Bundle Audit Committee 16 November 2023

1.1 09:30 - AC23.109 Welcome, introductions and apologies for absence

1.2 09:32 - AC23.110 Declarations of interest on current agenda

1.3 09:34 - AC23.111 Minutes of previous meeting for accuracy & matters arising and review of summary action plan
a) Action Tracker
AC23.111 Draft AC Minutes 15.09.23 v4 (002)
AC23.111a Audit Committee - Table of Actions Public session 16.11.23

2.1 09:40 - AC23.112 Details of Breaches of SOs (late papers etc.)
AC23.112 Audit Commtitee - Standing Order Breaches V3

2.2 09:45 - AC23.113 Corporate Governance Arrangements
a) Draft TOR for Board Committees
b) Draft Committees and Board workplan
c) Draft Corp. Calendar
d) Corp. Governance SOP
AC23.113 Corporate Governance report (2)

2.3 09:55 - AC23.114 Risk Management
a) Board Assurance Framework
b) Corporate Risk Register
AC23.114a Board Assurance Framework Report
AC23.114b Corporate Risk Register

2.4 10:00 - AC23.115 Special Measures Report
a) Update on milestones and arrangements related to AC
b) Feedback from Independent Reviews - OBS Review
AC23.115a Audit Special Measures Update
AC23.115b Independent Review Management Response Office of the Board Secretary

3.1 10:10 - AC23.116 Review of amendments to Health Board SFI's including EASC & WHSSC
AC23.116 Cover sheet SFI
AC23.116 SFIs and WHSSC and EASC SOs (1)
AC23.116a Appendix 1 - SFI Schedule 2.1 BCUHB V5 November 2023 FINAL
AC23.116b Appendix 2 - Table of Amendments for SFIs
AC23.116c Appendix 3 - WHSSC Standing Orders - Schedule 4.1 - Audit Committee November 2023
AC23.116d Appendix 4 - EASC Standing Orders - Schedule 4.2 - Audit Committee November 2023
AC23.116e Appendix 5 - Table of Amendments for SOs

3.2 10:20 - AC23.117 Amended Scheme of Reservation and Delegation
AC23.117 Audit Committee - cover sheet SoRD
AC23.117.1AComm paper for SoRD
AC23.117.2 Appendix 1 Table A - October 2023 Final Draft
AC23.117.3 Appendix 2 Table of Amendments for SoRD Table A
AC23.117.4 Appendix 3 - Table A with tracked changes AC
AC23.117.5 Appendix 4 Table B - October 2023 Final Draft
AC23.117.6 Appendix 5 Table B - August 22 Board

3.3 10:30 - AC23.118 Report on Single Tender Waivers and Losses & Special Payments Q4 22/23
AC23.118 Audit Committee - Single Waivers and Losses and Special Payments Q4 202223

3.4 10:35 - AC23.119 Dental Assurance Report
AC23.119 Audit Committee General Dental Services Assurance Report Q2 2023 24

4.1 10:40 - AC23.120 Internal and External Audit Tracker
AC23.120 Update on Internal and External Audit Recommendations
AC23.120a Appendix 1A - Audit Tracker - Proposed Recommendations for Closure
AC23.120b Appendix 1B - Audit Tracker - Open Internal Audit Recommendations
AC23.120c Appendix 1C - Audit Tracker - Open External Audit Recommendations.xlsx

4.2 10:45 - AC23.121 Internal Audit progress report
AC23.121 IA progress report Cover Sheet Nov 23
AC23.121a BCUHB Audit Committee progress report November 2023

4.4 10:50 - AC23.122 Any no assurance or limited assurance reports as a substantive item

AC23.122 Appendix C - Final Internal Audit Report GP Out of Hours

AC23.122 Appendix D - Final Internal Audit Report - Falls Management

4.5 10:55 - AC23.123 Executive update on Internal and External Audit Tracker and Limited Assurance Reports

a) OBS update
b) Operations update
c) GP OOHs report
d) Falls Report
VERBAL

4.6 11:30 - AC23.124 Follow up Outpatients Management Response

Verbal

AC23.124 BCUHB_Follow_Up outpatients report_final

5.1 11:40 - AC23.125 Auditor General's (external audit) progress reports

AC23.125 Auditor General's (external audit) progress reports - Nov 2023

5.2 11:45 - AC23.126 National audit reports for information

a)National workforce data briefing

AC23.126 NHS_Workforce_data_briefing_English

6.1 11:50 - AC23.127 Briefings and update sessions (as appropriate)

7.1 11:55 - AC23.128 Summary of private in Committee business to be reported in public

7.2 12:00 - AC23.129 Summary of Key Issues

AC23.129.1 - National Commissioning Implementation Programme

AC23.129.1 National Commissioing Implementation Programme - Covering Paper PID 21 09 2023v1

AC23.129.1 Project Initiation Document Final v0.9 (002)

Betsi Cadwaladr University Health Board

Minutes of the Audit Committee held on 15 September 2023, Boardroom, Carlton Court, St Asaph

Present	
Name	**Title**
Karen Balmer	Independent Member, Chair
Dyfed Jones	Independent Member
In attendance	
Nesta Collingridge	Head of Risk Management
Andrew Doughton	Performance Audit Manager Audit Wales
Dyfed Edwards	Independent Member/Health Board Chair
Dave Harries	Head of Internal Audit
Andrea Hughes	Interim Director of Finance
Nicola Jones	Deputy Head of Internal Audit
Phil Meakin	Interim Board Secretary
Marty McAuley	Deputy Director Corporate Governance / Deputy Board Secretary
Simon Monkhouse	Audit Lead Audit Wales
James Risley	Deputy Executive Medical Director
Carol Shillabeer	Interim Chief Executive Officer
Chris Stockport	Executive Director of Transformation and Planning
Bethan Wassell	Statutory Compliance, Governance & Policy Manager

Agenda item	**Action**
OPENING BUSINESS	
AC23.78 Welcome introductions and apologies AC23.78.1 Karen Balmer, Independent Member and Chair (Chair) of the Audit Committee welcomed everyone to the Audit Committee. AC23.78.2 Apologies were received from: • Gareth Williams, Independent Member • Russell Caldicott, Interim Executive Director of Finance – Represented by Andrea Hughes Interim Director of Finance • Nick Lyons, Executive Medical Director – Represented by James Risley, Deputy Executive Medical Director • Matt Edwards, Audit Wales • Michelle Phoenix, Financial Audit Manager, Audit Wales	
AC23.79 Declarations of interest on current agenda AC23.79.1 There were no declarations of interest noted.	
AC23.80 Draft Minutes of the meetings held on the 25 May 2023 and	

24 August 2023 AC23.80.1 The Chair noted an amendment in the agenda to update from 2023 to 2024. AC23.80.2 The minutes of the meeting held in May 2023 were confirmed as a true and accurate record of the meeting. AC23.80.3 The minutes of the meeting held in August 2023 were confirmed as a true and accurate record of the meeting. **ACTION**: **Simon Monkhouse confirmed that his attendance was incorrectly recorded for the August meeting. This is to be updated.**	MM
AC23.81 Action Log AC23.81.1 The Board Secretary presented the action point register and invited comments. The Committee reviewed the four open actions on the register. AC23.81.2 The Chair challenges the outstanding action on charitable funds (AC23.08.05G) and whether the new meeting date should be before or after the annual audit? **ACTION: The Board Secretary progress with the Head of Fundraising.** **AC23.81.– Annual Report AC23.62 – It was agreed that this action would be closed for ARAC and remain with PFIG** **AC23.81. – Annual Report AC23.62.5 The Chair noted that an answer to this question was provided at the last REMCOM meeting by Jason Brannan. It was agreed that this action would therefore be closed with the answer noted on the update at the next meeting.** AC23.81.3 Action point register was approved.	PM
AC23.82 ITEMS FOR APPROVAL OR ASSURANCE	
AC23.83 Special Measures Report AC23.83.1 Dr Chris Stockport, Executive Director of Transformation & Strategic Planning led the Committee through the report. The committee were informed that this is the first time that this report style has been presented to Committee. AC23.83.2 Cycle one of special measures has now been completed and the report is presented to the Audit Committee. Many deliverables move in to cycle two with new deliverables that will build on the cycle one success.	

AC23.83.3 The Chair of the Committee sought clarification on the independence of the Project Management Office (PMO). It was confirmed that whilst the PMO is not independent of the Health Board, the view and assurance that they offer is independent of the view of the lead Executive. AC23.83.4 The Audit Committee discussed the report, its style, content and presentation. The Committee acknowledged that it is clear and easy to read but noted that there was some confusion/lack of clarity on where we are. The Committee cautioned that whilst it was fully understood that this was not intentional, the openness and transparency of the reporting was paramount. AC23.83.5 The Committee discussed why this could appear to have less clarity and noted that there were not as many deliverables and again, agreed that it was clear that there is no intention to mislead but that reporting needs to be clear. AC23.83.6 The Board Secretary gave an update on recruitment and the timeline that is expected to be followed: • Chair recruitment closes on the 29th October 2023 with interviews in November • Vice chair recruitment closes on 3 October 2023, interviews October. • Independent Member (IM) interviews are taking place on 4 October 2023 • A further round of recruitment for IMs will begin at the end of October with interviews in Mid-January 2024. AC23.83.7 The Board Secretary reminded that the appointments were led by Welsh Government. The current term of office for those IMs directly appointed by the Minister will end on 29 February 2024.Interviews are scheduled for 15 January, and the Committee noted the potential and significant risk that all five IMs could be lost through the process and the Health Board would be back in the same position as previously. **ACTION: The Board Secretary to find the appropriate feedback route to highlight the concerns from the Committee.** AC23.83.8 The Board Secretary noted that we had re-established 8 committees but that we need to look at the deliverables in more details and the transition needs to avoid ambiguity. The Committee agreed and recognised the need for an audit work plan. **ACTION: The Board Secretary to facilitate an annual work plan for the Committee with the Chair of the Committee.**	PM PM
AC23.84 Review and approval of framework: Risk Framework AC23.84.1 The Interim Chief Executive and Head of Risk Management presented the risk framework to the Committee. It was noted that the	

committee were being asked to consider the risk appetite following the board development day not approve it. AC23.84.2 A Board development session was held on the 24 of August 2023 to determine the 2023/24 risk appetite and discuss the approach to risk management, in order to inform the risk management framework. AC23.84.3 The framework has moved from being quite procedural to now being more streamlined. AC23.84.4 A significant change is the role of the executive team taking on more of the accountability and escalation and de-escalation of risks, as opposed to the Risk Management Group. This allows for a more agile corporate risk register. There is much more emphasis on the Executives as individuals and as a team to review the strategic risks of the of the Health Board. AC23.84.5 The Chair thanked the corporate team for the progress made and the ongoing development of RM02. AC23.84.6 The Chair suggested that the following changes were made: • Risk Appetite: further describe the cautious appetite in relation to financial control to emphasise that the board were open to some financial risk as long as appropriate controls were in place. • Reputational risk: seek is the correct status but the definition aligned to an open appetite rather than seek. • Risk Strategy needs to have context of learning and continuous improvement with regard to risk mitigation. • Add further details on the three lines of defence. • More emphasis on continuous learning. **<u>ACTION</u>: The Board Secretary to review and make the changes** AC23.84.7 The Chair confirmed that further work was needed in the glossary to articulate what Risk Appetite is, what risk management is and what our Risk Management Framework is. The Chair thanked PM and in particular Nesta Collingridge for her hard work in pulling all of this together.	PM
AC23.85 Review and Approval of Standing Orders AC23.85.1 The Board Secretary presented the standing orders and explained the legislative requirement for them to be reviewed and maintained. These are from Welsh government all Health Boards have been asked to update the model ones.	

AC23.85.2 The Board Secretary conformed that these are seen in conjunction with the scheme of reservation and delegation of the Board and how they are a key part of our financial special measures action plan. AC23.85.3 The updated revisions will be presented to the next audit committee those revisions can then to go to the next Board meeting for approval. AC23.85.4 The Chair informed the Officers that this was a fundamental key control, particularly in our current environment and with such a financial challenge ahead. AC23.85.5 The Interim Director of Finance confirmed some of the challenges ahead and the amount of work taken to get the improvements that had been achieved so far. AC23.85.6 The Committee also recognised that there had been some significant breaches in terms of standing orders and standing financial instructions and that the prevention of these in the future has to become a priority focus for the Committee. AC23.85.7 The Finance Director conformed that to help prevent this in the future, people would receive training on standing orders, SFI and procurement training. AC23.85.8 The Committee was assured by the work to date.	
AC23.86 Implementation Plan Update on Declaration of Gifts and Hospitality AC23.86.1 The Board Secretary explained the requirement to establish and maintain a system for the declaration, recording and handling of health Board officers' interests and the register of gifts, hospitality and sponsorship. AC23.86.2 A position of partial assurance and stepped approach to improvements on previous position was noted but that further work was required for full assurance. A new system had been launched two weeks ago on 31 August 2023 and further engagement and training was needed in the next quarter to improve compliance. AC23.86.3 The Health Board has a duty under the Bribery Act to ensure that there are proper systems in place to prevent bribery within the Health Board and must be demonstratable that these are in place. AC23.86.4 The Committee noted that the only defence to section 7 of the Bribery Act is to show that there are good processes in place. As such	

regular undertaking of audits to show that the system is effective, as well as testing our staff was essential. AC23.86.5 The Chair reminded the committee that the previous audit had given a limited assurance and therefore it was imperative to get the new system working and to attain full compliance. The progress made was noted but further assurance was required. **ACTION**: **The Board Secretary to report back in January on progress and compliance.**	PM
AC23.87 Audit Tracker Update AC23.87.1 The Head of Risk Management presented the report noting that there were a number of high and overdue actions from audits. AC23.87.2 The Committee recognised the work that had been undertaken to date to get to this position but confirmed that overdue or delayed recommendations are unacceptable. It was noted that at the last committee meeting it had been agreed that the appropriate Exec Director would attend the audit committee to give an update and to answer questions posed by the committee. The Chair requested that this arrangement was given a priority for the next meeting. AC23.87.3 The Committee recognised that these were legacy issues and noted the improved governance that the Board Secretary had put in place with executive monthly oversight. AC23.87.4 The Chair recognised the work that had been undertaken to get to this stage and thanked the team, and made it clear about future expectations. This was the benchmark and it needed to be continually improved upon. The Chair request amends to the format of the report tables and asked that the following information be included going forward: • Who the responsible Exec Director is for each action and a summary table showing outstanding actions by Exec Director / directorate area rather than a list. • What the original deadline was and the number of times the deadline had been revised. • A note of which other committees are looking at the actions. • No acronyms. AC23.87.5 The Board Secretary confirmed that these would be presented to each Committee.	

AC23.87.6 The Committee re-iterated the need for assurance and oversight of actions and how this can be triangulated so they are all assured. AC23.87.7 The Committee noted the progress made to date and the Chair thanked Bethan Wassall for her efforts in getting this report in a betterplace.	
AC23.88 Policy on Policies AC23.88.1 The Board Secretary presented the report highlighting some of the key changes to the policy. AC23.88.2 There is greater delegation, however the policy needed to be clearer about what was reserved for the Board. The things that generally are reserved for the Board are areas where there is a particular legislative framework around them. **ACTION – amend Policy on Policies to be clearer** AC23.88.3 The Board agreed that this needed to be dynamic and reviewed to make sure that it was being effective. The Committee agreed on the need to be assured and to test that the things we believe to be happening actually are. It was noted that there was an ambition to streamline the numbers of policies, by utilizing standard operating procedures and protocols. AC23.88.4 The Board approach to prioritising the outstanding policies which are due for review was highlighted. The executive team agreed that we would identify a policy lead. A priority for the policy and a timescale for completion. AC23.88.5 The Committee noted the work to be done and the Chief Executive set expectations that this could take 12-18 months to recover the position. AC23.88.6 The Committee approved the new route for approving and managing policies and noted the plan to address the backlog of policy reviews.	
AC23.89 Financial Control and Single Tender Actions Summary AC23.89.1 The Interim Deputy Executive Director Finance presented an overview of the current financial position and the report providing an update on the first five months of 2023/24 (April 23 to August 23) on conformance with the Health Board's Standing Orders (SOs), incorporating Standing Financial Instructions (SFIs) and Scheme of Reservation and	

Delegation of Powers (SoRD), in relation to Single Tender Waivers and Losses payments.

AC23.89.2 The Health Board has a planned deficit of £134.2m. The expenditure run rate is materially above plan, with a Year-to-Date deficit at Month 5 of £20.3m.

AC23.89.3 There is a requirement for a formal Financial Recovery Plan, which will be presented to the next Board Meeting. Executive led actions designed to mitigate the pressures are being progressed.

AC23.89.4 The Finance Director gave an overview of some of the mitigating actions being considering to control and reduce expenditure. It is expected that the Welsh Government will ask NHS Wales to seek to further improve upon the planned deficit position.

AC23.89.5 The Committee reviewed the single tender waivers and noted the emergence of more 3 + 1 + 1 type contracts. The Committee highlighted one for a system for which there was only one provider. It was noted that this was a legacy system from about 15 years ago, which requires an annual maintenance contract to keep this system going. One of the gaps in the information being collected is the cumulative spend is not shown. The Chair emphasised the need to have a system in place to monitor the cumulative spend with specific providers so as to ensure value for money and to inform future procurement.

AC23.89.6 The Committee reinforced its position with regard to; the need for openness and transparency, the importance of following procurement rules in line with SFIs and ensuring value for money.

AC23.89.7 The Committee discussed its approach to fraud prevention and how they will be assured when single tender waivers cannot be used to circumnavigate our procurement controls.

AC23.89.8 The expectation of the Committee is that single tender waivers should be few and far between. Going forward, as set out in the SFIs the Committee reserves the right to require the budget holder/director to attend and explain the reason for breaching the SFIs.

AC23.90 Internal Audit Progress Report

AC23.90.1 The progress report was presented to the Audit Committee, noting that it was the first time reporting 100% of the reports turned around, from management response to draft report within 20 working days. The Chair commended this improvement.

