operative for the whole of the term this Annual Report covers. The Terms of Reference are appended at Appendix 1.

The work programmes, cycles of business and overall performance of each Committee/Group/Forum are reviewed by the Committee Business Management Group (CBMG) which meets quarterly. The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were 9 breaches of this nature in terms of individual papers not being available 7 days before the meeting.

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

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

Objective as set out in Terms of Reference	**Assurance Status (RAG)***	**Supporting narrative** *(Please provide narrative against all red and amber including the rationale for the assurance status)*
• seek assurance on the Financial Planning process and consider Financial Plan proposals	A	The Committee received assurance and approved the planning and budget methodology, but the Health Board did not deliver the planned deficit.
• monitor financial performance and cash management against revenue budgets and statutory duties;	A	The Committee received relevant reports and improvements were made to the quality of reports during the year but the Health Board

		did not meet its statutory duties
• consider submissions to be made in respect of revenue or capital funding and the service implications of such changes including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial Instructions;	G	The Committee received regular Capital reports and reviewed Business Cases for both capital and revenue projects; Capital was also considered and approved as part of the annual plan
• receive assurance with regard to the Health Board Turnaround programme progress and impact/pace of implementation of organisational savings plans.	A	The Committee received regular reports on the Turnaround programme but this was superceded by the Recovery programme from July 2019 and the Health Board did not deliver its savings target for the year
• receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual directorates, divisions and sites.	A	The Committee received regular reports of this nature and the finance report includes analysis of divisional financial performance
• to determine any new awards in respect of Primary Care contracts	G	The committee considered all new Primary Care Contracts awarded during the year
• approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).	G	The Committee has not reviewed the Performance management Framework in the last twelve months – it was on the cycle of business but was deferred due to the Covid 19 pandemic and will be completed during 2020/21
• ensure detailed scrutiny of the performance and resources dimensions of the Integrated Quality and Performance Report (IQPR);	G	The IQPR is scrutinised at each Committee meeting and feedback is incorporated into future reports
• monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets;	A	The Committee received regular dedicated reports access times during the year and this is also included in the IQPR but the Health Board did not deliver significant improvements against the previous year, which was in part due to Covid-19
• review in year progress in implementing the financial and	R	N/A – the Health Board submitted an annual plan to

performance aspects of the Integrated Medium Term Plan (IMTP);		Welsh Government for 2020/21
• review and monitor performance against external contracts	G	The Committee receives regular reports on the performance of external contracts for healthcare services
• Receive assurance reports arising from Performance and Accountability Reviews of individual teams.	A	The financial performance of divisions is regularly reported but there has been limited distribution of reports on individual teams
• Receive assurance reports in respect of the Shared Services Partnership.	G	The Committee receives quarterly reports relating to NWSSP which are reviewed and where required, feedback is provided to the organisation

**Key:*

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

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

Finance

- Monthly Finance reports
- Draft unaudited Financial report month 12 2018/19
- Turnaround Programme savings reports
- External Contracts updates
- Financial review action plan
- Financial policies and processes
- Value Based Healthcare
- Financial Recovery Action Plan progress
- Finance Academy Forecasting best practice guide
- Resource allocation review
- Financial plan 2020-21 - planning framework and timetable for delivery
- Presentation: Financial Planning
- Non Pay Costs 2018/19
- Savings Programme Group (SPG) meeting updates
- Financial Recovery action plan
- Monthly Financial Recovery Group (FRG) reports
- Winter monies - Utilisation of Health Board and Regional Partnership Board monies
- Budget setting framework and timetable for 2020/21

- Financial plan update 2020/21
- Update on delivery of PWC recommendations

Planning & Performance

- Monthly 2019/20 annual plan progress monitoring reports
- Developing our Plan for 2020/23 - draft planning principles and outline timetable
- Completed planning profiles supporting July Board 2019/20 annual plan
- 2019/20 annual plan refresh
- Three year outlook and 2019/20 annual plan update
- Monthly Integrated Quality and Performance reports
- Performance summary
- Presentation : Excellent hospital care ~ Planned Care
- Countess of Chester hospital update
- Unscheduled Care and Building Better Care reports and SICAT presentation
- Proposal for outsourcing elective Orthopaedic work as part of the Orthopaedic plan
- Referral to Treatment (RTT) reports
- Update on Referral to Treatment improvement programme and year-end forecast
- Referral to Treatment 2019/20 development plan

Estates

- Monthly capital programme reports
- Discretionary capital programme 2019/20
- Policy for revenue business case development
- Partnership project - Satellite hospice at Ysbyty Penrhos Stanley – position paper and way forward
- Hafan Wen Substance Misuse Service DETOX contract
- Re-location of services from Mount Street clinic, Ruthin – business justification case
- Wrexham Maelor hospital continuity programme business case
- Redevelopment of the Ablett Unit at Ysbyty Glan Clwyd – procurement of external support
- Development of new isolation facilities – Critical Care Unit, Wrexham Maelor hospital
- Replacement of a CT scanner at Ysbyty Glan Clwyd business case
- Critical Care business case
- Bryn Beryl integrated Dementia & Adult Mental Health centre capital business case
- Procurement of local frameworks for construction works

Workforce

- Quarterly Workforce performance reports
- Strategic recruitment position and plans
- Retention update

Governance

- Draft minutes of previous meetings and summary action plans
- Review of Corporate Risk Assurance Framework – risks assigned to the Finance and Performance Committee

- Draft Finance and Performance Committee annual report 2018/19
- Cycle of Business 2019/20
- Shared Services Partnership Committee quarterly assurance reports

Private session

Finance

- PWC reports
- Review of operational plan investments 2019/20
- Non-recurrent RTT spending
- Financial Plan 2019/20
- Financial recovery management arrangements report
- Unfunded cost pressures
- Identifying the drivers of financial deficit approach
- Continuing Health Care support proposals
- Financial control
- Proposed interim arrangements for Continuing Health Care and Free Nursing Care fee changes for 2019/20
- Review of RTT expenditure Jan - March 2020
- Financial plan update 2020/21
- Financial recovery cost
- Drivers of the deficit
- Value for money assessment of the financial recovery programme
- WHC 2019/013 : 2019/20 monthly monitoring returns

Planning and Performance

- Board and committee monitoring of the 2019/20 annual plan
- Draft three year outlook and 2020/21 annual plan
- Outputs from health economy accountability review meetings
- Mental Health division delivery plan reports
- Wrexham Maelor hospital performance reports
- North Wales endoscopy service
- Proposals in respect of stroke services
- Referral to Treatment update
- RTT update : Eye care services
- Musculoskeletal and Orthopaedic service plan update
- Countess of Chester hospital update

Estates / business cases / contracts

- Ysbyty Glan Clwyd redevelopment
- Ysbyty Glan Clwyd park and ride service
- Digital dictation and speech recognition
- Outline business case for delivering an acute digital health record
- Supply chain partner for the proposed North Denbighshire community hospital update
- Land lease to Nightingale hospice
- Rowley's Drive SMS accommodation, Shotton
- National Infected Blood Inquiry embargo on destruction – storage impact
- Contractor requests for recommissioning of dental services
- Procurement services contract briefing papers:

- Electrophoresis Managed Service Contract
- Glycated Haemoglobin Managed Service Contract
- Blood gas analyser managed service contract

Workforce

- Medical and Dental Agency Locum monthly report
- Nursing shift change proposals

Full details of the issues considered and discussed by the Committee in public session are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages
https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

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

Meeting Date	Key risks including mitigating actions and milestones
24.4.19	• Significant risks to delivery of a revised financial plan and savings programme - support from PWC on review of annual plan, grip and control action plan, gearing up savings approaches and recovery. • Risk to RTT delivery and achievement of goals in unscheduled care/building better care – development of action plans to address ○ Orthopaedics capacity issues and impact on RTT and cost implications • Secondary Care expenditure profile to address RTT and urgent care performance.
23.5.19	• Risks to delivery of financial plan and savings programme - month 1 adverse variance against plan of £0.9m primarily from Mental Health and Secondary Care. - total saving schemes gap of £16.8m - support from PWC on re-planning, grip and control action plan, gearing up savings approaches and recovery. • Risk to RTT delivery – development of expenditure, funding and impact estimates. • Delivery of the Health Board's financial duties, specifically in relation to the control total of £25m deficit.

June – Sept 2019	• Operational issues within diagnostic and imaging were highlighted to the Executive Team to address
	• RTT delivery which could be impacted by unscheduled care pressures and level of finance and other recovery available.
	• Wrexham Maelor Hospital performance issues
	• Risks to delivery of financial plan and savings programme
	  ○ year to date adverse variance against initial plan of £3.0m – year to date £14.6m deficit
	  ○ key areas for overspends were secondary care drugs (£1.4m), continuing healthcare (£0.7m), primary care prescribing (£0.5m) and other non-pay (3.2m)

	○ total savings delivered were £6.6m against budgeted anticipated savings of £9.8m, a shortfall of £3.2m. • Financial recovery is being addressed by the Interim Recovery Director's newly introduced processes, planning activity and regular Divisional and Improvement Group meetings • The Financial Recovery Action Plan was agreed to be reassessed to ensure all actions were accurately recorded and closed appropriately.
Oct – Dec 2019	The Committee questioned whether the Corporate Risk Register adequately addressed the risks of: • Overall financial sustainability of the Health Board • Clinical performance and patient experience • Overarching delivery of the overall plan • The Chairman stated the need for the Finance Division to work towards accurate reporting by day 5 following month end in order that the organisation be informed as to the financial position at the earliest point in time and thus aid local senior leadership teams in place in regard to decision making which would be a critical success factor in comparison to previous years. • The Committee expressed concern with reliance upon improvements to digital systems and initiatives which were being affected by delays in national developments and / or infrastructure issues. BCU's developing digital strategy including current IT capability, issues and current plans would be reviewed in the Board's workshop programme and considered at the next Digital and Information Governance Committee meeting. • The Chief Executive stated the need for tighter RTT management and improvement in the number of patients treated. A micromanagement approach was in place to ensure scrutiny at individual patient level, however there were significant challenges in orthopaedics, general surgery, gynaecology, urology and endoscopy. The Committee was advised on 24.10.19 that there was a fair chance of meeting the November targets set with the exception of orthopaedics. • Following three months of consecutive improvement in financial performance, there had been a deterioration in month 8 which was £1.6m in excess of the control total plan. In respect of year to date, the Health Board was overspent by £27.1m, £8.8m higher than the control total plan and £3.8m over the original plan. The main over spending area was noted to be secondary care, while the non-delivery of savings, agency premium pay costs and prescribing cost pressures were the main causes of the over spend. Despite the downturn in performance in Month 8, the savings pipeline continued to hold a number of schemes that were forecast to deliver in the final quarter of the year. On the basis of the