AC23.90.2 It was noted that despite this progress the Health Board remains an outlier as other organisations are working to 15. The Committee had discussed this in May 2023 and decided to stay at 20 and review later in the cycle as arrangements are more embedded. It was agreed that this would be something to aspire to in the new financial year.

AC23.90.3 There were 14 reviews that were finalized, with nine of those from 2022/23. The fourteen were rated as follows:

- Substantial assurance (green) – two;
- Reasonable assurance (yellow) – three;
- Limited assurance (amber) – seven;
- No assurance (red) – one; and
- Advisory (grey) – one

AC23.90.4 Contracted patient activity – Quality & Safety arrangements No assurance and four high level recommendations.

AC23.90.5 The Committee highlighted the Public Interest Report from the Public Services Ombudsman for Wales detailing the investigation of a complaint against the Health Board for the care and management of a Health Board patient. It was presented at the November 2022 Quality Safety and Experience Committee (QSE) and referred to in the subsequent Board meeting.

AC23.90.6 The Chair instructed that the Ombudsman's review is an action from this meeting, is circulated to the Committee and for them to review and consider if they are assured.

ACTION: Circulate Ombudsman's review and add to the next agenda.

PM

AC23.90.7 Recruitment of Substantive and Interim Executive and Senior Posts (ESP) Substantial assurance received with two medium recommendations

AC23.90.8 Planned Care Recovery and Transformation Group There was limited assurance given due to the has not met since December 2022, we are therefore unable to confirm that it is fulfilling its responsibility to provide assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented.

AC23.90.9 Data analysis – Triangulation of data Limited assurance report with 3 high level recommendations. It was highlighted that there was no evidence of issues escalated, and there was no regular report. The Committee were assured that there is now a revised programme waiting formalisation, and an inaugural meeting to launch the program is planned before the end of July.

AC23.90.10 The Chief Executive confirmed that the meeting had taken place and that she had chaired the meeting. Further strengthening of the programme is being undertaken to make it clearer on what's the start, the middle and the end.

AC23.90.11 Performance management and accountability arrangements Limited assurance with 2 high level and 1 medium level recommendation. Key feedback included:

- There is a process in place to collect data, but it's a lot, quite a few different areas, but there's no documented standard in terms of validating that thing to make sure it's correct.
- no follow up with those improvement actions to make sure that they were actually making a difference.
- That things are improving and in terms of accountability meetings, they've been sporadic over the last couple of years

AC23.90.12 The Committee noted that a lot of actions had gone past the deadlines and with no updates or changes

AC23.90.13 The Chief Executive offered some assurance. There is an Integrated Performance Framework due to go to the Board at the end of the month that will outline how we approach performance in the organisation and find it hard to operate without one. It will take some time to fully mature.

AC23.90.14 There is an Executive Delivery Group for integrated performance. Reviewing the integrated performance, so not just about finance or just about quality, but lining all those domains up and seeing what's what with that covering all of our business, not just the directly provided service, but Directorate Corporate Directorate.

AC23.90.15 The Chair sought clarification on the report, the action tracker and determination whether actions are still relevant. Progress is being made on the tracker,

AC23.90.16 Board Assurance Framework (BAF) & Risk Management Limited assurance report with four high level recommendations and one medium recommendation.

AC23.90.17 The Committee discussed the escalation and de-escalation risk, noting that the new framework covers that. The role of the executive team is also strengthened in the risk management framework. AC23.90.18 The BAF and Risk Register are now under a single point of leadership, thereby removing the false separation. AC23.90.19 Hergest Unit Notice of Contravention (NoC) Action Plan Limited assurance report with one high level recommendation. AC23.90.20 Clinical Audit – Tier 1 National Audits The timescale for delivery of actions was made clear to all, but realistic timescales are also needed when it is not possible to deliver things. The Chief Executive Officer agreed and the tracker will be updated of any new dates through the Board Secretary. **ACTION: Board Secretary to review the dates of any recommendations.** AC23.90.21 The Committee: • noted the Audit Universe/Rolling plan and the risks identified for consideration for 2024/25 • received the progress report and approved the recommendation to defer one review from the plan. • Confirmed the need for Exec director attendance	PM
AC23.92 Audit Wales (external audit) progress reports AC23.92.1 Audit Wales gave an overview of progress made against the audit plan which the Committee were assured on. AC23.92.2 The Committee noted charitable funds timeline difference to main accounts and thanked Audit Wales for the report.	
AC23.93 National Audit Report for information AC23.93.1 This was a national report covered across sectors, the key point from it around digital inclusion is thinking about in terms of new services and service provision. AC23.93.2 The Committee noted that there was no management response yet but noted the report. Digitally enabled services have a role but need to be inclusive for those most vulnerable to ensure they can access digitally enabled services. AC23.93.4 Through discussion it was agreed that the information section should be added to the Exec team agenda and that therefore Dylan	

Roberts, as the executive lead, can note and digest and make sure that we recognise the work and the work that we're doing on this. **<u>ACTION</u>: The Board Secretary to add digital inclusion to the Executive agenda and update the Audit Committee through matters arising.**	PM
AC23.95 CLOSING BUSINESS CLOSING BUSINESS	
AC23.95.1 The date of the next meeting – 16 November 2023. AC23.95.2 Noted that the Committee would now be bi-monthly. AC23.95.3 The Chair thanked everyone who had contributed.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

AUDIT COMMITTEE
TABLE OF ACTIONS LOG – ARISING FROM MEETINGS HELD IN PUBLIC

	Lead Executive / Member	Minute Reference and Action Agreed	Original Timescale Set	Update	Revised timescale/ Action status (O/C)	RAG status
Actions from 13 January 2023						
	Board Secretary	**Charitable Funds - AC23.08.5G** The role of the Charity would be discussed at the Audit Committee Workshop in May.	15-May-2023	This action remains outstanding due to the change in membership. New date to be set	Action outstanding This has been scheduled for the March 2023 Audit Committee	
Actions from 15 May 2023						
	Board Secretary	**Internal Audit Recommendations - AC23.26** PM to confirm that the Welsh Language Compliance report is coming to Board.	15-May-2023	Scheduled to be at Board on 28 September 2023. Propose that this action is closed after the Board meeting. This has been presented to Board on 28th September 2023	Proposed for closure	
	Executive Director of Finance	**Annual Report – AC23.62** The Executive Director of Finance to consider where is the best place for the Board to consider the topic of sustainability.	15 Sep-2023	Until all Committees are re-established this work will be continued through the PFIG Committee	Propose to monitor until Committees established	
Actions from 15 September 2023						
1.	Deputy Board Secretary	**AC23.80 Committee Attendance**	15 Sep-2023	This was amended immediately after the meeting.	Proposed for closure	

		Simon Monkhouse confirmed that his attendance was incorrectly recorded for the August meeting. This is to be updated.				
2.	Board Secretary	**AC23.81 Outstanding action on Charitable Funds Committee.** The Board Secretary to speak to the Head of Fundraising about how to progress things.				
3.	Board Secretary	**AC23.83 IM Appointments** The Board Secretary to find the appropriate feedback route to high-light the concerns from the Committee.		The Board received feedback on 28th September 2023 and the Chair noted and received feedback	Proposed for closure	
4.	Board Secretary	**AC23.83 Annual Work Plan** The Board Secretary to facilitate an annual work plan for the Committee with the Chair of the Committee.		Draft to be presented to Chair		
5.	Board Secretary	**AC23.84.6 Risk Framework** The Committee suggested that the following changes were made: • Risk Appetite: change the wording of the financial risk • Reputational risk: seek is the correct status but the definition may not be correct • Risk Strategy needs to have context of learning and continuous improvement The Board Secretary to review and make the changes		NC – all changes were adopted following Sept Board meeting where RM01 was approved	Propose for closure	
6.	Board Secretary	**AC23.86 Declarations of Interest/Gifts & Hospitality** Implementation Plan Update on Declaration of Gifts and Hospitality - The Board Secretary to report back in January on progress and compliance.	January 2024	Note that the Head of Corporate Affairs has been asked to develop implementation plan		
7.	Board Secretary	**AC23.88 Policy on Policies** The Policy on policies needed to be clearer about what	Nov 2023			

		was reserved for the Board, in particular matters with legislative framework around them.				
8.	Board Secretary	**AC23.90 Internal Audit** – The Board Secretary to circulate Ombudsman's review and add to the next agenda.	Nov 2023			
9.	Board Secretary	**AC23.90.20 Clinical Audit** – Tier 1 National Audits - Board Secretary to review the dates of any recommendations.		Ongoing		
10.	Board Secretary	**AC23.93 National Audit Report for information** - The Board Secretary to add digital inclusion to the Exec agenda and update the Audit Committee through the matter arising.		Board Secretary has updated Executive Team work plan for inclusion by end of Nov 2023		

Teitl adroddiad: ***Report title:***	Standing Order Breaches			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 November 2023			
Crynodeb Gweithredol: ***Executive Summary:***	To update the Audit Committee on Standing Order Breaches			
Argymhellion: ***Recommendations:***	The Committee are asked to: • **Note** that papers are published 7 days in advance rather than 10 as stated in the Standing Orders. • **Note** that the publication of papers is likely to continue to breach the 10 day publication and continue as 7 days electronic publication.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary and Associate Director of Governance			
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Affairs			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*** *On going monitoring by OBS team to improve compliance and clarity of current position gained so there is less ambiguity of arrangements. Subject to Audit Committee agreement this position will be taken to the Chair of the Health Board for his approval by 21 November 2023.*				
Cyswllt ag Amcan/Amcanion Strategol:				

Link to Strategic Objective(s):	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	There are no specific legal implications related to the activity outlined in this report.
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 (which now incorporates WP68) has an EqlA been identified as necessary and undertaken ?***	Do/Naddo *Y/**N*** Not applicable for the Standing Order Breach item
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	SP16 There is a risk of failing to effectively strengthen the Board arrangements following special measures and implement critical governance, accountability, planning, and performance improvements.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	None
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	None
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	SP16 There is a risk of failing to effectively strengthen the Board arrangements following special measures and implement critical governance, accountability, planning, and performance improvements.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Next Steps: • Note the recommendations and the Board continues to fulfil its role and meet its responsibilities through the conduct of the meeting with the 7 day publication period • Note that there were five breaches reported since January 2023 based on a 7-day publication due to the late publication of papers, details to be found in Appendix 1.	
List of Appendices:	

- *Appendix 1 - Breaches Reported since January 2023 based on 7-day publication*

AUDIT COMMITTEE MEETING IN PUBLIC
16 NOVEMBER 2023
STANDING ORDER BREACHES

1. Introduction/Background

1.1 The Office of the Board Secretary is seeking to clarify a matter of current practice in line with the Model of Standing Orders so that there is a clarity of position.

1.2 According to compliance in relation to the Model of Standing Orders:

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

1.3 In practice most Health Boards publish papers electronically 7 days prior to the Meeting. The 10 day notice was drafted when papers were sent out in hard copy, however, given that the Model Standing Orders have not changed and are unlikely to do so in the near future the Audit & Risk Committee should note that all Board and Committee Meeting publications are in breach of the 10 day publication period.

1.4 Further scrutiny of the Standing Orders will be undertaken and any other Breaches will be reported in future updates to the Audit & Risk Committee.

2. Specific Matters for Consideration by the Meeting

2.2 The Committee is asked to note that papers are published 7 days in advance rather than 10 as stated in the Standing Orders, however, the Board continues to fulfil its role and meet its responsibilities through the conduct of the meeting with the 7 day publication period.

2.3 If the Audit Committee is in agreement then the Acting Board Secretary will confirm this position with the Chair.

3. Rheoli Risg / Risk Management

3.2 No further information to note.

4. Goblygiadau Cydraddoldeb ac Amrywiaeth / Equality and Diversity Implications

4.2 No further information to note.

Record of Breaches of Publication of Committee Papers since last reported to Audit Committee in January 2023

Meeting Date	Body	Standard	Issue/Reason for Breach	Details of papers
17.1.23	Partnerships People Population Health Committee	Publication of papers 7 days before meeting	3 follow on papers	BAF Winter Resilience Plan Primary Care
19.05.23	Quality, Safety & Experience Committee	Publication of papers 7 days before meeting	Public papers published 5 days before meeting	All
15.05.23	Audit Committee	Publication of papers 7 days before meeting	Public papers published 5 days before meeting	All
30.6.23	Performance, Finance & Information Governance Committee	Publication of papers 7 days before meeting	A late paper was added 2 days before the meeting in private session	Property disposals at Ala road and Cilan Pwllheli
2.11.23	Performance, Finance & Information Governance Committee	Publication of papers 7 days before meeting	3 follow on papers	BAF CRR Integrated Performance report
14.11.23	Renumeration and Communication Committee	Publication of papers 7 days before meeting	Public papers published 6 days before meeting	Whole Agenda

Teitl adroddiad: ***Report title:***	Corporate Governance Report
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 November 2023
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide Audit Committee with an update on Corporate Governance. More specifically, the report follows up on the Board Report on 28 September that outlined the Committees that the Health Board will establish and the Corporate Governance arrangements that support this. This includes progress updates on 1. Next steps to develop the BCUHB Committees 2. Developing Committee workplans 3. Developing Terms of Reference for Committees. 4. Providing Corporate Calendars for 2023/24 and 2024/25 5. Corporate Governance Standing Operating Procedures 6. Board Induction arrangements 7. Providing Board Development arrangements The Acting Board Secretary would like to receive feedback from Audit Committee on the Committee that should have oversight of Information Governance
Argymhellion: ***Recommendations:***	*The Committee is asked to:* 1. Note and Consider the updates provided 2. Be Assured that progress is being made on Corporate Governance arrangements 3. Consider and feedback Audit Committee view on the Committee that should provide oversight and assurance related to Information Governance.
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin – Acting Board Secretary
Awdur yr Adroddiad: ***Report Author:***	Phil Meakin -Acting Board Secretary Supported by • Catrin Rhys-Williams • Laura Jones

	• Llinos Roberts			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*** *Partial Assurance reflects that these are "First Draft" Workplans, Terms of References that are under development for Chairs of Committees and Executive Leads to review during November and December 2023.*				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Strategic Priority 16 Board Leadership and Governance			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Corporate Governance arrangements must comply with the Health Board Standing Orders			
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?***	N/A			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF Risk SP 16 "There is a risk of failing to effectively strengthen the Board arrangements followjing Special measures and implement critical Governance, accountability, Planning and Performance improvements. Strategic Risk 16 "There is a risk that a lack of robust and consistent leadership could contribute to safety andquality across the Health Board. This could be caused by inadequate Governance arrangements across the Health Board.			
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith*	N/A			

Financial implications as a result of implementing the recommendations	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF Risk SP 16 "There is a risk of failing to effectively strengthen the Board arrangements following Special measures and implement critical Governance, accountability, Planning and Performance improvements.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** ***Reflect feedback from Audit Committee in update to Board on 30 November 2023***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** 1. Draft Committee workplans 2. Draft Terms of Reference for Committees and Advisory Groups (from page 72). 3. Corporate Calendars for 2023/24 and 2024/25 4. Corporate Governance Standing Operating Procedures 5. Board Induction Arrangements	

AUDIT COMMITTE MEETING IN PUBLIC
16 NOVEMBER 2023
CORPORATE GOVERNANCE REPORT

1. Introduction/Background

The purpose of this report is to provide Audit Committee with an update on Corporate Governance. More specifically, the report follows up on the Board Report on 28 September that outlined the Committees that the Health Board will establish and the Corporate Governance arrangements that support this. This includes progress updates on:

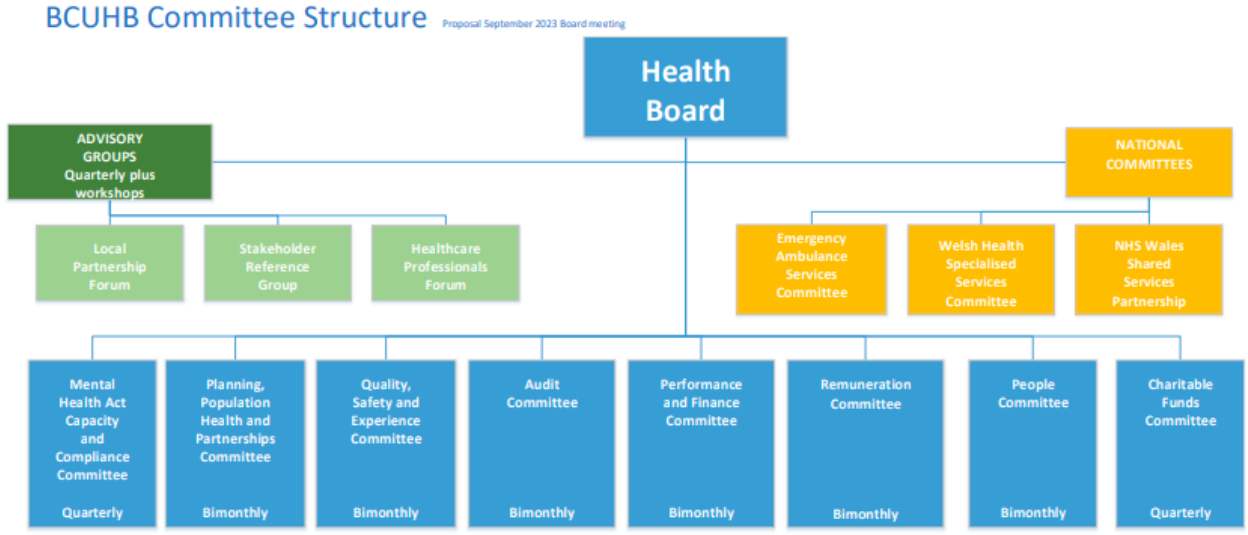
1. Next steps to develop the BCUHB Committees
2. Developing Committee workplans
3. Developing Terms of Reference for Committees.
4. Providing Corporate Calendars for 2023/24 and 2024/25
5. Corporate Governance Standing Operating Procedures
6. Board Induction arrangements
7. Providing Board Development arrangements

2. Next Steps to Develop the BCUHB Committees

The Board agreed at its meeting of the 28 September 2023 to a Committee Structure that is outlined in Figure 1 below. The Committee Structure complies to the requirements of the Standing Orders of the Health Board. It is important to note that three of the Board Committees will be established when there are sufficient Independent Members of the Board recruited through the Public Appointment process.