	conversion and delivery of these schemes, the £35m forecast deficit was considered challenging but achievable. • It was also noted that the run rate needed to be below £2m per month from month 8 in order to achieve year-end target. The Committee expressed concern regarding deliverability given performance to date. • Concern was raised in respect of capability and capacity issues within the Finance Department's staffing structure which would be reviewed, an effective clamp down was due to be introduced in terms of non-clinical expenditure in January; the need for expenditure to be restrained with particular need for low level expenditure to be addressed was highlighted; and it was understood that the efficacy of BCU's Improvement Groups would also be reviewed. • It was noted that the Health Board had been advised to continue with increased planned care activity until the second week in January 2020 by WG, which would require the Health Board to spend at risk albeit that there was also a risk of clawback should activity be ceased. • The Committee discussed the critical issue of the deterioration in unscheduled and planned care performance during the winter period. Performance was worse than the previous year however, there had been an increase in demand and acuity of patients presenting.
Jan – Feb 2020	• The Chairman stated that the Board had noted the scale of deterioration which could not continue and that fundamental change needed to be undertaken. He clarified that the Executive Team needed to realistically assess the plan for the coming year, taking the opportunity to modify expectations for the change programme needed that would encompass important areas eg the ED review and RTT. • The Chairman emphasised that organisation design needed to address resistance to change and accountability across the Health Board. • Deterioration of progress within Planned Care • The Chairman sought assurance that Planned and Unscheduled care would be prioritised going forward, which the Chief Executive and Executive Director of Planning and Performance affirmed. • Finance Programme: It was noted that financial governance was being discussed by the Chair, Vice Chair, Chief Executive and Deputy Chief Executive. • Draft Annual Operational Plan 2020/21 to be developed at the Board workshop on 12.3.20 • The in-month financial position reported an improvement in the run rate of £0.7m in Month 10. However, prescribing costs continued to increase and had a significant impact again in January i.e. £0.6m worse than expected. The in-month position was £1.6m in excess of the control total plan

	and £0.3m above the initial plan. In respect of year to date, the Health Board was overspent by £34.3m, £12.6m higher than control total plan and £5.1m over the original plan. • PWC recommendations had not been completed. Further narrative was requested to enable further consideration of the progress of actions. • In consideration of the risks assigned to the Committee on the Corporate risk register CRR06 Financial Stability and CRR12 Estates and Environment risk ratings were increased.
March	Cancelled meeting

9. Focus for the year ahead:

The primary focus of the Committee over the next twelve months will be progressing service improvements in the clinical and operational performance of the Health Board while managing the unprecedented implication of the Covid 19 pandemic across the Health Board. This will include but is not limited to the significant impact on clinical services across the Health Board, our patients and staff and the resulting financial consequences. A review of the Health Board's Performance Management framework would be addressed as a priority in 2020/21,

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 2.

Strategy, Partnerships and Population Health Committee Annual Report 2019/20

1. Title of Committee:

Strategy, Partnerships and Population Health Committee

2. Name and role of person submitting this report:

Mr Mark Wilkinson, Executive Director Planning and Performance

3. Dates covered by this report:

01/04/2019-31/03/2020

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

The Committee was routinely scheduled to meet 6 times and otherwise as the Chair deemed necessary. During the reporting period, it met on 6 occasions during Committee session and held workshop sessions on 3 occasions. Attendance at Committee meetings is detailed within the table below:

Members of the Committee	2.4.19	4.7.19	3.9.19	1.10.19	3.12.19	5.3.20		
Independent Members								
Mrs Marian Wyn Jones	P	P	P	P	◆	◆		
Mrs Lyn Meadows	◆	P © ◆	◆	◆	P	P		
Mrs Helen Wilkinson	A	P	P	P	A	P		
Cllr Medwyn Hughes	P	A++	P	P	P	◆		
Prof Nicky Callow	◆	◆	◆	◆	◆	P		
Mr John Cunliffe	◆	◆	◆	◆	◆	P		
Mrs Jackie Hughes	◆	◆	◆	◆	P © ◆	◆		

Formally In attendance (as per Terms of Reference)	2.4.19	4.7.19	3.9.19	1.10.19	3.12.19	5.3.20		
Directors								
Executive Director Planning and Performance Mr Mark Wilkinson (Lead Director)	P	P	P	P	P	P		
Executive Director Public Health Miss Teresa Owen	P	P	P	A	P	P		
Executive Director Workforce & OD Mrs Sue Green	A	P	A	A	A	A		
Executive Director Primary and Community Services Dr Chris Stockport	A	P*	P*	A	P	A		

Key:

P - Present P* **-** Present for part meeting

P © - Present (co-opted for meeting)

A - Apologies submitted X - Not present

A++ - Apologies submitted, however member was available to attend on the original scheduled date

◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Committee is designed to provide:

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

> The purpose of the Committee is to provide advice and assurance to the Board with regard to the development of the Health Board's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales. The Committee will do this by ensuring that strategic collaboration and effective partnership arrangements are in place to improve population health and reduce health inequalities. In addition the committee will ensure that the Health Board meets its duties in relation to Welsh language, civil contingencies legislation and emergency preparedness

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference which were operative for the whole of the term this Annual Report covers. The terms of reference are appended at Appendix 1.