The Chair of the Board will work with the Office of the Board Secretary throughout November and December 2023 to agree when these Committees will be estabilised, based on the progress made on the Public Appointments and the Independent Members that will be the members of each Committee. A final proposal will be received at the January 2024 Audit Commitee and January 2024 Health Board meeting.

Figure 1 – BCUHB Committee Structure



2.1 Developing Committee and Board Workplans

Commitee and Board workplans are being developed to support the effective Governance of the Committees in Figure 1. Appendix 1 highlights the Draft Workplans and Audit Committee are asked to consider these workplans.

There are draft workplans in place for the committees that are already established and these will continue to be refined with Chairs of Committees and lead Executives throughout November and December 2023. The versions that are presented to the Committee today only reflect the development of an initial version ready for Chairs and lead Executives to review. These are:

- The Board
- Audit Committee
- Charitable Funds Commitee
- Performance Finance and Information Governance Committee
- Quality Safety and Experience Committee
- Remuneration Committee

Initial workplans will need to be developed for the three Committees that have not yet been established. These will need a longer lead time to align with the recruitment of Independent Members through the Public Appointment process and require a longer timescale to develop workplans. These draft workplans will be provided by end of December 2023. These are:

- Mental Health Act Compliance and Capacity Committee
- People Committee
- Planning, Population Health and Parterships Committee

2.2 Developing Terms of Reference for Committees

The Board approved outline Terms of Reference at its meeting on the 28th September 2023 bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/hb-agenda-bundle-28-09-23-v4-compressed/. The Office of the Board Secretary (OBS) has developed Draft Terms of Reference based on this and they are provided in Appendix 2 for the Board Sub Committees and Advisory Groups.

After consideration by Audit Committee the Terms of Reference for established Committees will be shared by Chairs and Executive Leads of those Commitees. This will take place throughout November and December 2023.

It is important to note that feedback has been received since the last meeting of the Board related to the duty of the Health Board to have a Committee that has responsibility for Information Governance. In the Board Report this was proposed to be Audit Committee (currently Performance, Finance and Information Governance Committee). The Audit Chair has provided feedback that this may not be an optimal position due to the size and scope of the Audit Agenda and because there is a need to make sure Information Governance has sufficient profile. The Audit Committee is asked to provided feedback on this matter.

The committees that are yet to be established will be shared with Chairs and Executive Leads when they have been identified. This will be actioned by end of December 2023.

2.3 Developing Corporate Calendars for 2023/24 and 2024/25

Significant progress has been made on the development of the Corporate Calendar for 2023/24 through effective engagement with Board Members. The detail of which is attached in Appendix 3.

Until there is clarity on the future Independent Member recruitment it is not possible to complete the Corporate Calendar for 2024/25 to reflect the establishment of new Committees.

The OBS has developed a summary of key principles for the development of the Corporate Calendar to give assurance that the approach is appropriate. This is also attached Appendix 3.

2.4 Corporate Governance Standing Operating Procedure (SOP)

A SOP has been developed to improve process and clarity on Corporate Governance arrangements for BCUHB staff and report writers. A copy of this is attached in Appendix 4. This will allow for improvements in the basic disciplines of Corporate Governance.

2.5 Board Induction Arrangements

A key deliverable for Special Measures is the development of a suitable Board Induction Programme. The Chair of the Health Board has reviewed the Induction Programme and the details of the Induction Programme are attached in Appendix 5. The current version reflects the Chair's feedback and will be regurly reviewed. The Induction arrangements will be utilsied immediately with new Independent Members that are appointed.

2.6 Board Development Arrangements

Another key deliverable for Special Measures is the development of an appropriately designed Board Development Programme.

An outline Programme is under development and will be shared for feedback with the Chair and Interim Chief Executive prior to sharing it with the Board on 30 November 2023. At the time of writing this report it is not developed sufficiently to share it with the Board until it has been reviewed by the Chair and Chief Executive (a target date is set as 22 November 2023).

3. Risk Management

Strategic Risk 16 "There is a risk that a lack of robust and consistent leadership could contribute to safety andquality across the Health Board. This could be caused by inadequate Governance arrangements across the Health Board.

4. Next Steps

- ***Implementation of recommendations***
- ***Reflect feedback from Audit Committee in update to Board on 30 November 2023***
- ***Arrange meetings with Chairs and Lead Executives of Committees.***

Teitl adroddiad: ***Report title:***	Board Assurance Framework			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 November 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to highlight progress and to seek assurance from the Committee on the approach taken to have an effective BAF related to the strategic priorities for the 2023/24 Annual Plan. Noting that it be mandatory for NHS bodies to have a Board Assurance Framework (risks, controls and action plans in relation to strategic objectives). The Committees have a key role in providing assurance to the Board and this report highlights work on this.			
Argymhellion: ***Recommendations:***	The Committee is asked: 1. To be **assured** that the monitoring of risks in relation to delivering on the Annual Plan, Board Assurance Framework (BAF) enabled by the planning team, performance team and corporate risk team and is underway. 2. To **note** that requests have been made to all leads on their risk score in relation to deliverables on the Annual Plan. Where high risks are being identified by leads an individual BAF risk report is to be completed. 3. To **approve** BAF risk report completed in Appendix 2.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge, Head of Risk Management			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐

	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: N/A ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:N/A***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	BAF linked to strategic priorities			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	N/A			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF paper			
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.			
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith	N/A			

Workforce implications as a result of implementing the recommendations	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	QSE 27/10/23, PFIG 02/11/23 and the Executive Team Meeting 08/11/23 discussion around the draft outline of the BAF and it's alignment to the strategic priorities further detailed below.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF paper which further links Tier 1 and Corporate Risk Register.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: ***Next Steps:*** Hold 1-1s for all corporate and BAF risks and further develop controls, action plans etc. Corporate Team to monitor and escalate any new BAF risks to Executive Team for review.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 2-BAF Risk reports	

Introduction/Background

The purpose of the Board Assurance Framework (BAF) is to inform and assure the Board with controls and action plans for identified high-extreme risks that relate to any possibilities of not delivering on the objectives of the Health Board.

The purpose of this report is to highlight progress and to seek assurance from the Committee on the approach taken to have an effective BAF related to the strategic priorities for the 2023/24 Annual Plan. The objectives of the Health Board have not yet been set and the BAF will subsequently be aligned to BCU objectives.

Following the 22/23 archive of the BAF and previous strategic priorities. The 23/24 Annual Plan has been reviewed in order to develop possible descriptions for BAF risks. Not all the descriptions below will be a high risk. Only those which are thought to be high risk will be further developed to ensure they have controls and action plans in place for close monitoring by the Board. The corporate risk team will continue to work closely with the Executive Director Transformation and Strategic Planning and Director of Transformation & Improvement to ensure progress on the Annual Strategic Priorities and monitoring of any risks.

All leads in relation the Annual Plan strategic priority deliverables have been contacted to further understand the risks they face in not achieving their priorities.

Following the presentation draft outline of the BAF at PFIG, concerns were received from the Head of Internal Audit on the BAF not being aligned to the Health Board's objectives but to the strategic priorities and subsequently to the Annual Plan. This also related to the Internal Audit limited assurances report received for risk management where recommendations were made around the BAF. The BAF was subsequently presented to the Executive Team on the 08/11/23 where further steer was provided to continue with the work as planned and the Executive Director Transformation and Strategic Planning will progress the 24/25 objectives with the Board.

Six high risk reports have been received from leads:

SP1-Prevention and Health Protection
SP5-Cancer
SP9-Women's
SP13-Digital (was received at PFIG but not discussed for approval, attached)
SP16- Board Leadership & Governance (attached for AC approval)
SP18-Quality Innovation and Improvement

A further three might be high risk but reports not yet completed:

SP3-Planned Care
SP4-Unscheduled Care
SP14-Estates and Capital

Appendix 1-BAF Risk Report

Next steps

1. AC to consider the approval of 'SP16- Board Leadership & Governance'
2. Corporate Risk Team to quality assurance the five reports received, Executives to sign off reports prior to Board.
3. Ongoing monitoring of risks in relation to the Annual Plan Strategic Deliverables.
4. Align to objectives once developed.

<table>
<tr><td rowspan="4">BAF
SP13</td><td colspan="2">Executive: Director of Digital (Chief Digital Information Officer (CDIO)</td><td>Date Opened: July 2022</td></tr>
<tr><td colspan="2">Committee: Performance, Finance and Information Governance Committee (Will revert to Partnerships, People and Population Health Committee or equivalent once the meetings recommence)</td><td>Date Last Reviewed: October 2023</td></tr>
<tr><td>Strategic Priority: P13
Digital, Data & Technology</td><td>Link to CRR: Availability and Integrity of Patient Information
Link to Tier 1's: 2819, 3659, 4595, 4603, 4766</td><td>Last Reviewed by Committee: 02.11.23
Target Risk Date: May 2024</td></tr>
<tr><td colspan="4">There is a risk of failing to meet the Health Board's strategic and operational priorities caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled projects and change.</td></tr>
<tr><td colspan="2">Mitigations/Controls in place</td><td>Gaps in Controls</td><td>Current Risk Score</td></tr>
<tr><td colspan="2">These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised.

1. Minimal controls in place with the introduction of rigour and governance to the commissioning of new Digital, Data and Technology project requests through a Project and Portfolio Management function that will ensure prioritisation, impact assessment in terms of deliverability, best use of technology, interoperability, longevity and value for money. This includes insisting that for all new projects the business change element and service design aspect up front which includes the users is built in.
2. Where possible the Health Board will bring in the necessary expertise from external service providers that the Health Board do not currently possess.
3. To set the expectations with the Health Board and Welsh Government on the inability to effectively architect and deliver Digital, Data and Technology projects and realise benefits in line with the strategy of the Health Board.</td><td>1. Funding currently not secured to implement the new operating model.
2. Unable to deliver new models of care with local and national strategies.
3. No clear technology plan, future blueprints or architectural considerations with due regards for the whole.
4. No single integrated digital health care record to address the fragmented care record concerns to deliver the special measures framework requirements.
5. Unable to replace or decommission obsolesce systems due to no funding to manage replacement or consider new ways of working.
6, Significant gaps in workforce in specific patient records and IT areas, which is resulting in decreased support for the Health</td><td>
<table>
<tr><th>Impact</th><th>Likelihood</th><th>Score</th></tr>
<tr><td>4</td><td>5</td><td>20</td></tr>
</table>
Movement since last Qtr:

Increased likelihood from 4 to 5 since August 2023.

NB. The tolerate score for this risk is 16 which is a high level of tolerance for the risk due to an inability to fund necessary resources.
</td></tr>
</table>

	Board which will impact on patient care.	

Actions and Due Date

Costed proposals (£1.7m recurrent) and plans have been produced, validated and presented to Partnerships, People and Population Health Committee and Board for the implementation of a new operating model for Digital, Data and Technology which requires new capabilities and capacity to effectively deliver. This includes new functions for: Intelligence and Insight, Digital Project Management Office, Architecture Software engineering, service design and clinical change. These proposals were dependent on funding £500K of which was provided by the Health Board with due regards to other priorities for investment.	April 2023
Alternative plans to be developed within the current funding constraints that will have a small but positive impact over time.	April 2024
Commission external service providers to fill the gaps in capabilities and skills to support the delivery of objectives and special measures requirements.	April 2024

Lines of Defence			Overall Assessment
1	**2**	**3**	**Next steps:**
1. Digital, Data and Technology Objectives and Operating Plan reviewed quarterly by Digital Senior Leadership Team.	1. Regular Assurance Reporting to Partnerships, People and Population Health Committee and Executive Management Team in its absence.	1. Benchmarking the service against external assessments, e.g. Gartner Group IT Score. 2. National Cyber Security Centre. 3. Cyber Essentials+ 4. Information Governance Toolkit. 5. Access to external service providers to support in critical areas. 6. Government Digital Service Digital, Data and Technology roles and possibly SFIA assessments.	The Board previously agreed a high risk tolerance score of 16, which may need to be reviewed. Risk has increased in likelihood due to significant financial pressures and Health Board.

BAF SP16	**Executive:** Board Secretary		**Date Opened:** 19 October 2023
	Committee: Audit Committee		**Date Last Reviewed:** Not yet taken place
	Strategic Priority: P16 Board leadership & governance	**Link to CRR:** Leadership/Special Measures **Link to Tier 1's:** 4480	**Last Reviewed by Committee:** 16.11.23
			Target Risk Date: 31 January 2024 to review score. If progress made below then recommend a reduction to a score of 12 (3 x 4) by end of February 2024

There is a risk of failing to effectively strengthen the Board arrangements following special measures and implement critical governance, accountability, planning, and performance improvements.

Mitigations	**Gaps in Controls**	**Current Risk Score**		
This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity). 1. The development and agreement of the Special Measures "**Governance and board effectiveness domain"** deliverables and milestones that give clarity on what needs to be delivered by when. This includes development of Board Development and Board Induction products to support Board arrangements. This is detailed in the action section. 2. Close working with Welsh Government on the recruitment of new Board members through the public appointment process. 3. Comprehensive response to the Board Effectiveness Review by Audit Wales that aligns to the Special Measures approach.	1. Welsh Government control the public appointment process but we have weekly catch ups to counter this. 2. The implementation of the review of the OBS is reliant upon following the organisational change policy and this will impact timescales for that part of the improvements 3. The appointment of some Executive appointments is reliant on the timely review of the Exec Portfolio review	Impact	Likelihood	Score
		4	4	16
		Movement N/A		

Actions and Due Date

	Target Date
SM Ref no C1-1.3: Implement phase 1 induction for all Board members	Nov-23
SM Ref no C1-1.4: Develop phase 1 Board development programme	Dec-23
SM Ref no C1-1.5: All committees with assigned IMs operational, including ToR, Corp Calendar and Workplans	Mar-24
SM ref no C1-1.6: Design Risk management framework and commence implementation	Dec-23

SM ref no C1-1.7: Permanent Chair/IM/CEO/Exec recruitment – dependent on Exec Portfolio Review and Senior HR Cases	Mar-24
SM ref no C2-1.8: OBS team – implement interim and design permanent structure	Dec-23
SM ref no C2-1.9: Policy management and implementation/audit approach	Oct-23
Feedback from Audit Wales follow up review – December 2023	Dec-23
Scrutiny of progress through Audit Committee	November 2023, January 2024 and March 2025
Assurance on progress through Board	November 2023, January 2024 and March 2026

Lines of Defence			Overall Assessment
1	**2**	**3**	If the above deliverables are put into place then a score of 12 could be achieved by March 2024 or earlier if new Committees and OBS Team are in place by February 2024 Next steps • Executive Team to review • Audit Cttee to scrutinise on 16 Nov 2023 • Board receive report on 28 November 2023 • Deliver plans as outlined above.
• Special Measures meeting and assurances to committees on 90 day plan etc • OBS Team Meetings	• Committees and Board • Audit Committee in November, January and March • Board in November, January and March • Executive Team Meetings • Throughout 2023/24.	• Welsh Government • Audit Wales follow up reviews	

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 November 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update from the Risk Management Group (RMG) meeting on the 3rd October 2023 and present the Corporate Risk Register (CRR). Following the approval of the Risk Management Framework at Board, Audit Committee are presented with a consolidated view of all high-extreme operational risks and 16 new strategic risks for consideration which would form a revised Corporate Risk Register. This continues to be in draft and will be further reviewed through 1-1s with Executives.			
Argymhellion: ***Recommendations:***	The Committee is asked to: 1. receive assurances from RMG The Committee is asked to consider: 2. the new approach of consolidating all high-extreme operational risks to thematically formulate strategic corporate risks and if the correct strategic corporate risks have been captured. 3. provide any feedback to the Head of Risk Management for further refinement prior to Board. 4. review the overall accountable committee for the newly proposed strategic risk.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:N/A ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the second paper BAF report and how the CRR aligns to the revised BAF
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	See Board Assurance Framework paper which highlights the relation.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Same paper received at: QSE 27/10/23 PFIG 02/11/23 Feedback detailed in the body of the report.

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	1 high risk has been removed from the appendix which is confidential
Camau Nesaf: ***Next Steps:*** Feedback to the Head of Risk Management for further refinement of the Corporate Risk Register Updated positions will be provided to Committees. 1-1s with Executives ongoing, update the Corporate risk template with nominated representatives of Executives.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Corporate Risk Register Report	

1.0 Risk Management Group Meeting Summary
2.0 Proposed Revised Corporate Risk Register

1.0 RMG update

1.1 The Risk Management Group (RMG) met on the 3rd October

1.2 During the Risk Management Group meeting on the 3rd October 2023 a deep dive was undertaken for the following Estates risks which was presented at PFIG. To note during the presentation of the four deep dives into the Estate risks, Estates noted a lack of maturity around the relationship between sites and Estates, and blurred lines between the accountability of some of the risks. This was taken as an action to be raised in the Executive Team meeting for further discussion.

1.3 The following risks have been approved by the relevant Executive Directors for de-escalation/closure, and were presented to the Risk Management Group on the 3rd October for discussion and de-escalation:
Five risks were de-escalated and presented to QSE as the overall accountable committee and two closed risks were presented at PFIG.

1.4 The following risks were escalated and approved onto the Health Board's risk register and following Executive approval and presentation at the Risk Management Group.

- Vaccination Programme - Inability to increase delivery (Covid 19 programme) capacity by 400% within 7 days due to access to additional resources.
- Asylum Seeker Support.

1.5 Work remains ongoing with the People Services team with planned development of the following high risks:

- Financial governance related to staffing.

1.6 RMG received Risk Register Reports

- Capital and Estates, assurances received.
- Finance, assurances received.
- Partnership, Engagement & Communications, no risk register is maintained by the department, the action for the Corporate risk team to provide the department with risk training and support the development of a risk register was noted.
- The Digital risk register report noted Tier 2-3 risks needed to be reviewed in line with procedures. Assurances were provided that actions would be taken to ensure the register is regularly reviewed.

1.7 Key highlights from the RMG Annual Report have been detailed:

Reporting of Tier 1 high priority risks has increased with more risks being escalated to the Corporate Risk Register. However, Tier 2 and 3 risks have decreased over the past two years.

Timely review rates for Tier 1 risks have improved significantly, with 100% being reviewed on time. However, over half of Tier 2 and 3 risks are still not being reviewed by their target date.

A high number of Tier 1 risks are shown as "being developed" which implies delays in formally escalating and managing high priority risks.

Risk closure rates have improved for Tier 2 and 3 risks, indicating enhanced mitigation.

The majority of risks related to patient care, estates, service delivery, finance and informatics. Resource constraints being noted as a common theme.

Risk management training numbers have reduced, although plans are in place to improve e-learning package and training compliance.

Good progress has been made completing actions from the risk management improvement plan.

RMG meeting frequency and membership attendance declined last year, this is being closely monitored as a result. Assurance reports to RMG have been inconsistent and this is also being monitored closely through the agenda and COB.

1.8 RMG received a Q1 Risk Management Performance and Assurance Report from the Corporate Risk Team. The report analysed risk reporting volumes, risk severity mix, monitoring practices, and mitigation progress across BCUHB's risk register. It evaluated performance against the 2022 risk management strategy key performance indicators. In summary, the analysis showed an increase in reporting of high priority Tier 1 risks, variable compliance with risk review timelines, and good progress on risk closure rates. 50% of lower priority risks- Tier 2 and 3 risks were not being reviewed by their target date.

Key areas for focus were noted as reducing delays in formally escalating and managing Tier 1 high priority risks - a high volume were shown as "being developed". Enhancing risk management training and compliance monitoring. Strengthening governance through more consistent RMG meetings, membership attendance, and standing agenda items.

Increasing regular risk management performance reporting across the Health Board.

Continued focus on risk identification, prioritisation and mitigation, especially for corporate risks related to patient care, workforce, finance etc.

Embedding risk management through all levels of the organisation via training, support, and continuous improvement.

2.0 Corporate Risk Register Report

2.1 Following the approval of the Risk Management Framework, the corporate risk register has been reviewed in order to develop strategic risks.

According to our previous Risk Management Strategy all Tier 1 risks were to be reflected on the corporate risk register. This procedure has now been modified and Tier 1 risks (15-25) can now be locally owned and a consolidated approach can provided the Board with a strategic view. There are currently 123 Tier 1 risks in total which have been analysed and thematically grouped.

A list below of 16 themes and potentially 16 corporate risks have developed from the analysis and a proposed description of the strategic risk has been outlined. Tier 1 risks titles have also been detailed as well as the accountable Executive for the operational risk providing the rationale for the strategic risk.

A committee has been proposed as the accountable meeting to oversee the risk as well as an overarching accountable Executive/Director for the strategic risk.

N.B. some of the Tier 1 risks noted below are 'problems' (e.g. inadequate staffing) and the titles will need reviewing however a risk have been further articulated in the body of the operational risk. The corporate risk team will be addressing this through a more robust quality assurance process outline in the Risk Management Procedures, prior to escalation to Executives going forward.

Through reviewing this bird's eye view of all high-extreme risks, gaps may be apparent. Any noted gaps in Tier 1 risks can be escalated to the Corporate Risk Team to support the progression with a service representative.

2.2 A proposed CRR (Appendix 1) highlights the rationale of the corporate risk through the Tier 1 (high-extreme operational) risk titles.

1. Proposed title.
2. Proposed description.
3. Proposed overall accountable Executive.
4. Proposed overall accountable Committee.

These items will be further worked through with the Executive as the accountable lead for the risk.

Following presentation of the paper at QSE and PFIG, it was generally well received. QSE discussed the role of the committee is deciding which Corporate risks are then reviewed by the Board, allowing for a more focused approach on risks discussed at Board. PFIG felt that further work could be done on risk no. 10 'community provision' and is due to be further discussed and refined with the Interim Executive Director of Operations.

See Appendix 1 below

Next steps

1. Descriptions and the allocation of the accountable Committee on the risk to be agreed prior to Board approval.
2. Feedback to Head of Risk for further refinement in preparation for approval at Board.
3. Corporate Team to monitor and escalate any new Tier 1s to Executives for further information and consolidation with the CRR as per RM02.

Appendix 1-CRR Titles, Descriptions, and Underlying Operational Risks

1	Financial Sustainability			Committee
Strategic	There is a risk to the **financial sustainability** and performance of the Health Board. This could be driven by a failure to deliver £38.7m in planned **savings** and **disinvestment**, coupled with potential non-funding of the £134.2m forecast deficit by Welsh Government. This could be caused by the lack of fully formed savings plans, workforce and healthcare spending commitments limiting flexibility, and limited income generation opportunities. The impact could further deteriorate the deficit position, potentially impacting on service delivery if savings aren't achieved, rejection of the financial plan by Welsh Government, and significant reputational damage.			PFIG
Operational Risks Consolidated	4861	Risk of failure to achieve the initial financial plan for 2023/24 (£134.2m deficit), because of failure to achieve the level of	Executive Director of Finance	Overall Risk Lead
	4862	WG cash funding for 2023/24		Executive Director of Finance
	4859	Risk of the cost of planned care recovery exceeding the £27.1m funded from WG which is included in the budget		
	4860	Financial outturn for 2022/23		
2	Suitability and Safety of Sites			Committee
Strategic	There is a risk that the poor condition, suitability and safety of the **estates** and infrastructure across BCU could severely impact on service delivery, staff and patient safety. This could be caused by aging and **unsuitable buildings**, **backlog maintenance** issues, non-compliance with regulations, inadequate space capacity, and lack of capital funding. The impacts may include inability to meet service needs, reduced access to diagnostics and treatment, risks of infection, fire, asbestos, legionella and other hazards, increased costs, regulatory enforcement action, and significant reputational damage. This presents risks to the continuity of care, patient outcomes, staff wellbeing, and the Health Board's ability to provide safe, therapeutic environments across the region.			PFIG
Operational Risks Consolidated	4843	Risk of compromise to patient care, safety and quality due to environmental and capacity issues at Shooting Star Unit.	Executive Director of Nursing and Midwifery	Overall Risk Lead
	4959	Radiopharmacy Production Unit	Executive Medical Director	Executive Director of Finance
	4835	Risk of service failure due to poor/aging ventilation systems in the endoscopy unit	Executive Director of Finance	
	1672	Residential Accommodation - Public/Private Sector Partner Procurement		
	3600	Lack of capacity to deliver clinical care across NWMCS due to lack of suitable accommodation	Executive Director of Therapies & Healthcare Sciences	
	4838	YGC FLOOD Risk of damage to equipment, infrastructure, injury to staff/patients and increased waiting lists		

	3019	Asbestos Management and Control	Executive Director of Finance	
	3020	Contractor Management and Control		
	3023	Legionella Management and Control.		
	3024	Non-Compliance of Fire Safety Systems		
	2724	Fire Safety and Infrastructure Non-compliance - Ysbyty Gwynedd		
	4251	Non-compliance of North Wales Adolescent Service Bedroom Fire Doors	Director of Mental Health and Learning Disabilities	
3	Availability and Integrity of Patient Information			Committee
Strategic	There is a risk of compromised patient safety and substandard care due to lack of access to complete, accurate and timely patient information. This could be caused by fragmented systems and data repositories, incomplete or poor-quality record keeping, inadequate storage and archiving, incompatible systems, and lack of integrated electronic records. The impacts may include patient harm, inability to make fully informed clinical decisions, delays to treatment, unnecessary duplicate testing, non-compliance with legislation, and reputational damage. This presents risks to patient care quality, safety and experience, legislative duties, information security, productivity and value for money.			PPPH (PFIG)
Operational Risks Consolidated	2819	Informatics - Patient Records pan BCUHB	Chief Digital and Information Officer	Overall Risk Lead
	4595	Retention and Storage of Patient Records		Chief Digital and Information Officer
	4603	Risk of Lack of access to clinical and other patient data		
	4766	Duplicate Hospital Numbers		
	4576	Risk of inability to provide general X-Ray services using Computed Radiography (CR)	Executive Director of Therapies & Healthcare Sciences	
	4420	Non-compliance with the subject access rights of an individual under the Data Protection Act	Executive Medical Director	
	4604	Risk of poor clinical recording of patient information		
4	Failure to Embed Learning			Committee

Strategic	There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from **mortality cases**, inspections, **incidents** and **complaints**. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national mortality review framework, and reputational damage.			QSE
Operational Risks Consolidated	3025	Failure to learn from mortality reviews	Executive Medical Director	Overall Risk Lead
	4519	Mortality Review Risks to include Datix Module		Executive Director of Nursing and Midwifery
	4520	Mortality staffing and level 1 reviews		
	Not on datix	Learning from incidents, internal & external recommendations, safety alerts etc	Executive Director of Nursing and Midwifery	
	3795	Complaints timeliness to completion	Executive Director of Nursing and Midwifery	
	3759	Achieving Deadlines - Meeting Complaint Compliance		
5	Patient Safety			Committee
Strategic	There is a risk to patient safety, in particular harm as a result of slips, trips and **falls** within Secondary Care acute sites. This may be caused by patients acuity/clinical condition/frailty alongside contributory factors such as **reduced staffing**, segregated areas and **premises** which do not allow for ease of oversight, access to **manual handling training** or delays in risk assessment completion or reduced observation. Could lead result in poorer patient health outcomes, extended hospital stay, regulatory compliance and litigation and associated financial impact.			QSE
Operational Risks Consolidated	4748	Compliance of Women's Services Clinical staff compliant with Manual Handling training has fallen below an acceptable level.	Executive Director of Nursing and Midwifery	Overall Risk Lead
	3869	Increased risk of falls in Emergency Care		Executive Director of Nursing and Midwifery
	3893	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	Executive Director of Workforce and Organisational Development	
	4562	FALLS - Compliance with HSE improvement notice for fall and manual handling risk assessment	Executive Director of Nursing and Midwifery	
6	Safeguarding			Committee

Strategic	There is a risk that BCU may fail in its statutory duties to protect **vulnerable** groups from harm. This could be caused by gaps in **safeguarding governance**, insufficient workforce training and engagement, complexity of legal frameworks, and lack of resources to manage growing demand. The impact may be harm to at-risk adults, children or young persons, victims of violence/abuse, patients unlawfully detained, financial penalties, reputational damage and non-compliance with Social Services, Wellbeing (Wales) Act 2014 and the Health Board's reputation.			QSE
Operational Risks Consolidated	3766	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	Executive Director of Nursing and Midwifery	Overall Risk Lead
	2548	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.		Executive Director of Nursing and Midwifery
7	Staffing			Committee
Strategic	There is a risk that BCU **staffing** shortfalls across multiple professional groups and specialties could severely **impact service delivery** and patient **care**. This is driven by shortages in several staffing groups, recruitment and retention challenges, high workload and poor staff wellbeing. The impact could include increased waiting times, delayed treatment, reduced service access, risks to patient safety, lower quality of care, higher spend on agency staff, increased staff and patient complaints, regulatory non-compliance and significant reputational damage.			People Committee (PFIG)
Operational Risks Consolidated	3766	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	Executive Director of Nursing and Midwifery	Overall Risk Lead
	4431	Potential increase in mortality rates due to insufficient staff to provide the acute Heart Failure pathway for patients		Deputy Director of Workforce
	4773	Compliance with Birth Rate Plus		
	4432	Oncology workforce will be unable to deliver service due to reduce workforce which will impact patients care and treatment	Executive Medical Director	
	3947	There is a risk in relation to the recruitment and supply of senior doctors.	Director of Mental Health and Learning Disabilities	
	4726	Critical Care Consultant Establishment is Inadequate	Executive Medical Director	
	4939	Risk to Patient Care under Hepatology	Executive Medical Director	
	2758	Failure to implement new NICE approved treatments due to reduced staffing levels within pharmacy team	Executive Director of Therapies & Healthcare	

	4564	Risk of failure to support BCU wide Radiology Informatics Systems and key deliverables	Sciences	
	4669	SLT acute care		
	4285	Failure to meet patient care due to SLT staffing vacancy rate		
	4671	SLT Stroke Care		
8	Staff safety and Wellbeing			Committee
Strategic	There is a risk to staff wellbeing and safety such as potential injuries to staff, high workload, general staff shortages, acuity of patients increasing overtime, current organisational culture, perceived slow recruitment, frequent line management changes and low compliance with one to ones, supervision and staff development. The impact could be absence from work, an associated impact on service delivery, increased sickness, staff burnout, poor morale, recruitment or retention difficulties, higher staff turnover, increased reliance on agency use and subsequently a financial impact.			People Committee (PFIG)
Operational Risks	4771	Risk of muscular skeletal injuries to portering staff from excessive handling of patient records to and from patient records	Executive Director of Workforce and Organisational Development	Overall Risk Lead
	2070	Risk of compromise to staff welfare across the West IHC		Deputy Director of Workforce
9	Population Health			Committee
Strategic	There is a risk the Health Board fails to adequately allocate resources, including transformation capacity, to improve health outcomes for the population and reduce inequalities. This could be caused by the financial and resource constraints of the Health Board as well as the socioeconomic factors like poverty, lack of investment in proactive education and prevention strategies, and limited access to necessary services such as specialist weight clinics. The impact could be continued high rates of chronic illnesses like diabetes, cardiovascular disease and cancer as well as preventable morbidity and mortality rates and future increased demand on services.			PPPH (QSE)
Operational Risks Consolidated	4200	Residents in north Wales are unable to achieve a healthy weight due to multifactorial and complex system wide factors that promo	Executive Director of Public Health	Overall Risk Lead
	4201	Lack of Specialist Weight Management Services (Children and Adults)	Executive Director of Public Health	Executive Director of Public Health
	1642	Smoking Cessation	Executive Director of Public Health	
10	Community Care Provision			Committee

Strategic	There is a risk of fragility across health and social care community provision in North Wales. This is caused by internal staffing resources to support children **CHC package reviews**, SLT staff **provision** to support **schools**, staff deployment to covid and **screening** services for **asylum seekers**, **primary care** provision to support discharge general independent sector fragility and particularly external support from independent services such as **pharmacy** and domiciliary **care packages**. The impacts may include extended hospital stays, delayed discharges, avoidable admissions, gaps in care, substandard packages, regulatory breaches, and deteriorating population health outcomes. This presents risks to patient flow, performance, care standards, partnerships, value for money, and the sustainability of community models.			QSE or PPPH
Operational Risks Consolidated	4738	Limited access to GA Paediatric Dentistry	Director of Primary and Community Care	Overall Risk Lead
	4598	Risk to sustainable provision of Children's Continuing Care Packages (West)	Executive Director of Nursing and Midwifery	Executive Director of Operations
	3263	Lack of available domiciliary care provision	Executive Director of Nursing and Midwifery	
	4688	The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow	Executive Director Transformation, Strategic Planning, And Commissioning	
	Not on datix	Pharmacy clinic space-lack of impacting on service delivery by pharmacies	Director of Primary Care	
	4684	Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Ca	Executive Director Transformation, Strategic Planning, And Commissioning	
	4696	Asylum Seeker Support for the Flint Area	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	4666	SLT Staffing Special Schools	Executive Director of Therapies & Healthcare Sciences	
	4960	SLT in mainstream schools	Executive Director of Therapies & Healthcare Sciences	

	4337	Inability to increase delivery capacity by 400% within 7 days due to access to additional resources	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
11	Urgent and Emergency Care			Committee
Strategic	There is a risk of mortality in relation to **critically ill** patients being seen in a **timely** manner through unscheduled **care** routes. This may be caused by delayed dispatching of ambulances, ambulance queues at emergency departments, Out of Hours access and EDs and UTCs being at capacity. This could impact on pressures for other services, reputation and litigation implications.			PFIG or QSE
Operational Risks Consolidated	3873	Inability to deliver safe, timely and effective care - Wrexham Emergency Department.	Executive Director of Nursing and Midwifery	Overall Risk Lead
	4486	Delays with time critical transfers from the ED to specialist services	Executive Director Transformation, Strategic Planning, And Commissioning	Executive Director of Operations
	4490	Temporary Suspension of Home Birth Service due to WAST provision	Executive Director of Nursing and Midwifery	
	4583	Risk of Emergency Department becoming unsafe due to the Ambulance Release Protocol	Executive Director of Nursing and Midwifery	
	4864	Flow out from the Emergency Units resulting in length of stay in EU being > 12 hours.	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	4866	Inability to manage ambulance demand in a safe timely fashion.		
	4867	Inability to deliver safe timely care in Emergency Units		
	4260	Stage 1 Validation: Patient Deterioration Statements		
12	Planned Care			Committee
Strategic	There is a risk of harm, mortality and morbidity which is caused by **long waits** and **delays for planned** care services. This could be caused by insufficient capacity, staffing shortages, increasing demand, and backlogs exacerbated by COVID. The impact would be worsening patient outcomes and experiences, increased complaints, financial penalties for target breaches, and reputational damage.			PFIG or QSE