The work programmes, cycles of business and overall performance of each Committee/Group/Forum are reviewed by the Committee Business Management Group (CBMG) which meets quarterly. The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were 4 breaches of this nature in terms of individual papers not being available 7 days before the meeting.

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

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

Objective as set out in Terms of Reference	**Assurance Status (RAG)***	**Supporting narrative** *(Please provide narrative against all red and amber including the rationale for the assurance status)*
ensure that current and emerging service strategies adhere to national policy and legislation, the priorities of the Health Board and are underpinned by robust population health needs assessment, workforce and financial plans and provide for sustainable futures;	Green	Strategies effectively overseen by the Committee, including Services Strategy and Third Sector Strategy
advise and assure the Board in discharging its responsibilities with regard to the development of the Health Board's Medium and long term plans, together with the Annual Operating Plan;	Green	Regular reports were provided as part of core cycle of business. Specific Workshop sessions also held, incorporating Health Economy Planning Progress and plans for Health and Care clusters.
ensure the Health Board's response to new and revised legislative	Green	Regular reports were provided as part of core cycle

requirements in relation to service planning and delivery, providing assurance that statutory duties will be appropriately discharged, ensuring strategic alignment between partnership plans developed with Local Authorities, Universities, third sector and other public sector organisations;		of business relating to partnership work eg PSBs, Regional Partnership Board. Specific agenda items where Area Director updates were incorporated to fully address issues for each PSB area
Receive regular performance and assurance reports from the Public Service Boards and Regional Partnership (Social Services and Partnership part 9 Board and Mental Health Partnership Board).	Green	In place at the end of the year - linked to the above where Area Directors gave full updates on a rolling basis.
Ensure that the Health Board meets its duties in relation to Welsh language, civil contingencies legislation and emergency preparedness;	Green	Regular reports were provided as part of core cycle of business
Ensure the alignment of supporting strategies such as Workforce, Capital Planning, Estates infrastructure and Information, Communications and Technology (ICT) in the development of the Strategic Plans;	Green	Details and alignment considered as part of the development of the Quarterly plans that are currently being requested by Welsh Government
Ensure that the partnership governance arrangements reflect the principles of good governance with the appropriate level of delegated authority and support to discharge their responsibilities; and monitor sources of assurances in respect of partnership matters ensuring these are sufficiently detailed to allow for specific evaluations of effectiveness.	Green	Progress continued in year to align partnership working with Committee business.
Ensure appropriate arrangements for continuous engagement are in place; and review assurances on Consultation feedback.	Green	Regular updates on the approach to engagement with staff and public, including feedback reports from engagement activity

**Key:*

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

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

At each meeting the following are considered as regular reports:

- Monitoring progress of the annual operating plan 2018/19 and 2019/20 (including revisions to the 2019/20 programme)
- Monitoring of progress of the three year outlook
- Developing 2020/23 planning principles and timetable
- Review of the Committee's allocated corporate register risks (twice per annum)
- North Wales four Public Service Board updates delivered by Area Directors
- North Wales Regional Partnership Board meeting updates

The following agenda items were also considered:

2.4.19

- Development of Integrated Research and Innovation strategy (4.7.19 / 7.11.19)
- Mental Health transformation project progress
- Learning Disability transformation project progress
- Community services transformation project progress
- Civil Contingencies and Business Continuity draft work programme 2019/20
- Progress on development of BCU's Third Sector Strategy
- Wylfa redevelopment progress update
- Governance structure for Adverse Childhood Experiences (ACEs)
- Reducing smoking prevalence to improve population health
- Regular updates on North Wales Regional Partnership Board meetings
- Regular update by Area Directors on attendance at Public Service Boards : Anglesey & Gwynedd, Conwy and Denbighshire, Flintshire and Wrexham
- Draft Committee Annul report 2018/19, Terms of Reference and Cycle of Business

4.7.19

- Services strategy development – timeline progress
- Approval, on behalf of the Board of the Equalities annual report 2018/19
- Cycle of Business 2019/20 review
- Stroke services review position report
- Staff engagement – NHS Wales 2018 staff survey and monitoring progress against the organisational improvement plan
- University health board status triennial review progress
- Welsh Language annual monitoring report 2018/19
- Update on tobacco control within BCUHB
- International Health Group annual report

3.9.19

- Cycle of Business 2019/20 review
- Third Sector strategy update
- EU Exit – EU Exit task and finish group
- Civil Contingencies annual report 2018/19
- Public Health : Update on promoting healthy weight (adults) within BCUHB
- Gender Identity services progress

- Transformation Programme : Community services

7.11.19
- Update on public engagement
- Public Health : Well North Wales annual report 2018/19
- Enabling strategy : Quality Improvement strategy briefing
- Transformation programme : Children and Young People
- Substance Misuse planning board update
- Welsh Language standards update
- Draft strategic Equality plan and objectives 2020/24 (prior to consultation)
- InCommittee session : Clinical Services strategy development progress update underpinned by a new digital approach