Operational Risks Consolidated	2512	Delivery of Planned Care	Executive Director of Nursing and Midwifery	Overall Risk Lead
	1161	Failure to deliver timely access for patients to all Elective Planned Care Specialties.	Executive Director of Nursing and Midwifery	Executive Director of Operations
	4948	Risk to delay of patients requiring orthopaedic surgery at YGC	Executive Medical Director	
	4714	Risk of avoidable harm due to the protracted length of time patients are waiting to be seen or treated	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	4863	Loss of beds due to the number of Medically fit for discharge patients (MFFD) across BCUHB.	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	4411	Waiting List Backlog Physiotherapy Centre Area	Executive Director of Therapies & Healthcare Sciences	
13	Areas of Clinical Concern			Committee
Strategic	There is a risk of service failure and patient harm across multiple **specialist medicine services**. This could be caused by **severe staffing shortages**, lack of capacity, **unsustainable demand**, estates and equipment deficits, and delays in care. The impacts may include irreversible sight loss for ophthalmology patients, delayed diagnosis and treatment of skin cancers for dermatology patients, worsening patient outcomes and experiences, increased complaints, and reputational damage. This impacts patient safety, public health outcomes, healthcare access targets, staff wellbeing, and the financial sustainability of specialist medicine services.			PFIG or QSE
Operational Risks Consolidated	**Ophthalmology**			Overall Risk Lead
	2498	Risk that the Ophthalmology Service within the West IHC is unable to deliver safe, effective and timely care	Executive Director of Nursing and Midwifery	Executive Medical Director or Executive Director of Operations
	4693	Age related Macular Degeneration (AMD) and Intra Vitreal Injection Service (IVT)	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	

	4694	Risk of Irreversible Sight-Loss from Delayed Care for “New” and “Follow-Up” Glaucoma Patients	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	Dermatology			
	4643	Risk of delayed access to dermatology expertise for the population in the West	Executive Medical Director	
	4199	Dermatology - Unsustainable Service		
14	Timely Diagnostics			Committee
Strategic	There is a risk of delay in diagnostics, service failure, poor performance or disruption to **radiology** and **pathology** services across. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage.			QSE
Operational Risks Consolidated	4521	Risk of non-compliance and regulatory breaches due to no governance support team	Executive Director of Therapies & Healthcare Sciences	Overall Risk Lead
	4842	Risk of failure to report on radiology examinations due to not having adequate workstations leading to late reporting of images		Executive Director of Therapies & Healthcare Sciences
	4925	Diagnostic Reporting Service - Clinical Workstations and Technology		
	4184	Results Management pan BCU	Executive Medical Director	
	4625	Pathology Laboratory Information Management System LIMS2 (formerly LINC)	Executive Director of Therapies & Healthcare Sciences	
15	Harm from the Medical Devices/Equipment			Committee
Strategic	There is a risk of harm and infection from aging, **unsuitable** or unreliable **medical equipment** and devices. This could be caused by equipment breakdowns, **lack of replacement funding**, ineffective cleaning and **decontamination**, insufficient **staff training**, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.			QSE
Operation	4552	Risk to staff and patient safety due to failing mobile shelving unit and contamination of sterile equipment	Executive Director of Nursing and Midwifery	Overall Risk Lead

	4363	Risk of loss of traceability of medical devices reprocessed in SSDs Pan BCUHB due to existing electronic system is unsupported.		Executive Director of Therapies & Healthcare Sciences
	4935	Risk of service failure due to endoscopy unit patient trolleys being condemned and no longer fit for purpose		
	3820	Risk of service failure and harm to patients due to poor decontamination unit infrastructure		
	4553	Failure to deliver surgical intervention due to aging/obsolete equipment		
	1087	There is a risk to patient safety if staff are not trained and competent in the use of high risk medical devices		
	4879	Risk of device failure, infection and loss of traceability due to use of re-usable screws,pins,plates and k-wires	Executive Medical Director	
	4775	Lack of Cystocopy Stacker Equipment	Executive Medical Director	
	4946	There is a risk that ultrasound may not be able to provide Womens gynae scans	Executive Director of Therapies & Healthcare Sciences	
16	Leadership/Special Measures			Committee
Strategic	There is a risk that a lack of robust and consistent leadership could contribute to safety and quality across the Health Board. This could be caused by inadequate governance arrangement across the Health Board. This could have an impact on the sustainability of staffing and subsequently patient care and safety and service delivery.			AC
Operational Risks Consolidated	4480	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns	Executive Director of Workforce and Organisational Development	Overall Risk Lead
	3969	Declaration of Interests and Gifts and Hospitality	Board Secretary	Deputy Director of Workforce

Teitl adroddiad: ***Report title:***	Special Measures Update			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	16th November 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date on the deliverables associated to this Committee.			
Argymhellion: ***Recommendations:***	The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the areas of challenge, the process for independently assessing evidence within the PMO, along with processes for how changes are managed.			
Arweinydd Gweithredol: ***Executive Lead:***	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
Awdur yr Adroddiad: ***Report Author:***	Geraint Parry, Special Measures Programme			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures			

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps:*** Implementation of recommendations	

Audit Committee 16th November 2023

Special Measures Update

1) Introduction

This report presents an update on the Special Measures deliverables aligned to this Committee, building on the approach developed during the first 90-day cycle (June to August 2023).

The report reviews the progress being made during the second 90-day cycle (September to November 2023) and describes the transition from cycle 1 to cycle 2.

2) Background

The background to the Health Board escalation into Special Measures and the resultant organisational response has been covered in previous committees. It has previously been agreed that a summary will be provided to each committee that covers the deliverables for which the committee has agreed to provide oversight, and that the committee will then invite relevant colleagues to attend for any particular deep dives that they wish to undertake.

3) Progress to date

The table at the end of this paper provides an update on the relevant deliverables agreed for the Audit Committee's oversight. The table has been collated from the weekly reporting received from respective teams and from the tracking against the milestones which have been agreed.

Independent Reviews

A process is in place for the development and then delivery of recommendations associated to reviews received. There is one review under the remit of this committee which is the review of the Office of the Board Secretary and as members will be aware, this was presented to a development session of the committee on the 15th September.

A management response has been created following that session and is covered via a separate paper being submitted to this committee by the Interim Board Secretary, all as part of a thematic approach to addressing the real organisation wide root causes.

Cycle 3 and Standardisation Phase Preparation

Whilst monitoring arrangements are in place for Cycle 2, preparation is also underway around developing plans for Cycle 3 (December 2023 to February 2024) and beyond to ensure that early traction is maintained. Discussions have begun with colleagues including due consideration for how we prepare for the standardisation phase in April, where the intention is for stronger alignment between Special Measures priorities and the Annual plan. This reflects the fact that Special Measures is a level of escalation and that the ultimate success will be dependent on how we can integrate effectively into Business as Usual activities.

4) Portfolio Management Office (PMO) Assessment

The table provides details of the progress against deliverables and milestones and is complemented by the objective assessment that is undertaken by the PMO on behalf of the organisation, to ensure that a robust assurance process is in place and that progress is verified.

Overall, solid progress has continued in most areas and it is evident that there has been some early success in Cycle 2, in particular progress being made with recruitment activities that are likely to lead to appointments during this cycle. All other areas are progressing, including induction and Board development, however there are some risks to some of the Cycle 2 deliverables concluding in their entirety.

The halfway point of this cycle has now passed and with many milestone dates weighted towards the end of the cycle there will be a requirement for continued focus throughout the remaining weeks to ensure delivery.

5) Change Control

As part of Special Measures governance arrangements any proposed changes require approval through a change control process. This is approved through the Special Measures Senior Responsible Officer (SRO) before being submitted to the Board for final approval.

Milestones scheduled for Cycle 1 that did not conclude within the originally intended timescales have been mapped during the transition to Cycle 2, in order to ensure that no milestones were overlooked. These changes fall within the scope of the Change Control process; Appendix 1 details those pertinent to this committee, and these will be submitted to the Board for approval along with those mapped to other committees.

6) Recommendations

The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the areas of challenge, the process for independently assessing evidence within the PMO, along with processes for how changes are managed.

Table 1: Audit Committee Oversight Report – 16 November 2023

Outcome 1: A well-functioning board			
Deliverable brief summary	**Lead Executive**	**Delivery Assessment**	**Update**
1.3 Implement phase 1 induction for all Board members	Phil Meakin		**Summary extracted from team updates** All current Independent Members have received an induction utilising the existing induction process. Feedback received reflects the fact that the induction needs to be improved, therefore when the revised induction process is completed their induction will be revisited and the new pack made available to all IM's. With regards to the new Induction process this will include a handbook accompanied by a SharePoint site to access key information. The Chair has been consulted on the material and comments have been incorporated, with the work currently being finalised and due to go live in early November.
			PMO Assessment Evident that plans to ensure all current IM's have been through some form of induction via the existing process has been delivered, whilst acknowledging feedback from IMs that the quality of the induction has room for improvement. This is coupled with plans to develop a new Board induction programme which will require Board sign off, and is on track for this to be delivered via the November Board meeting. It will be critical to ensure that the new induction programme addresses the feedback received, however plans appear on track for this to be achieved.

1.4 Develop phase 1 Board development programme	Phil Meakin		**Summary extracted from team updates** An initial programme has been developed and submitted to the CEO before onward sharing with the Chair to ensure that it aligns with Board requirements. A Board Development session took place on the 26th October focusing on the Winter Plan, Emergency Medical Retrieval and Transfer Service (EMRTS) and a Finance Overview. This session also incorporated a site visit at Ysbyty Gwynedd.
			PMO Assessment Evident that this deliverable is undergoing extensive consultation with key individuals such as the Chair and the Chief Executive to ensure that it meets the ongoing requirement of the Board and that iterative steps are being taken towards to the overall delivery. Work in this area did however roll forward from cycle 1 and it is therefore critical that a consensus is reached at the November Board.

1.5 All committees with assigned IM's operational	Phil Meakin		**Summary extracted from team updates** A proposal for Board Committees was successfully adopted by the Board at the September Board meeting. Terms of Reference, Cycle of Business, and the Corporate Calendar are to be taken to the Audit Committee and then Board by 30 November 2023. IM recruitment continues to be the dependency to enact these Committees in full and that process is underway via the public appointment process.
			PMO Assessment The findings from the Independent Reviews have been supplied to Board committees, both via detailed discussions with the reviewers at committee development sessions, and through subsequent management responses to formal committee meetings. The appointments process for new Board members is progressing well during Cycle 2, however timings of appointments may determine that finalisation of work in this area will need to roll forward to Cycle 3.

1.7 Permanent Chair/IM/CEO /Exec Recruitment – dependent on the Exec Portfolio Review and Senior HR cases	Phil Meakin		**Summary extracted from team updates** Interviews for the Vice Chair and Independent Members took place as planned during October. The proposed appointments are currently with the Minister for approval. The recruitment process for the permanent Chair is also underway and expected to conclude during November and the CEO advert has closed and interviews being scheduled during November. Additionally, the Remuneration Committee has approved relevant executive posts to proceed. **PMO Assessment** Evident that plans across all areas have commenced, with good progress being made and with appointments likely before the end of this cycle.

1.8 OBS team - implement interim and design permanent structure	Phil Meakin		**Summary extracted from team updates** An interim approach to improving the OBS service to the Health Board has been agreed with the Chair and CEO and has been in effect since late October. The role of Director of Corporate Governance has been reviewed and noted at the Remuneration Committee in September. However, the proposal on a permanent OBS structure may well take longer than the intended milestone date of October 31st and has been escalated for further discussion by the Interim Board Secretary. The Risk Management function is now working as part of the OBS and is having a beneficial impact. **PMO Assessment** Evident that progress has been made during Cycle 2 with interim changes being enacted, however based on the current assessment completing this deliverable in its entirety is likely to carry forward into Cycle 3.

1.9 Policy management and implementation /audit approach	Phil Meakin		**Summary extracted from team updates** The Policy on Policies approach was approved through Executive Team and the Audit Committee during September and then proceeded to consultation during October, with feedback being collated. The available resource to progress this work has been reduced, however mitigations in place via the Risk and Assurance team.
			PMO Assessment Good early traction evident and the first 2 milestones have been completed. Likelihood that the first tranche of actual policies for review at Executive team may carry forward into December.

Outcome 5: A learning and self-improving organisation

Deliverable brief summary	Lead Executive	Delivery Assessment	Update
5.6 Embed Special Measures assurance approach	Chris Stockport		**Summary extracted from team updates** Change Control procedure in place and approved by the SRO, and a small number of changes have been approved via this process. This includes extending the Cycle 2 scope of the Orthopaedic Business Case (deliverable 4.3) to include WG approval, and the transition of non-completed milestones from Cycle 1 to future cycles so that nothing is overlooked. Assurance SOP drafted and being finalised and is on track for the milestone date of 10th November.
			PMO Assessment On track to complete within planned timescales, subject to the SOP meeting with the SRO's approval.

Appendix 1

Change Log Activity – Audit Committee

The Special Measures Change Control process outlines the steps to be taken when a modification is suggested for a Deliverable, Milestone, or a Special Measures process after it has received Board approval.

The table below provides a change log specific to the Audit Committee, highlighting updates pertinent to the committee from the broader Special Measures Change Control Register, which is presented to the Board for approval.

Several milestones did not conclude by the end of Cycle 1 and therefore required transition to Cycle 2 (a small number mapped direct into Cycle 3, however none of these relate to the Audit Committee), making them subject to the Special Measures Change Control process. A mapping exercise was conducted to confirm that no milestones were overlooked. The table below provides details of changes made due to non-completion of Cycle 1 milestones by the end of Cycle 1, for milestones relevant to this committee.

Change Log Table for Cycle 1 milestones not completed by the end of the cycle

Outcome	Deliverable	Cycle 1 Milestone not completed in cycle 1:	Carried forward in Cycle 2 as:
1. A well-functioning Board	1.3 Board inductions	1.3.2 Incorporate learning from other health boards and launch a refreshed induction programme	1.3.4 New Board induction programme for IMs agreed by Board Members
	1.4 Board development	1.4.1 Agree Board development programme to reflect the discussion from the Board development workshop on 22.06.23	1.4.4 Phase 1 of the new Board development programme agreed by Board Members
		1.4.2 Board to agree content of programme by end of July	1.4.4 Phase 1 of the new Board development programme agreed by Board Members
		1.4.3 Commence implementation of the Board programme	1.4.4 Phase 1 of the new Board development programme agreed by Board Members

	1.6 Risk	1.6.2 Develop risk management framework and approach with Audit Committee and Risk Management Group through July and (targeting Board in September)	1.6.3 Board approval of Risk management framework at Sep Board
	1.7 Permanent Board recruitment	1.7.5 Executive board appointments following outcome of the Executive Portfolio Review (due end of July, consider it during August)	1.7.10 Exec recruitment: Adverts live to close gaps in Executive Team where appropriate (dependent on Exec Portfolio Review and Senior HR Cases)
5. A learning and self-improving organisation	5.6 Special Measures assurance approach	5.6.2 To agree final assurance approach at SMRG on 21.06.23	5.6.5 – Final SOP(s) for Special Measures Assurance signed off by SRO
		5.6.4 Implement agreed assurance approach	5.6.5 – Final SOP(s) for Special Measures Assurance signed off by SRO

Appendix 2

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Collated Cycle 2 Milestones relating to Audit Committee

(i.e. carried forward milestones listed in appendix 1 plus new Cycle 2 milestones)

1. A well-functioning Board			
Exec Lead	**Milestone**	**Due Date**	**Why it's important to track**
C1-1.3: Implement phase 1 induction for all Board members			
Phil Meakin	1.3.3 Induction completed for all current IMs (as at 01/09/23) using existing induction process	01/11/2023	All new Independent Board Members will then be at a consistent level of understanding as to how the organisation, the roles and governance works. They will then be able to fully discharge their responsibilities in ensuring the organisation delivers against its strategic priorities
Phil Meakin	1.3.4 New Board induction programme for IMs agreed by Board Members	30/11/2023	All new Independent Board Members will then be at a consistent level of understanding as to how the organisation, the roles and governance works. They will then be able to fully discharge their responsibilities in ensuring the organisation delivers against its strategic priorities
C1-1.4: Develop phase 1 Board development programme			
Phil Meakin	1.4.4 Phase 1 of the New Board development programme agreed by Board Members	30/11/2023	It's important that all Board Members with their varying backgrounds and experience have a common understanding of the BCU culture and leadership model, their role within it and the capabilities required to deliver it. They will then be able to fully discharge their responsibilities in ensuring the organisation delivers against it's strategic priorities
C1-1.5: All committees with assigned IMs operational			
Phil Meakin	1.5.5 Findings from the Independent Review reports available received by each of the relevant Board Committees	01/10/2023	To ensure that the independent review findings are properly socialised and understood by appropriate Board Members and a proper governance followed to process and publish them. This will give full visibility and transparency to the public and other stakeholders on what the reviews found and the organisation's resultant action plans
Phil Meakin	1.5.6 The following findings from the OBS review implemented: 1) ToR for all Committees, 2) Confirmed membership for each Committee, 3) Cycle of Business (CoB) for each Committee, 4) Corporate calendar to reflect CoB	30/11/2023	To implement recommendations from a Welsh Government commissioned review that will support the creation of a well functioning Board

C1-1.6: Design Risk management framework and commence implementation			
Phil Meakin	1.6.3 Board approval of Risk management framework at Sep Board	30/09/2023	To ensure a common understanding across Board members on how the organisation identifies, manages and mitigates risk. To enable delivery of necessary actions to implement and embed robust risk management processes.
Phil Meakin	1.6.4 Commence implementation of risk management framework implementation plan (developed during this cycle)	30/11/2023	To enable delivery of necessary actions to implement and embed robust risk management processes.
C1-1.7: Permanent Chair/IM/CEO/Exec recruitment – dependent on Exec Portfolio Review and Senior HR Cases			
Phil Meakin	1.7.6 Permanent Vice Chair and 2x permanent IMs recruitment: "Phase 2" appointments made by WG	30/10/2023	For the non Executive members of the Board to be at full complement and be able to run all necessary Board governance
Phil Meakin	1.7.7 Permanent Chair recruitment: Interview dates set	30/11/2023	For the non Executive members of the Board to be at full complement and be able to run all necessary Board governance
Jason Brannan	1.7.8 Permanent CEO recruitment: Interview dates set	30/11/2023	To have a permanent substantive CEO who can provide stable leadership for the organisation over the long term
Phil Meakin	1.7.9 3x Permanent IMs recruitment: "Phase 3" job adverts closed	30/11/2023	For the non Executive members of the Board to be at full complement and be able to run all necessary Board governance
Phil Meakin	1.7.10 Exec recruitment: Adverts live to close gaps in Executive Team where appropriate (dependent on Exec Portfolio Review and Senior HR Cases)	30/11/2023	To have a permanent substantive Executive Team who can provide stable leadership for the organisation over the long term
C2-1.8: OBS team – implement interim and design permanent structure			
Phil Meakin	1.8.1 Assessment of current capabilities in the OBS team, matched against requirements set out in OBS Review and subsequent follow up work	30/11/2023	This information will be used to inform a capability development plan for the Office of the Board Secretary. Once delivered this will ensure that the team has the required skillset to run effective Board governance and business.
Phil Meakin	1.8.3 Proposal on permanent OBS structure	31/10/2023	To ensure the Office of the Board secretary team have the necessary roles and resources to run effective Board governance and business.