3.12.19
- Update on development of BCU's Digitally Enabled Clinical Strategy
- Transformation programme : Community services update
- Public Health: Alcohol strategy and Adverse Childhood Experiences updates
- Recommended the Strategic Equality Plan to the Board for approval and publication

4.3.20
- Environmental sustainability and decarbonisation in BCUHB
- Civil contingency and business continuity progress
- Estates strategy ~ one year on
- Public engagement and monitoring impact update
- Integrated Care Fund (ICF) briefing
- Private session: Developing BCU annual plan 2020/21 and beyond

3 workshops were held in which the following was discussed:
- Cluster planning and development of Health Economy plans in East, West and Centre
- Updates on timetable for 2020/1 annual operating plan
- Environmental sustainability

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

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

Meeting Date	Key risks including mitigating actions and milestones
2.4.19	• The effects of Adverse Childhood Experiences are well documented. But the lifelong prevention approach is not currently fully reflected within BCUHB service plans and

	ownership of this agenda is required across all divisions. The new plan should help mitigate against the risk. • Failure to work effectively in partnership with the third sector could have a detrimental impact on the quality of care and failure to engage appropriately would breach current legislative expectations. • The BCUHB Corporate Risk Register highlights the risk if population health issues such as smoking are not fully addressed. • Service developments within the MHLD Transformation projects could not be sustainable at project end. A project evaluation has been commissioned in mitigation so that lessons are learnt alongside.
4.7.19	• Agreed that the (Clinical) Services Strategy to be reported to the July Board required further detail on engagement and emphasising the purpose as an enabling strategy • Questioned financial expenditure plans to support stroke service development and sought further clarity within presentation to the Board in July. • It was noted that whilst WG guidance was awaited on BCUHB's 'University' designation review, work was underway to collate supportive evidence.
3.9.19	-
7.11.19	None
3.12.19	The Committee requested that CRR18 EU Exit be reviewed at each meeting given the political situation
5.3.20	• The annual plan 2020/21 was not yet in a cohesive draft document – executives were escalating focus to ensure provision by the March Board meeting following further discussion scheduled at 12.3.20 Board workshop. • CV19- risk being developed for inclusion to the corporate register • Concern regarding light capacity within the Board's emergency preparedness and resilience team – to be addressed within Executive Team • Lack of BCU Environmental Strategy to be developed by the Director Estates and Facilities • BCUHB's public engagement survey reflects a deteriorated perception of BCU in comparison to 2 years previously. The progress of University status work was questioned given the understanding that WG required an update shortly, which was being followed up by the Executive Director Planning and Performance with the Executive Director Therapies and Health Sciences.

9. Focus for the year ahead:

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

- *Overseeing the service strategy development work in accordance with the annual plan and stakeholder expectations*
- *Encouraging the development of health economy approaches to planning to inform the BCU wide plan for 2020/21.*
- *Developing our awareness of partnership working focusing on public service boards and the regional partnership board.*
- *Gaining assurance on our engagement with statutory partnership fora and that targeted investment (eg transformation funding) is delivering the anticipated benefits.*
- *Receiving updates on key enabling strategies including workforce / engagement, and estates.*

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 2.

V1.0 Approved SPPHC 13.8.20

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 19/09/20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Legislation Assurance Framework (LAF)
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:	Appendix 1: Legislative Developments Appendix 2: Areas of Limited Assurance

Argymhelliad / Recommendation:

The Audit Committee is asked to:

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

This paper details a summary of the work undertaken in the development of the BCUHB Legislation Assurance Framework (LAF). Including:

- Operational engagement in developing the LAF and the collation of assurances.
- Legislative developments (legislation enacted since the previous report)
- Specific items of no or limited assurance.

Cefndir / Background:

Work undertaken between the All Wales Audit Committee Chairs and Board Secretaries Network previously acknowledged that it was essential that Boards had an effective system in place in which identifying and managing risk was a continuous thought process for the Board in order to satisfy the Audit Committee that risks were being managed well. It was acknowledged that the approach in Wales would be to produce three distinct products (whilst acknowledging the need for local variation), namely:

- A narrative BAF document
- The Assurance framework map
- The Corporate Risk Register

Part B of the Assurance map comprises the Legislation Assurance Framework (LAF). NHS bodies in Wales must operate in accordance with the law in relation to all aspects of their business. The Health Board has developed a system to capture compliance and assurance information on a centralised register and management system. The Audit Committee reviews the LAF bi-annually. The system provides the Board with an oversight of legislative obligations/liabilities, the assurance level, the impact of non-compliance and the control measures in place for each.

Operational engagement in developing the LAF and the collation of assurances.