Phil Meakin	1.8.4 Risk Management function moved into OBS	31/10/2023	To ensure the Office of the Board secretary team have the necessary roles and resources to run effective Board governance and business.
Phil Meakin	1.8.5 Met necessary governance and achieved necessary sign offs to enable full implementation of OBS structure by start of January	30/11/2023	To ensure the Office of the Board secretary team have the necessary roles and resources to run effective Board governance and business.
C2-1.9: Policy management and implementation/audit approach			
Phil Meakin	1.9.1 Present outline approach for Policy Management to Audit Committee on 15/09/2023	15/09/2023	Key milestone on the journey to ensuring that the organisation has a robust policy management, implementation and audit approach. This will enable consistency across all key areas of organisational and service delivery, throughout the organisation.
Phil Meakin	1.9.2 Present final "policy on policies management and implementation approach" to Audit Committee on 09/11/2023	09/11/2023	Key milestone on the journey to ensuring that the organisation has a robust policy management, implementation and audit approach. This will enable consistency across all key areas of organisational and service delivery, throughout the organisation.
Phil Meakin	1.9.3 First tranche of new or revised priority policies presented to Executive Team for approval (This is an extensive programme of policy reviews that will need an 18 month programme)	30/11/2023	Key milestone on the journey to ensuring that the organisation has a robust policy management, implementation and audit approach. This will enable consistency across all key areas of organisational and service delivery, throughout the organisation.

2. A clear, deliverable plan for 2023/24

No deliverables from Outcome 1 fall under the remit of this committee.

3. Stronger leadership and engagement

No deliverables from Outcome 1 fall under the remit of this committee.

4. Improved access, outcomes and experience for citizens

No deliverables from Outcome 1 fall under the remit of this committee.

5. A learning and self-improving organisation

Exec Lead	Milestone	Due Date	Why it's important to track
C1-5.6: Embed Special Measures assurance approach			
Chris Stockport	5.6.5 Final SoP (s) for Special Measures Assurance signed off by SRO	10/11/2023	This will ensure there is robust Special Measures related assurance activity, so there is clear evidence that actions taken have led to the intended improvements

Teitl adroddiad: ***Report title:***	Independent Review Management Response: Review of the Office of the Board Secretary			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	16 November 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the initial management response following the Review of the Office of the Board Secretary			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Phil Meakin, Acting Board Secretary Elin Gwynedd, Chief of Staff			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures			

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps:*** Implementation of recommendations	

Audit Committee, 16 November 2023

Special Measures Independent Reviews - Management Response

Review of the Office of the Board Secretary

1) Background and context

On 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of the Health Board (BCUHB) to Special Measures with immediate effect. This decision reflected serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership, and financial management. A number of Independent Advisors (IAs) were appointed to form a BCUHB improvement and support team to provide the support and advice necessary to enable BCUHB to implement the changes required to deliver improvements. The support and advice in this instance refer to an objectively derived blend of measures (monitoring, assurance, evaluation, guidance, encouragement, and support) which in combination will provide assurance to stakeholders (including patients, staff and the wider public).

This report provides the initial management response following the review of the Office of the Board Secretary that was undertaken by an Independent Advisor.

2) Overview from Development Session

The Independent Advisor who led on the review presented the report to the Committee in a development session on 15 September 2023. This allowed the Committee to hear from the lead and to ask questions.

The review has not made specific recommendations but rather areas of focus. These areas of focus align fully to the overarching themes identified from all of the collective reviews undertaken as part of Special Measures to date (see below for mapping).

However as mentioned earlier, a number of other complimentary reviews are imminent or underway such as the Executive Portfolio Review.

Where the areas of focus detailed in the report already show alignment to other reviews and improvement activity (such as the Executive Portfolio Review) then actions are not included here to avoid duplication).

3) Key Feedback from The Development Session on the 15 September 2023

1. The Independent advisor introduced the review report and set on record her thanks for the cooperation of all the staff members involved.

2. The role of OBS / governance is key to keeping the Organisation, the Chair, CEO and Staff safe. Without this in place and working well there is a lack of internal control.

3. There is a lot of good points in the report and a recognition that there are people working very hard. This purpose of this review is to support those staff members and the organisation. Need to promote sustainability of Governance arrangements – need to have stability – then move to standardisation and sustainability. Governance needs to be the bedrock of the organisation – the foundation.

4. Clear need for Director of Corporate Governance but operational Board Secretary role needs to be separate to allow focus. Exciting opportunity to reset and build their structure. However, was acknowledged that there are some actions that need to be taken forward immediately whilst others may need to wait until the Director of Corporate Governance (and Board Secretary) is in post. At this point, there could be a case for renaming or rebranding to 'Director of Governance' to be seen as providing advice and support to the organisation as a whole.

5. Structure of teams needs to be reviewed to reflect need and banding - 2 different arms of the team need to work together and be more balanced. Clarity needed on roles to avoid duplication and gaps – what does everybody do / who's leading/admin for the Board, Board Committees and Risks

6. Further acknowledged that there are a number of vacancies and secondments currently with a need to work to a full contingent and suggest anchor days in the office to regroup. Secondments from the OBS left the team weakened.

7. There are some associated training needs – in Quality Governance, specifically NHS Wales Health Governance.

8. There is a need to further improve fundamental standards which set the house standards for the whole organisation – accuracy in distribution lists, names of meetings, accuracy in note taking, accuracy of actions, version control, house styles (note taking). Needs to be gold standard and build in quality checking. OBS do these checks. **SOPs need to be in place** which ensure cross organisational working and communication - Give people the tools, help them comply / write the papers.

9. There is always a need to comply with Standing Orders & WG guidance with little or no additions or moving away - model ToR, JDs etc – quick wins. Membership of Committees should be reviewed to ensure all are appropriate. i.e. Chair and Audit Chair should not attend all meetings – need separation. Audit Committee to make a recommendation to the Board to agree all the ToR.

10. In terms of Governance flow – committee cycle / work programme /schedule of meetings forward corporate calendars should be planned well in advance and set (suggested 2 years). Current flow and timing is not quite there so difficult to give assurance to the Committees Would be useful to have organagram to show the flow through the organisation.

11. Clarity is needed on where decisions lie and which committees decide on what matters. Has it gone through Execs first for decision and to give assurance to Committees/Board. Governance route needs to be clear on audit route up to committees and then Board.

12. All Board committees to be in place with Governance reviewed

13. People and culture focus is a gap in Committee consideration

14. Audit tracker to be further strengthened (revisit in 6 months) needed to triangulate hotspots and robust tracking of Welsh Health Circulars

15. Whole workforce needs to understand their role in supporting the governance function. And a clear link to objectives of special measures so need to work closely together.

16. Vice Chair and more Independent Board members – need to be clear on their roles, induction, training, forward calendar and forward work programme.

17. Consider what are our measures of success? What does good look like? What metrics do other HBs use? Could ask special advices and internal audit for support here. CEO and Jo Williams will also have ideas on this and will want to contribute.

4) Key Themes from the Review

Themes from reviews received to date	Applicable to this review *Check box if applicable*
1. Data, Intelligence & Insight Ensuring that there is an organisation wide approach with prioritised interventions into improving our data, intelligence and insight tools and capabilities. This will be a key enabler for sustainable improvement as well as supporting identification of future potential services of concern.	☐
2. Culture Defining, engaging and committing to the long-term work necessary to improve the culture of the organisation. Integrated into our broader organisational development plan across Culture, Leadership and Engagement.	☒
3. Risk Management Reviewing and refining our approach and appetite to risk, including how risks are identified, managed, mitigated, reported and monitored.	☒
4. Patient, Family, Carer Involvement A single coordinated approach to maximise involvement and engagement with our patients and their families and carers, using their experiences to guide our ongoing service improvement.	☐
5. Operating model Ensuring our operating model is designed to best deliver our strategic priorities, with clarity for everyone across all levels of the organisation on the roles and responsibilities, systems and processes within divisions and Pan BCU services.	☐
6. Organisation Governance and compliance Ensuring organisation wide visibility and understanding of governance best practice and ensuring adherence to it.	☒
7. Integrated Planning A well understood integrated approach to planning as a discipline, as well as contributions to our annual planning process.	☒

4) Recommendations

The committee is asked to **APPROVE** the management response in readiness for onward publication into the public domain.

Table 1: Management Response Action Plan

Please note that the deliverables and in the Special Measures Domains will action the key recommendations in the OBS Review. The actions below are additional to these and reflect some of the specific actions referenced in the Development Session (Section 3 above)

Culture					
Ref	**Action**	**Lead**	**Deadline**	**RAG status[1]**	**Progress Update**
1	Board Induction Programmes for new Independent Members established that support role of Governance in the organisation so that a "Governance culture" continues to emerge	Acting Board Secretary	3/11/2023		Board Induction programme agreed with Chair and ready for deployment
2	Board Development Programmes to be agreed with the Chair and reflect the importance of Leadership and Culture within it	Acting Board Secretary	30/11/2023		Draft Board Development programme is under development and will be sent to Chair for his review by 20 November

3	The actions contained above will promote a stronger "Governance Culture"	Acting Board Secretary	30/11/2023		Contained within the OBS Review and detailed recommendations.
4	Introduction of a People Committee	Acting Board Secretary	1/3/2024		Remit of People Committee includes consideration of Culture and was approved by the Board on 28 September 2023. Note that this is dependent on effective recruitment of Independent Members.

[1] **RAG status definitions: Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Risk Management					
Ref	**Action**	**Lead**	**Deadline**	**RAG status[1]**	**Progress Update**
5	Bring the Risk Management function together with the OBS function so that "Corporate Risk Management" and "Board Assurance Framework" are managed by the same team	Acting Board Secretary	11/11/2023		An interim OBS team approach that has included the Risk Management Team reporting to the Acting Board Secretary. Risk Management Framework developed and agreed at Board 2023/24 BAF approach has been developed ready for Executive Team and Committees to consider and endorse
6	Risk Management Training to be reviewed in light of new Framework	Head of Risk Management	30/11/2023		Approach developed and mobilisation plan required to ensure it is effectively deployed.

[1] **RAG status definitions: Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Organisational Governance and Compliance					
Ref	**Action**	**Lead**	**Deadline**	**RAG status[1]**	**Progress Update**
7	Recruit to Director of Corporate Governance role	Chief Executive	9/11/2023		Role approved by Remuneration Committee in September 2023 Role ready for advertising in November 2023
8	Rationalise OBS Team through a review. Develop short term approach in interim period	Acting Board Secretary	To be confirmed		Organisational Change programme to determine timescales. In the interim period an approach has been developed with the team that brings Risk Management into the structure and creates clarity between the "arms" of the Directorate. Reflects engagement with the Chair, CEO and staff.
9	Anchor days agreed with key OBS staff	Acting Board Secretary	1/11/2023		Agreed and in place. Review effectiveness at end of December 2023
10	Ensure secondees return and agency staff stood down	Acting Board Secretary	7/11/2023		Actioned and now in place. Head of Corporate Affairs and Policy lead back from secondment. All agency resource now stood down

11	Governance Training required in basic disciplines and in relation to understanding the requirements of Governance in NHS Wales	Acting Board Secretary	Throughout 2023/24		Minute taking hour style agreed and sessions to be developed by end of December 2023. Training on NHS Wales Governance requirements to be developed and agreed with support from wider Director of Governance network
12	Develop Standard Operating Procedure	Acting Board Secretary	November 2023		Developed by OBS Team and approved by Exec Team Receiving scrutiny at Audit Cttee on 16 Nov
13	Develop Committee structure and associated Terms of Reference for the Health Board	Acting Board Secretary	30/11/2023		Board approved Committee structure on 28 September Completion to green relies upon effective recruitment of IMs and development of Terms of Reference, Workplans and corporate calendar to support it. Audit Committee review on 16 November 2023.

[1] **RAG status definitions: Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Integrated Planning					
Ref	**Action**	**Lead**	**Deadline**	**RAG status[1]**	**Progress Update**
14	The strategic deliverables in the Annual Plan are used to inform the Board Assurance Framework.	Head of Risk Management	30/11/2023		Clarity is required on Strategic Objectives for the BAF to be truly effective.
15	Ensure that Annual Plan deliverables are reflected in the Committee and Board workplans	Acting Board Secretary	30/1/2024		Committee Workplans are being updated during November 2023

[1] **RAG status definitions: Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track
mitigations in place to bring back on track

Teitl adroddiad: ***Report title:***	**Review of Health Board Standing Financial Instructions and Standing Orders for WHSSC and EASC**
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 November 2023
Crynodeb Gweithredol: ***Executive Summary:***	Welsh Government have amended and updated the Model Standing Orders for NHS bodies in Wales as per the report presented to Committee on 15 September 2023. As part of the Standing Orders, Schedule 2.1 relates to the Standing Financial Instructions for the regulation of the financial proceedings and business of the Health Board in its day to day operations. The Health Board are being asked to incorporate and adopt the latest version of the Standing Financial Instructions as appropriate as Schedule 2.1 of the Standing Orders. All Health Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Standing Orders for the Health Board also contain the Standing Orders for the Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) as Schedules 4.1 and 4.2 respectively. The Model Standing Orders for WHSSC and EASC have also been amended and updated and are to be incorporated and adopted as relevant schedules within the Standing Orders of the Health Board.
Argymhellion: ***Recommendations:***	The Audit Committee is asked to take assurance from the report and support the incorporation and adoption of the Standing Financial Instructions as Schedule 2.1 of the Standing Orders for consideration and approval by the board on 30 November 2023. The Audit Committee is also asked to support the incorporation and adoption of the Standing Orders for WHSSC and EASC as Schedules 4.1 and 4.2 of the Standing Orders for consideration and approval by the Board on 30 November 2023.
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance
Awdur yr Adroddiad:	Andrea Hughes, Finance Director – Operational Finance and Neil Williams, Senior Finance Manager

Report Author:				
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	There are no associated strategy implications.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The review is provided in order to comply with Standing Orders 1.4 and 2.0
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	None identified as necessary
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	None identified as necessary
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF 2.3 and 2.7 As per the requirement for the achievement of meeting Statutory Financial Duties in accordance with the adoption of Standing Orders for the Health Board
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Relevant staff are obliged to be aware of these Standing Financial Instructions and to adhere to them in undertaking financial proceedings for the Health Board
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF 2.3 and 2.7 As per the requirement for the achievement of meeting Statutory Financial Duties in accordance with the adoption of Standing Orders for the Health Board
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf:
Next Steps:

To bring the draft Standing Financial Instructions (Schedule 2.1 of the Standing Orders) and the Standing Orders for WHSSC and EASC (Schedules 4.1 and 4.2 of the Standing Orders) to Board on 30 November 2023 for approval

Rhestr o Atodiadau:
List of Appendices:

Appendix 1: Standing Financial Instruction (SFIs) for BCUHB
Appendix 2: Table of amendments in SFIs from previous adopted version
Appendix 3: Standing Orders for Welsh Health Specialised Services Committee (WHSSC)
Appendix 4: Standing Orders for Emergency Ambulance Services Committee (EASC)
Appendix 5: Table of amendments in WHSSC and EASC SOs from previous versions

Review of Standing Financial Instructions for BCUHB and Standing Orders for the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC)

Audit Committee 16 November 2023

1. Introduction and Background

Health Boards and all NHS organisations in Wales must agree Standing Orders (SOs) that inform its "ways of working". The Standing Orders should be based upon the Model determined by the Welsh Government Ministers. The whole suite of Standing Orders include:

- Model Standing Orders
- a set of Standing Financial Instructions (SFIs)
- a Scheme of Decisions reserved to the Board;
- a Scheme of Delegations to officers and others; and
- a range of other framework documents set out the arrangements within which the Board, its Committees, Advisory Groups and staff make decisions and carry out their activities.

Model documents were last issued by Welsh Government for all Welsh NHS organisations on 27 July 2023. A circular from the Health Minister to all Health Boards clearly instructs that "Your Board is required to incorporate and adopt this latest review into your organisations Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions (which form part of the Standing Orders) as appropriate"

The Model Standing Orders were presented to Audit Committee and Board in September 2023. The additional documents listed above, which form part of the updated suite of Model documents issued by Welsh Ministers, were under review prior to being received by Audit Committee and Board in future meetings.

The following documents are now presented to the Audit Committee at this meeting for review:

- Schedule 2.1, Standing Financial Instructions for the Health Board;
- Schedule 4.1, Standing Orders for the Welsh Health Specialised Services Committee (WHSSC); and
- Schedule 4.2, Standing Orders for the Emergency Ambulance Services Committee (EASC)

2. Considerations for the Audit Committee

There is a requirement to keep the health Board's Standing Financial Instructions (SFIs) updated and documents under review to ensure they remain accurate and current. An in depth review has taken place of the proposed SFIs which involved consultation with Executive Directors, Local Counter Fraud Service, Internal Audit and Chief Finance Officers (and linking into their directorates).

Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Welsh Health Specialised Services Committee's (the WHSSC or the Joint Committee), and the Emergency Ambulance Services Committee's (the EASC or the Joint Committee), proceedings and business. These WHSSC Standing Orders (WHSSC SOs)

and EASC Standing Orders (EASC SOs) form a schedule (Schedules 4.1 and 4.2) to each LHB's own Standing Orders, and have effect as if incorporated within them.

The Audit Committee has a role to make sure that there are effective arrangements in place in relation to adopting the SFIs and Standing Orders. The formal incorporation and adoption of the documents would be received by the Board for approval at its meeting on 30 November 2023.

The Appendices highlight the key changes to the SFIs received from Welsh Government

Appendix 1 (Standing Financial Instructions for Betsi Cadwaladr University Health Board) contains the Draft SFIs issued by Welsh Ministers and to be adopted by the Health Board.

Appendix 2 (Table of amendments for SFIs) details the changes in the latest version of the Draft SFIs from the previous version adopted by the Board in 2021.

Appendix 3 (Standing Orders for WHSSC) contains the amended Model SOs with changes and updates issued by Welsh Ministers highlighted in red.

Appendix 4 (Standing Orders for EASC) contains the amended Model SOs with changes and updates issued by Welsh Ministers highlighted in red.

Appendix 5 (Table of amendments for WHSSC and EASC SOs) details the changes in the latest version of the SOs from the previous versions.

3. Key changes in the review of the Standing Financial Instructions

The Table of Amendments (see appendix 2) lists the changes made to the proposed version of the SFIs from the version previously adopted by the Health Board in 2021. The majority of the amendments are based on changes to the Model SFIs for Local Health Boards issued by Welsh Ministers. These predominantly relate to updates to external website links within the document where links have changed or have been removed.

There are two additional changes made by the Health Board to the proposed SFIs from those issued by Welsh Ministers following a review by Internal Audit. These relate to section 11.13, Single Quotation Application (SQA) or Single Tender Application (STA). Additions have been made to clarify the process for the application and approval of Single Waivers and reference the inclusion of the Executive Director of the service area in the application process (11.13.2) and the acceptable reasons for why an SQA / STA may be made (11.13.4).

The Table of Amendments (see appendix 5) lists the changes made to the Standing Orders of WHSSC and EASC from the versions previously agreed by the Health board.

4. Recommendations

The Audit Committee is asked to take assurance from the report and support the Adoption and Incorporation of the following as part of the Standing Orders of the Health Board

- Standing Financial Instructions for BCUHB
- Standing Orders for the Welsh Health Specialised Services Committee (WHSSC)
- Standing Orders for the Emergency Ambulance Services Committee (EASC)

Appendix 1

Schedule 2.1

STANDING FINANCIAL INSTRUCTIONS FOR BETSI CADWALADR UNIVERSITY HEALTH BOARD

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders (incorporated as Schedule 2.1 of SOs).

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Scheme of decisions reserved to the Board and a scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the LHB. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

Contents

Betsi Cadwaladr University Health Board

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by Betsi Cadwaladr University Health Board (the LHB). They are designed to ensure that the LHB's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the LHB.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the LHB and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Director of Finance and Audit Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the LHB's SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non-compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members

and LHB officers have a duty to report any non-compliance to the Director of Finance and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of LHBs

1.3.1 The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the LHB meets its statutory obligation to perform its functions within the available financial resources.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall funding

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and LHB officers, and LHB committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. This will be via powers and authority delegated to committees, sub-committees, joint committees or joint sub-committees that the LHB has established or to an officer of the LHB in accordance with the 'Scheme of delegation' document adopted by the LHB.

2.2 The Chief Executive and Director of Finance

2.2.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the LHB's activities; is responsible to the Chair and the Board for ensuring that financial

provisions, obligations and targets are met; and has overall responsibility for the LHB's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and LHB officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

a) Implementing the LHB's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the LHB's transactions, in order to disclose, with reasonable accuracy, the financial position of the LHB at any time; and

d) Without prejudice to any other functions of the LHB, and Board members and LHB officers, the duties of the Director of Finance include:

(i) the provision of financial advice to other Board members and LHB officers, and LHB Committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LHB may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to effect these SFIs.

2.4 Board members and LHB officers, and LHB Committees and Advisory Groups

2.4.1 All Board members and LHB officers, and LHB Committees and Advisory Groups, severally and collectively, are responsible for:

a) The security of the property of the LHB;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and LHB officers, and LHB Committees and Advisory Groups who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board, Committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the LHB to commit the LHB to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.

nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manualdocuments/useful-documents/nhs-wales-audit-committee-handbookjune-2012/

3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,
- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the LHB;

c) Access at all reasonable times to Board members and LHB officers;

d) The production of any cash, stores or other property of the LHB under a Board member or a LHB official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the LHB. The Auditor General may nominate his representative to represent him within the LHB and to undertake the required audit work. The cost of the audit is paid for by the LHB. The LHB's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report [1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion

[1] Note: The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

on the annual report and accounts, is central to the core work of the Audit Committee.

3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.

3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.

3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs that relate to the exercise of many of his core functions, including his statutory audit of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the Trust that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the LHB and its officers and staff, but also to, among others, suppliers to the LHB.

3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the LHB (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the LHB may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some

of which are specified in the Auditor General's Code of Audit and Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements
- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the LHB and other public sector bodies. At LHBs he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the LHB Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The LHB shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005 (as amended).

https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-what-why/supporting-good-governance/nhs-counter-fraud-service-wales/

3.5.3 The LCFS shall report to the LHB Director of Finance and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS

Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.

3.5.4 The LCFS will provide a written report to the Director of Finance and Audit Committee, at least annually, on proactive and reactive counter fraud work within the LHB.

3.5.5 The LHB must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The LHB should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

3.6.1 In line with their responsibilities, the LHB Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts." They are as follows:

- First Duty - A duty to secure that its expenditure, which is attributable to the performance by it of its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.
- Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

4.1.2 The details and requirements for the two duties are set out in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts."

Full details of the WHC can be obtained by contacting the HSSG Director of Finance at hywel.jones38@gov.wales

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Health Board has a statutory duty to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years, that is to breakeven over a 3-year rolling period.

4.2.2 Welsh Government will determine revenue and capital allocations prior to the start of each financial year and notify Health Boards.

4.2.3 Health Boards must ensure their boards approve balanced revenue and capital plans in line with their notified allocations before the start of each financial year.

4.2.4 The Director of Finance of the LHB will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year allocations and other adjustments and their proposed

distribution to delegated budgets, including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements;
c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and
d) Regularly update the Board on significant changes to the initial allocations and the application of such funds.

4.2.5 The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Health Board has a statutory duty to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers**.**

4.3.2 The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

4.3.3 The NHS Planning Framework directs Local Health Boards to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context, including population health needs, within which the Health Board will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
  - delivering their well-being objectives, including how the five ways of working have been applied
  - contributing to the seven Well-being Goals,
  - establishing preventative approaches across all care and services

- demonstrate how the Health Board will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium Term Plan should be based on a reasonable expectation of future service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the LHB's response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans and
- Outcomes Framework

4.3.6 The Integrated Medium Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

a) Approve the Integrated Medium Term Plan prior to the beginning of

the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the LHB plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the LHB and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1. Budget Setting

5.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan, and Medium Term Financial Plan, and focused on delivery of improved population health, safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioning, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced, specified and non-recurring allocations and funding;

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents)

h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;

i) Identify available reserves;

j) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

k) Identify potential risks and opportunities.

5.2. Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Director of Finance, the

management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

5.2.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3. Financial Management, Reporting and Budgetary Control

5.3.1 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position, and

financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to LHB Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Director of Finance will devise and maintain systems of financial management, performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:

- Understand the current and forecast financial position
- Evaluate risks and opportunities
- Use insight to make informed decisions
- Be consistent with other Board reports, and as a minimum the reports will cover:
    - Current and forecast year end position on statutory financial duties
    - Actual income and expenditure to date compared to budget and showing trends and run rates
    - Forecast year end positions
    - A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
    - Explanations of material variances from plan
    - Capital expenditure and projected outturn against plan
    - Investigations and reporting of variances from financial, activity and workforce budgets.
    - Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
    - Statement of performance against savings targets
    - Key workforce and other cost drivers
    - Income and expenditure run rates, historic trends, extrapolation and explanations
    - Clear assessment of risks and opportunities
- Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and SFI 9.1.

5.4. Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate

monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Board must approve the LHB's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the LHB. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.

6.3 The Director of Finance, on behalf of the LHB, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.

6.4 The LHB's annual accounts must be audited by the Auditor General for Wales. The LHB's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

6.5 The LHB will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include

- The Accountability Report containing:
  - Corporate Governance Report
  - Remuneration Report and Staff Report
  - Accountability and Audit Report

- The Performance Report, which must include:
  - An overview
  - A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Director of Finance is responsible for managing the LHB's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the Welsh Ministers. LHBs are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Director of Finance is responsible for:

a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Health Board business transactions;

b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;

c) Establishing separate bank accounts for the LHB's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Ensuring accounts are not overdrawn except in exceptional and planned situations.

f) Reporting to the Board all arrangements made with the LHB's bankers for accounts to be overdrawn;

g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the LHB. No officer other than the Director of Finance shall open any account in the name of the LHB or for the purposes of furthering LHB activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the LHB and the relevant third party contractor.

7.3 Banking Procedures

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the LHB's accounts.

c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.

d) Authorised signatories are identified with sufficient seniority, and in the case of e-banking approvers, together with an appropriate payment approval hierarchy.

e) Procedures are in place for prompt banking of money received.

f) Ensure there are physical security arrangements in place for cheque stationery, e-banking access devices and payment cards.

g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.

h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.

i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Director of Finance must advise the LHB's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Director of Finance shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled

stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

7.4.1 The Director of Finance will review banking arrangements of the LHB at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Director of Finance is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;

c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the LHB.

e) Ensuring effective control systems are in place for the use of payment cards,

f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the LHB is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the LHB from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be

undertaken by two officers together, except as may be authorised in writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

8.2.1 The Director of Finance will issue instructions restricting the use and value of petty cash purchases.

8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.

8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

9.1.1 The LHB shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).

9.1.2 The LHB can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The LHB should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

9.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

9.2.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

9.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

9.3.2 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

9.4.1 Delegated budget holders and managers are responsible for informing the Director of Finance of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

9.4.2 Delegated budget holders and managers must inform the Director of Finance when overpayment of salary or expenses have been made, in order that recovery can be made.

9.4.3 The Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.

9.4.4 Income not received should be dealt with in accordance with losses procedures.

9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

9.4.6 The Chief Executive and the Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON-PAY EXPENDITURE

10.1 Scheme of Delegation, Non-Pay Expenditure Limits and Accountability

10.1.1 The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2 The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the LHB's scheme of delegation.

10.1.3 The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Director of Finance's responsibilities

10.2.1 The Director of Finance will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds would be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of

creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or LHB officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal

gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase;

10.3.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the LHB's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Health Boards must consult with NWSSP Procurement Services, Director of Finance and Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Health Board Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the LHB, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of Managing Welsh Public Money
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the LHB if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Health Board. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the LHB, maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Revised General Consent to enter Individual Contracts included as **Schedule 1** of these SFIs**.**

11.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures

- Are kept up to date;
- Conform to statutory requirements and regulations;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Procurement Principles

11.3.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the LHB to perform its functions, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.3.2 The main legal and governing principles guiding public procurement and which are incorporated into these SFIs are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;
- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Equal treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Proportionality: requirements and conditions in the procurement should be reasonable in proportion to the object of procurement and measures taken should not go beyond what is necessary;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement;
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

11.4 Legislation Governing Public Procurement

11.4.1 There are a range of EU Directives which set out the EU legal framework for public procurement. These EU Directives have been implemented into UK law by statutory regulations which govern public sector procurement, the primary statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102.' From 1 January 2021, all aspects of EU law in respect of the EU Directives relating to public procurement, except where expressly stated otherwise by domestic legislation, will continue to govern public sector procurement, although further amendments or developments of EU related procurement law following this will not be incorporated into domestic

law. The Welsh Government policy framework and the Wales Procurement Policy Statement (WPPS) also govern this area. One of the key objectives of governing legislation is to ensure public procurement markets are open and that there is free movement of supplies, services and works. Legislation, policy and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB's SFIs.

11.4.2 The main Regulations (the Public Contracts Regulations (2015 No. 102)) cover the whole field of procurement, including thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for seeing that those Regulations are understood and fully implemented. The protocols set out in the Regulations, and any Procurement Policy Notices, are the model upon which all formal procurement shall be based.

11.4.3 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the LHB and Procurement Services e.g. Engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.4.4 Other relevant legislation and policy include:

- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Policy Framework
- The Wales Procurement Policy Statement (WPPS)

11.5 Procurement Procedures

11.5.1 To ensure that the LHB is fully compliant with UK Procurement Regulations, EU Procurement Directives and Welsh Ministers' guidance and policy, the LHB shall, through NWSSP Procurement Services, ensure that it shall have procedures that set out:

a) Requirements and exceptions to formal competitive tendering requirements;
b) Tendering processes including post tender discussions;
c) Requirements and exceptions to obtaining quotations;

d) Evaluation and scoring methodologies
e) Approval of firms for providing goods and services.

11.5.2 All procurement procedures shall reflect the Welsh Ministers' guidance and the LHB's delegation arrangements and approval processes.

11.6 Procurement Consent

11.6.1 Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on LHBs to obtain the consent of the Welsh Ministers before:

- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust, either for the general or any specific purposes of the LHB or for any purposes relating to the health service).

The provision allows the Welsh Ministers to give consent, which may be given in general terms covering one or more descriptions of case.

11.6.2 General Consent has been granted to LHBs by the Welsh Ministers for individual contracts up to the value of £1 million in each case with the exception of those contracts specified in SFI 11.6.4. All contracts exceeding this delegated limit, all acquisitions and disposals of land of any limit, and the acceptance of gifts of property, must receive the written approval of the Welsh Ministers before being entered into. In addition, Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let.

11.6.3 **Schedule 1** details the requirement and process for LHBs to obtain consent to enter into contracts exceeding £1m and monitoring arrangements for contracts below £1m.

11.6.4 The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and/or Welsh Ministers direction, and therefore does not apply to:

i) Contracts of employment between LHBs and their staff;
ii) Transfers of land or contracts effected by Statutory Instrument following the creation of the LHBs;

iii) Out of Hours contracts;
iv) All NHS contracts, that is where one health service body contracts with another health service body; and
v) Contracts entered into by Health Education and Improvement Wales (HEIW) for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning also do not require further Ministerial notification or consent.

To ensure consistency with guidance issued by NWSSP Procurement Services, further exceptions highlighted below should also be applied:

vi) Contracts over £500k - £1 million (for noting) and £1 million+ (for approval);
    (i) Wales Public Sector Framework Agreements e.g. Frameworks established by national Procurement Services (NPS) or NWSSP (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award or mini competition.
    (ii) Third Party Public Sector Framework Agreements e.g. Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under the Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

11.6.5 The Revised General Consent does not remove the requirement for LHBs to comply with SOs, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy, in support of social, environmental and economic regeneration, Health Boards must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible. The principles of the Well-being and Future Generations Act (Wales) 2015 (WBFGA 2015) should be adopted at the earliest stage of planning. Procurement solutions must be developed embracing the five ways of working described within the Act and capture how they will deliver against the seven goals set out in the Act.

11.7.2 The WBFGA 2015 requires that bodies listed under the act must operate in a manner that embraces sustainability. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

11.7.3 The 7 Wellbeing goals are

- a prosperous Wales
- a resilient Wales
- a healthier Wales
- a more equal Wales
- a Wales of cohesive communities
- a Wales of vibrant culture and thriving Welsh language
- a globally responsible Wales.

These goals have been put in place to improve the social, economic, environmental, and cultural well-being of Wales

11.7.4 Public bodies need to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future. The Act expects them to:

- work together better
- involve people reflecting the diversity of our communities
- look to the long term as well as focusing on now
- take action to try and stop problems getting worse - or even stop them happening in the first place.

11.7.5 The LHB is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on ethical employment in supply chains which commits public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.

11.7.6 The LHB shall make use of the tools developed by Value Wales in implementing the principles of the WBFGA 2015. The LHB shall benchmark its performance against the WBFGA 2015. For all contracts over £25,000, the LHB shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with Welsh Government commitments policy set out in the current WPPS and subsequent versions of this statement the LHB shall ensure that it provides opportunities for these organisations to quote or tender for its business.

11.9 Planning Procurements

11.9.1 Health Boards must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks governing public procurement and the requirement of open competition.

11.9.2 Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost
- the likely 'route to market' which will consider the legislative and policy framework set out above.
- The availability of funding to be able to award a contract following a successful procurement process.
- That the procurement follows current legislative and policy frameworks including Value Based Procurement

11.9.3 The procurement specification should factor in the 4 principles of prudent healthcare:

- Equal partners through co-production;
- Care for those with the greatest health need first;
- Do only what is needed; and
- Reduce inappropriate variation.

Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

11.9.4 Where free of charge services are made available to the Health Board, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Health Board does not unintentionally commit itself to a single provider or longer term commitment. Regular reports on free of charge services provided to the Health Board should be submitted by Board Secretary to Audit Committee.

11.9.5 Health Boards are required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government and the opinions of NWSSP Procurement Services and NWSSP Legal and Risk prior to external opinion being sought where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Health Board's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales.

11.10.2 In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the table below. Health Boards must ensure the value of their requirement considers cumulative spend across the Health Board for like requirements and opportunity for collaboration with other Health Boards and Trusts:

11.10.3 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in EU Procurement Directives and UK Procurement Regulations.

Goods/Services/Works **Whole Life Cost Contract value** **(excl. VAT)**	**Minimum competition[1]**	**Form of Contract**
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SFI 11.6.3.