Due to significant staffing / capacity issues within the Office of the Board Secretary (OBS) and the requirement of operational leads to focus on the COVID-19 response, the LAF development has been generally limited to basic monitoring and updates. This means that all newly enacted legislation and/or amendments are reviewed for applicability and impact, disseminated to governance leads for information and input/updated in the main database where applicable. Members can be assured that the master database is continuously updated though engagement with the relevant leads to confirm allocation and complete the assurance criteria has been limited overall. An initial review of Estates & Facilities legislation has been undertaken with the Director of Estates and a baseline of assurance completed. This is a substantial piece of work / self-assessment covering approximately 100 pieces of legislation. The data is in the process of being quality checked (for example, where allocation is queried / incorrectly assigned) by the Statutory Compliance, Governance & Policy Manager. Feedback will then be provided to the Director of Estates & Facilities before the allocated legislation assurance is finalised. Areas of limited assurance will be reported to Audit Committee via the next iteration of the LAF. Pharmacy & Medicines Management are similarly at the same stage (awaiting allocation review by the Statutory Compliance, Governance & Policy Manager). A Governance meeting is Scheduled with Primary Care (to include LAF discussion) 30/09/20 and preliminary discussions have taken place with the Dental lead.

Members are also asked to note that the LAF has proven to be a useful tool for supporting the review and implementation of the Policy on Policies (as per the HASCAS and Ockenden external review recommendations); acting as a reference point to ensure any legislation cited is correct.

Legislative developments (legislation enacted since the previous report)

Members should note that the report does not detail new legislation that has been enacted in order to address failures of retained EU law to operate effectively arising from the withdrawal of the United Kingdom from the European Union. The majority of amendments have no practical application and generally remove EU references that are no longer appropriate. For example, ‘The Planning

(Hazardous Substances and Miscellaneous Amendments) (EU Exit) Regulations 2018 amended the Planning (Hazardous Substances) Regulations 2015 and would not be included unless the amendment introduced changes in the legislation's application to BCUHB. Similarly, the Health Protection (Notification) (Wales) (Amendment) Regulations 2020 which place obligations on various persons for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination have been enacted to amend/include Coronavirus Disease 2019 (COVID-19) into Schedule 1 of the existing 2010 Regulations and would therefore not be incorporated into the LAF.

Due to the current political landscape (COVID-19 response and prioritisation / Brexit preparation), the volume of legislation enacted has been significantly reduced. Detailed at Appendix 1 is a summary of relevant legislation enacted since the previous report.

Specific items of no or limited assurance.

Areas of no or limited assurance are detailed in Appendix 2. Items have been reviewed and updated where applicable by the relevant leads. Items that reported substantial or reasonable assurance in the previous report have been removed as previously agreed. Items detailed that are now showing as substantial or reasonable will be removed from the next iteration of the report unless Members direct otherwise.

Asesiad / Assessment & Analysis

Strategy Implications

The LAF contains approximately 600 pieces of legislation. These include items that impact on strategic goals and plans. For example, the Social Services and Wellbeing (Wales) Act 2014, the Well-being of Future Generations (Wales) Act 2015 or specific environmental obligations to improve air quality / reduce waste etc. or general sustainability such as Public Services (Social Value) Act 2012.

Financial Implications

The LAF contains approximately 600 pieces of legislation. These include items that impact on financial regulation or operational finance requirements, for example – Bribery/Money Laundering/Modern Slavery, Charities, Consumer Credit, Late Payment of Commercial Debts Regulations/Public Contracts Regulations, Incidental lotteries, Government financial reporting manuals, tax and pensions and the duties under the National Health Service Finance (Wales) Act 2014.

Risk Analysis

Where there is evidence of limited or no assurance, items are included in appendix 2. Directorate Governance Leads / Owners are directed that areas of non-compliance should be reflected in the appropriate risk register as appropriate. This supports the triangulation of data analysis. The LAF also details mitigating controls in place. The Health Board has committed to ensuring that there is a managed system in place to capture compliance information in accordance with the Board's Risk Appetite. This includes risks which could be identified from the Health Board's inability to comply with legislation, regulation, policies and procedures including professional standards.

Legal and Compliance

NHS bodies in Wales must operate within the law in relation to all aspects of their business. The Health Board has a responsibility to ensure that its governance arrangements encompass an assessment of compliance with all applicable legislative obligations. These will include, but not be restricted to the following categories:

- Accreditation, registration or licensing requirements
- Reporting requirements (the provision of statistics or information)
- Complying with timeframes for performing activities
- A requirement to provide a specified service or range of services
- Restrictions or limitations on how these services can be offered
- Financial obligations
- Employer duties
- Powers of inspection or review
- Data protection
- Professional regulation
- Other key pieces of legislation such as health & safety or environmental obligations

Impact Assessment

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

Appendix 1: Legislative Developments

Title	Explanatory Note	Divisional Assignment	Additional info
Health and Social Care (Quality and Engagement) (Wales) Act 2020	The Act introduces changes that will: • Place quality considerations (Duty of Quality) at the heart of all that NHS bodies in Wales and the Welsh Ministers (in relation to their health functions) do through a specific duty, building upon the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014. • Place a duty of candour on all NHS bodies at an organisational level, requiring them to be open and honest when things go wrong. • Create a new Citizen Voice Body to represent the views of people across health and social care. • Strengthen the governance arrangements for NHS Trusts. • The Act also provides the Welsh Ministers with regulation-making powers to set out a procedure to be followed by an NHS body when the duty of candour has been triggered.	Nursing	A briefing paper was taken to the Quality, Safety & Experience Committee earlier in the year. The Health board are currently awaiting the guidance to accompany these new duties and the timescale for implementation (all delayed with COVID). In the interim, assurance can be provided as follows: **Duty of quality** – awaiting national guidance on commencement date and implementation (implementation not expected until summer 2021); as the Health Board already has a Quality Strategy and publishes an Annual Quality Report, it anticipates the transition to the new framework will be smooth. **Duty of candour** – awaiting national guidance on commencement date and implementation (implementation not expected until spring 2022); the current incident process review is proceeding with the duty of candour in mind and will incorporate this so the Health Board will be ready on a principles basis a year ahead of national implementation. **Citizen Voice Body** – awaiting national guidance on what this new organisation will look/operate like and awaiting a commencement date (implementation not expected until autumn 2021); the Health Board already interfaces well with Community Health Councils and expects to work well with the new body in whatever form it takes.

Appendix 2: Areas of Limited Assurance

Keys:

⬆	**Compliance Level Increased.**
⟷	**Compliance Level no change.**
⬇	**Compliance Level Declined.**

- The **type** of assurance (verbal, a written report, licences or certificates)
- The **level** of assurance (where the type of assurance is overseen: operational management, oversight/Committee, independent/third party verification
- The **compliance level** (as per Internal Audit Assurance Ratings: substantial, reasonable, limited, no assurance)
- The **compliance impact** rating (as per the RM01, Risk Scoring Matrix)
- The **key controls** and/or assurances in place (policy & procedures, staff training, annual reports, key performance indicators, etc.)
- **Third Party Assurance** – whether compliance has been subject to an external or independent review

Legislation	Explanatory note	Assurance Type	Assurance Level	Responsible Division	Compliance Impact	Compliance Impact Rating	Key Controls	Third Party Assurance	Comments
National Health Service Finance (Wales) Act 2014	This Act amends the National Health Service (Wales) Act 2006 so that the existing duty on each Local Health Board in Wales to secure that its expenditure does not exceed its funding in a financial year instead becomes a duty to secure that its expenditure does not exceed its funding over a period of three financial years; and may be subject to a margin of tolerance permitted by the Welsh Ministers. The Welsh Ministers must give directions to a Local Health Board requiring it— (a) to prepare a plan which sets out its strategy for securing that it complies with the duty under subsection (1) while improving— (i) the health of the people for whom it is responsible, and (ii) the provision of health care to such people; (b) to do such other things as appear to be requisite to secure that it complies with that duty.	Written	Oversight	Finance	No Assurance ⟷	High (15-20)	Reporting of compliance forms part of the Statutory Annual Accounts	Wales Audit Office	The Health Board did not achieve its statutory target in 2019/20 and this was reported through the Finance & Performance Committee to the Health Board. It is also addressed in the Corporate Risk (CRR06) around financial performance. The Health Board developed a challenging plan for 2020/21 of a £40m deficit based on delivering £45m savings, but this did not take into account the impact of the COVID-19 pandemic. The Health Board is working with Welsh Government to establish and agree the level of additional funding available to support the Health Board's exceptional expenditure due to the pandemic as this will impact on the forecast position for the year. As a consequence of COVID-19, the Recovery Programme implemented in 2019/20 was suspended in March and a financial improvement group is planned for Quarter 3 2020/21.
Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013	These regulations maintain requirements that the responsible person must notify, and subsequently send a report to, the relevant enforcing authority by an approved means in relation to fatal and certain non-fatal work-related accidents, specified diseases contracted by persons at work and certain specified dangerous occurrences.	Written	Oversight	Workforce & OD	**Reasonable** ⬆	Low (5-10)	Policy & Procedure. Staff training. Dedicated Corporate H&S leads. Annual and quarterly reporting.	Internal Audit	The planned visit by HSE was cancelled due to COVID-19. COVID has had a serious impact upon the H&S of BCUHB and as a result, the H&S team has implemented a range of measures, including a 72-hour review of all RIDDORs. Working closely with the Patient Safety team, various pieces of operational guidance have also been issued to support staff in meeting the reporting requirements. BCUHB has clarified its RIDDOR reporting approach with the HSE who are now satisfied with the systems implemented.

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									Since the 8th of April, 509 RIDDORs have been reported. RIDDORs are also reported to Risk Leads on a bi-monthly basis and Trade Unions on a weekly basis through partnership meetings. The Strategic Occupational Health & Safety Group (SOHSG) meeting was stood down in March 2020 due to COVID. The Group plans to reconvene in October (pending approval of the revised Governance meeting/group Structure at the Quality, Safety & Experience (QSE) Committee in August 2020). RIDDORS are reported annually / quarterly to the QSE Committee.
Public Health (Wales) 2017 Act	An Act of the National Assembly for Wales to make provision for a national strategy on tackling obesity; smoking; about the performance of certain procedures for aesthetic or therapeutic purposes; about intimate piercing of children; about health impact assessments; about assessing the local need for pharmaceutical services; about pharmaceutical lists; about assessing the local need for public toilets; about fixed penalty receipts for food hygiene rating offences.	Verbal	Operational	Public Health	**Reasonable** ↑	Low (5-10)	None	None	The Public Health (Wales) act sets out provisions in a number of priority areas of public health policy, including obesity, smoking, 'special procedures' (such as body piercing, tattooing), pharmaceutical services and toilets for public use. During Stage 1 scrutiny of the Act in the Health, Social Care and Sport Committee of Senedd Cymru, it was noted that further work would need to be undertaken to develop the secondary legislation and guidance needed to implement the provisions. This secondary legislation has been delayed due to capacity issues surrounding legal support that is currently aligned to Brexit and the COVID-19 pandemic response. Given this position, the assessment is that the level of assurance is reasonable for the overarching Act, with the specific obligations to be provided for in subsequent legislation. These subordinate regulations will be included in the LAF once enacted, and reported on independently. An outline of the Health Board's obligations under the Act, and the measures undertaken are detailed below: • Obesity: Part 2 of the Act requires the Welsh Government (WG) to publish a national strategy on preventing and reducing obesity. The Healthy Weight: Healthy Wales long-term strategy was published in 2019 and ensures that the WG works in partnership with Regional Partnership Boards and Public Service Boards to develop transformative ways of working. WG are required to publish a progress report following each review of the Strategy. • Tobacco and nicotine products: Part 3 of the Act places restrictions on smoking in outdoor hospital grounds. The draft regulations for smoke-free sites have been consulted on and it is anticipated that the Regs will be laid in Autumn 2020 with a 3-4 month lead time to come into force. As it currently stands, Hospital Managers will have a duty to take 'reasonable steps' to prevent smoking on hospital grounds. Welsh Government (WG) have established a working group looking at enforcement of the ban and are working with enforcement colleagues to develop implementation plans and guidance. The Task and Finish Group will be reconvened

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									when new details surface. Background work, where possible, continues including planning for smoke free signage. • Health Impact Assessments: Part 6 of the Act places a duty on the Welsh Ministers to make regulations that require public bodies to carry out heath impact assessments (HIA). Assessments are limited to policies, plans and programmes which have outcomes of national or major significance, or which have a significant effect at a local level on public health. HIAs were first proposed in 1998 and the Wales Health Impact Assessment Support Unit (WHIASU) is an all Wales service responsible to Public Health Wales and funded by WG. The unit provides advice, guidance and support for HIAs. • Pharmaceutical Services: Part 7 of the Act provides that Health Boards will be required to prepare and publish 'pharmaceutical needs assessments' (PNA) for their areas. The Act amends the current 'control of entry' test so that decisions on applications to join a Health Board's pharmaceutical list will be based on whether the application meets the need(s) identified in the local pharmaceutical needs assessment. The Act aims to improve the planning and delivery of pharmaceutical services, and strengthen the role of community pharmacy in promoting and protecting public health. The National Health Service (Pharmaceutical Services) (Wales) Regulations 2020 are in draft form and being considered by the Senedd. The BCUHB Chief Pharmacist is aware and a lead within Pharmacy has been identified to lead the work on the PNA.
The Functions of Local Health Boards (Dental Public Health) (Wales) Regulations 2006	These Regulations set out the functions to be exercised by Local Health Boards in Wales in relation to oral health. Those functions relate to oral health promotion programmes, dental inspection of pupils in schools maintained by local education authorities and oral health surveys.	Written	Oversight	Public Health	**Reasonable** ↑	Low (5-10)	Action Plan	None	A Local Oral Health Action Plan is in place in response to WG National Oral Health Plan. The Health Board continues to link with Public Health Wales in respect of Dental and Oral Health surveys. (Preliminary discussions between the Statutory Compliance, Governance & Policy Manager, and the North Wales Community Dental Services Business Manager have been undertaken and a meeting is to be arranged with the clinical lead to review all legislation assigned to Dental Services).

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The Information and Consultation with Employees Regulations 2004	These Regulations establish a general framework for informing and consulting employees. An employer may be under an obligation to inform and consult about its proposals where: • It intends to implement the change by dismissing employees who refuse to agree, and 20 or more dismissals are proposed • The change amounts to "measures" in connection with the transfer of an undertaking • There is a recognised trade union and the proposed change is subject to collective bargaining with trade union representatives. • The Information and Consultation of Employees Regulations 2004 apply and there is an information and consultation agreement in place. In accordance with the terms of that agreement, the employer may have to inform and consult with employees about proposed substantial "changes in contractual relations" unless they are changes to pay or monetary benefits. • The change relates to a pension scheme. The employer may have to comply with consultation obligations under regulations made under the Pensions Act 2004. If there is an information and consultation agreement in place, the employer may choose whether to consult under this agreement or under the regulations.	Verbal	Operational	Workforce & OD	**Substantial** ↑	Low (5-10)	Policies & Procedures	None	These regulations give employees the right, subject to certain conditions, to request that their employer sets up or changes arrangements to inform and consult them about issues in the organisation. The requirement to inform and consult employees does not operate automatically. It can occur either by a formal request from employees for an agreement, or by employers choosing to start the process. The updated all Wales Organisational Change Policy was agreed/approved in March 2017 by the Welsh Partnership Forum. In addition, the BCUHB Organisational Change Policy Process was approved in June 2019. Both of these documents and further supporting documentation (FAQs / Redeployment guidance) are available on the staff intranet. As per its Terms of Reference, the Remuneration & Terms of Service Committee provides assurance to the Board in relation to arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined in NHS Wales. In addition, the Committee approves, on behalf of the Board, any policy within the remit of the Committee's business including the approval of Workforce policies. This is further supported by the BCUHB Policy on Policies, which mandates that all BCUHB *policies* are approved by the relevant Board level Committee.