11.11.2 Advice from the Procurement Services must be sought for all requirements in excess of £5,000.

11.11.3 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable
- Specifications are drafted which:
  - are fit for inclusion in competition documents;
  - are drafted in a manner encouraging innovation by the market;
  - are capable of being responded to and do not narrow competition;
  - deliver in line with legislative and policy frameworks.
  - include robust performance measures to effectively measure and manage supplier performance; and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price;
- consider cost of change where relevant;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost.

11.13 Single Quotation Application or Single Tender Application

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all Wales competition/National strategy.

11.13.2 The appropriate Executive Director must approve all single waivers for their service area prior to submission to Procurement Services. Procurement Services must be consulted and comments provided on whether the application is supported or not from a procurement perspective (see 11.13.3) prior to the application being submitted for final approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided;
- A value for money test has been undertaken;
- No bias towards a particular supplier;
- Future competitive processes are not adversely affected;
- No distortion of the market is intended;
- An acceptable level of assurance is available before presentation for approval in line with the Health Board Scheme of Delegation; and

- An “or equivalent” test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Health Board has already entered into an arrangement directly. A lack of sufficient time to complete the procurement process is not an acceptable reason for the requesting of an SQA/STA.

11.13.5 As SQA or STA are only used in exceptional circumstances the Health Board, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent recurrence by the Health Board.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- Instruct a representative of the Health Board to attend Audit Committee;
- Escalate to the Board;
- Request an internal Audit Review;
- Request further training or
- Take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA’s not endorsed by Procurement or any exceptional matters.

11.14 Disposals

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Health Board making use of any agreements covering the disposal of such items.

11.14.3 The Health Board must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the operational service of the Health Board. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder, shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records
- Monitoring contract performance measures
- Engaging suppliers to ensure performance delivery
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- Permitting stage payments as part of a formally agreed

Implementation / delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 Extending, modifying or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the Health Board budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Health Boards compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LHB. The budget holder will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Health Board will ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy which was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;
b) State the LHB's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Health Board by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Health Board will commission healthcare services for its resident population both internally, from its own LHB provided services, and externally, from other LHBs, Trusts and other providers. The Chief Executive is responsible for ensuring the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for the provision of health care services from external providers.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the LHB by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables Health Boards to commission certain healthcare services. The relevant sections under the Act are as follows:

- Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body;
- Section 9 sets out arrangements to be treated as NHS contracts for ophthalmic and pharmaceutical services;
- Section 32 makes provision in relation to services which can be provided to Health Boards by local authorities;
- Section 33 enables the Welsh Ministers to make provision which enables Health Boards and Local Authorities to enter into prescribed arrangements as to the provision of services which are

in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;

- Part 4 enables Health Boards to make arrangements for the provision of primary medical services;
- Part 5 enables Health Boards to make arrangements for the provision of primary dental services;
- Part 6 enables Health Boards to make arrangements for the provision of general ophthalmic services;
- Part 7 enables Health Boards to make arrangements for the provision of pharmaceutical services;
- Section 188 enables the Welsh Ministers to make provision which enables Health Boards and the prison service to enter into prescribed arrangements as to the provision of services which are in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;
- Section 194 sets out the Health Boards powers to make payments towards expenditure on community services; and
- Section 195 sets out the conditions for payment where expenditure proposed under section 194 is in connection with services to be provided by a voluntary organisation.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements with external providers. These reports will be linked to, and consistent with, other Board reports on commissioning and financial performance.

13 GRANT FUNDING

It is a matter for LHBs to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the LHBs functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the LHB has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement (Annex 1):

13.2 Policies and procedures

13.2.1 The LHB shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Welsh Government's Code of Practice to funding the third sector:

https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf

13.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the

award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, LHBs should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money .The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on LHBs or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted

where it is most needed and where it can have most impact;
- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, LHBs should ensure principles of good practice available from a number of external sources are considered and reflected in grant programmes.

13.4.1 Health Boards must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.2 For grant programmes that span a number of financial years, the LHB is responsible for evaluating the programmes to ensure they are fit for purpose, achieving required outcomes and continue to provide value for money.

13.4.3 LHBs are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.4 LHBs are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the LHB to potential financial loss, fraud or reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.5 The LHB must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the LHB should ensure principles of good practice available from a number of external sources are considered and reflected.

13.4.6 The LHB is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

14.1.1 In accordance with SOs the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

14.1.3 The Board will, after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

14.1.4 The LHB will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.

14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

14.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e., the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents) as per SFI 5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without

the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or LHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of Workforce and Organisational Development, has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of Workforce and Organisational Development is responsible for:

a) The control framework and detailed procedures which are in place to:
   - To ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
   - reduce the risk of fraud and error within the payroll function.

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation;

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment; and

k) A system to ensure the recovery from those leaving the employment of the LHB of sums of money and property due by them to the LHB.

14.5.3 The Chief Executive is responsible for:

a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records, and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

14.6 Contracts of Employment

14.6.1 The Director of Workforce and Organisational Development must:

a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The actual capital plan and programmes must be delivered within Welsh Government capital finance resource limits.

15.1.2 The Director of Planning (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the capital allocations, as set out in the Welsh Government (WG) Capital Resource Limit for the year, and the LHB must not exceed the allocation resource limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) https://gov.wales/nhs-wales-infrastructure-investment-guidance
- Better business cases: investment decision-making framework https://gov.wales/better-business-cases-investment-decision-making-framework

15.2.2 The Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Health Board's Scheme of Delegation

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that formal confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that the three year Capital Plan, and detailed annual

Capital Programme, is approved by the Board, as part of the IMTP, prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate LHB personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme by the Health Board shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender; and

c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the LHB's SOs.

15.4.7 The Director of Planning and Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall

fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The LHB must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The LHB shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease

and included on the LHB's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Regular verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and

negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Director of Finance.

15.7.4 Whilst individual officers have a responsibility for the security of property of the LHB, it is the responsibility of Board members and senior LHB officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the LHB's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and LHB officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as LHB property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take; and
c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Director of Finance is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements for receipt, issues, and returns of goods to stores, and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Director of Finance.

16.2.6 The designated officer/manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals

and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance or authorised officer who shall satisfy themselves that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a LHB asset and goods, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Director of Finance;

b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the assets and goods are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Director of Finance or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must notify:

a) The Audit Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the LHB's interests in bankruptcies and company liquidations.

17.2.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social

Services Group Director of Finance.

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The LHB must obtain the Health and Social Services Group Director General's approval for special severance payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the LHB for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology.

18.1.2 The LHB shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the LHB that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the LHB digital systems and data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the LHB's digital systems and data, for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;

b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information System Regulations 2018 are being carried out;

d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information System Regulations 2018; and

e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Director of Finance

18.3.1 The Director of Finance shall need to ensure that new financial data and systems, and amendments to current financial data and systems, are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Digital Data and Technology shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the LHB arising from the use of data, information and digital are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 LHB Responsibility

19.1.1 The LHB has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Health Board will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:

a) Notices and information booklets;

b) Hospital admission documentation and property records; and

c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Director of Finance

19.3.1 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 Paragraph (x) of Section A to the SOs refers to the LHB having specified powers to act as corporate trustee for the management of funds it holds on trust (charitable funds). SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the LHB's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The LHB shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the LHB is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the LHB's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and LHB officers must take account of that guidance before taking action.

20.2.3 The LHB shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018, and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

Schedule 1

REVISED GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales & HEIW

Our Ref: SE&IG/

Date: 31 March, 2022

Dear All

This letter supercedes the consent guidance issued in our joint letter on 30 November 2020.

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:
- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

Acquiring and disposing of property

WHC (2018) 043 NHS Wales Infrastructure Investment Guidance issued 22 October 2018 sets out at section 10.1:

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LHBs and HEIW
Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

NHS Trusts
Whilst formal Ministerial consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Guidance on disposals is contained in Section 11

WHC (2015) 031 issued 22 June 2015 clarified the approval process linked to the acquisition or disposal of a lease, where approval does not form part of a business case process. A lease being a property right requires the consent of the Welsh Ministers in accordance with paragraph 13(2) (a). The WHC set out for NHS Trusts and LHBs a notification and consent process mirroring the contract processes noted below.

Entering into contracts
Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly any issues relevant to the exercise of the Minister for Health and Social Service's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;
- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,

Steve Elliot & Ian Gunney
Cyfarwyddwr Cyllid dros dro - Interim Director of Finance
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
Y Grwp Iechyd a Gwasanaethau/Health and Social Services Group

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

7 November 2022

Chief Executives of Local Health Boards and NHS Trusts

Dear All

ADDENDUM TO STANDING FINANCIAL INSTRUCTIONS

PROCEDURES FOR CONSENT FOR LOCAL HEALTH BOARDS TO ENTER INTO CONTRACTS EXCEEDING £1 MILLION

Some confusion has arisen in relation to the procedures for the consent to enter contracts over £ 1 million. The latest version of the Standing Financial Instructions issued in April 2021 state in paragraph 11.6.2 :

General Consent has been granted to LHBs by the Welsh Ministers for individual contracts up to the value of £1 million in each case with the exception of those contracts specified in SFI 11.6.4 All contracts exceeding this delegated limit, all acquisitions and disposals of land of any limit, and the acceptance of gifts of property, must receive the written approval of the Welsh Ministers before being into. In addition, Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being entered let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales. Further detailed guidance is incorporated within the Procurement Procedures.

Paragraph 11.6.4 states that the exceptions mentioned above are as follows :

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and/or Welsh Ministers direction, and therefore does not apply to:

i) Contracts of employment between LHBs and their staff;

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ii) Transfers of land or contracts effected by Statutory Instrument Model Standing Orders, Reservation and Delegation of Powers for LHBs Schedule 2.1: Standing Financial Instructions Status: Update – March 2021;
iii) Out of Hours contracts;
iv) All NHS contracts, that is where one health service body contracts with another health service body.

To ensure consistency with guidance issued to NWSSP Procurement Services, further exceptions highlighted below should be applied;

v) Contracts over £ 500k - £1 million (for noting) and £ 1 million + (for approval);

i) ***Wales Public Sector Framework Agreements e.g. Frameworks established by National Procurement Services (NPS) or NWSSSP (not exhaustive) - no further approval required to award contracts under these Frameworks through a direct award or mini competition.***

ii) ***Third Party Public Sector Framework Agreements e.g. Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.***

All Health Boards in Wales and Special Health Authorities bodies should apply these exceptions from the date of this letter.

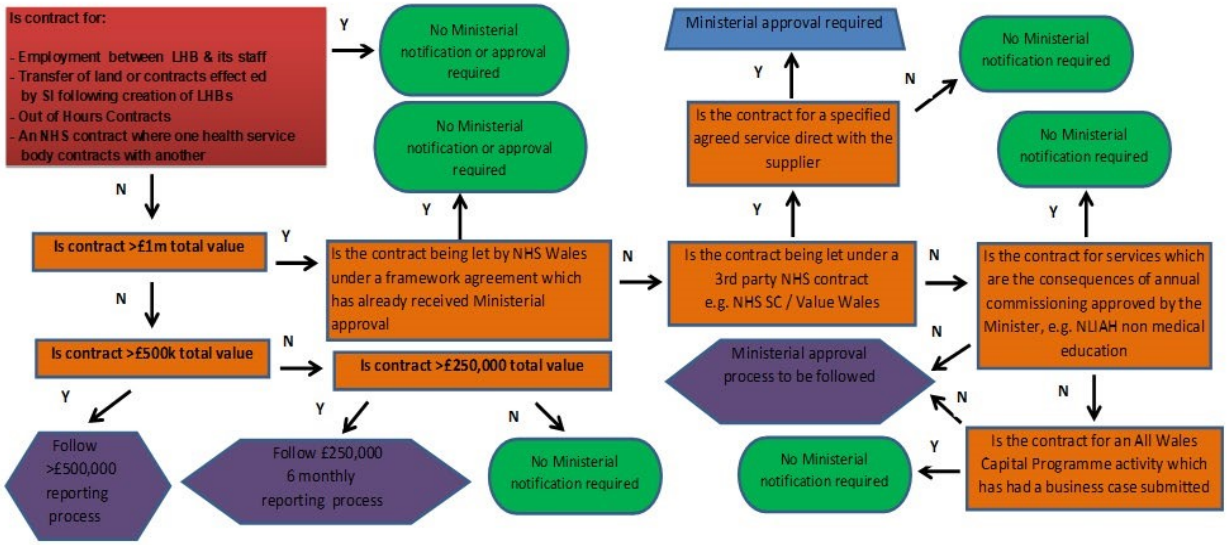
The revision introduced in point v) above will be included formally in the next version of the Standing Financial Instructions.

Yours sincerely

SR Elliot

Steve Elliot

Cyfarwyddwr Cyllid dros dro | Interim Director of Finance


Is contract for:
- Employment between LHB & its staff
- Transfer of land or contracts effect ed by SI following creation of LHBs
- Out of Hours Contracts
- An NHS contract where one health service body contracts with another
Y
No Ministerial notification or approval required
N
Is contract >£1m total value
Y
No Ministerial notification or approval required
Y
Is the contract being let by NHS Wales under a framework agreement which has already received Ministerial approval
N
Is contract >£500k total value
N
Is contract >£250,000 total value
Y
Follow >£500,000 reporting process
Y
Follow £250,000 6 monthly reporting process
N
No Ministerial notification required
Ministerial approval required
Y
Is the contract for a specified agreed service direct with the supplier
N
No Ministerial notification required
Y
Is the contract being let under a 3rd party NHS contract e.g. NHS SC / Value Wales
N
Is the contract for services which are the consequences of annual commissioning approved by the Minister, e.g. NLIAH non medical education
Y
No Ministerial notification required
N
Ministerial approval process to be followed
N
Is the contract for an All Wales Capital Programme activity which has had a business case submitted
Y
No Ministerial notification required

Appendix 2

Table of Amendments for Standing Financial Instructions (SFIs), Schedule 2.1 of the Standing Orders

The amendments below are based on the changes applied by Welsh Ministers to the Model SFIs issued to Local Health Boards except for the amendments to Sections 11.13.2 and 11.13.4 highlighted below which were additions included by the Health Board to clarify the approval procedure for Single Waivers

Page Number	Section	Original	Changed to	Comment
12	3.1 Audit Committee	http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf	nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manualdocuments/useful-documents/nhs-wales-audit-committee-handbookjune-2012/	Change to link on website
16	3.5.2 Fraud and Corruption	http://www.wales.nhs.uk/sitesplus/documents/1064/WHC%282005%2995%20%28Revised%29%20Directions%20to%20National%20Health%20Service%20bodies%20on%20Counter%20Fraud%20Measures%202 005.pdf	(as amended). https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-what-why/supporting-good-governance/nhs-counter-fraud-service-wales/	Change to link on website
18	4.1.2 Legislation and Directions	http://www.wales.nhs.uk/sitesplus/documents/863/12b%29%20Statutory%20Duties%20of%20Welsh%20Health%20Boards.pdf	Full details of the WHC can be obtained by contacting the HSSG Director of Finance at hywel.jones38@gov.wales	Change of link to website to contact details

19	4.3.2 Second Financial Duty – The Planning Duty	https://gov.wales/sites/default/files/publications/2019-09/nhs-wales- planning-framework-2020-23%20.pdf		Remove link to website
25-26	5.5.1 Reporting to Welsh Government – Monitoring Returns	https://gov.wales/health-boards-and-trusts-financial-monitoring- guidance-2019-2020-whc-2019013		Remove link to website
27	6.2 Annual Accounts and Reports	The Chief Executive has responsibility for signing the Annual Governance Statement and the Annual Quality Statement.	The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.	Changes to references within the Annual Accounts
42	11.6.2 Procurement Consent	This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales. Further detailed guidance is incorporated within the Procurement Procedures.		Replaced by addition to Section 11.6.4 (see below)
42-43	11.6.4 Procurement Consent		v) Contracts entered into by Health Education and Improvement Wales (HEIW) for services which are the consequences of annual commissioning approved by the Minister e.g. annual education	Addition to replace section in 11.6.2 (see above)

			and training commissioning also do not require further Ministerial notification or consent. To ensure consistency with guidance issued by NWSSP Procurement Services, further exceptions highlighted below should also be applied: vi) Contracts over £500k - £1 million (for noting) and £1 million+ (for approval); (i) Wales Public Sector Framework Agreements e.g. Frameworks established by national Procurement Services (NPS) or NWSSP (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award or mini competition. (ii) Third Party Public Sector Framework Agreements e.g. Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under the Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.	

49	11.13.2	Procurement Services must be consulted prior to any such application being submitted for approval.	The appropriate Executive Director must approve all single waivers for their service area prior to submission to Procurement Services. Procurement Services must be consulted and comments provided on whether the application is supported or not from a procurement perspective (see 11.13.3) prior to the application being submitted for final approval.	Additional text for the approval process
50	11.13.4		A lack of sufficient time to complete the procurement process is not an acceptable reason for the requesting of an SQA/STA.	Additional text
58	13.4.1 Grant Procedures	Information on grants management is available on the Audit Wales website at: https://www.audit.wales/good-practice/grants-management-miniguides		Remove link to website

Schedule 4.1

STANDING ORDERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

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

Foreword

Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing Standing Orders Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Welsh Health Specialised Services Committee's (the WHSSC or the Joint Committee) proceedings and business[1].

These WHSSC Standing Orders (WHSSC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Welsh Health Specialised Services Committee (Wales) Regulations 2009[2] and LHB Standing Orders into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

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

All LHB Board members, Joint Committee members, LHB and Welsh Health Specialised Services Team (WHSST) staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

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

Contents

Section: A – Introduction

Statutory framework

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

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

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

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

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

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

vii) Each LHB's functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and specialised services for the citizens in their respective areas. The WHSSC

3 c.42
4 c.41

Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and will establish the joint committee for the purpose of jointly exercising those functions.

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

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

x) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers think about the quality of health services when making decisions (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
- The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The guidance outlines the responsibilities of Local Health Board when commissioning services for their population. WHSSC shall ensure they consider these responsibilities in the discharge of their duties.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

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

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/nhs-duty-candour

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

NHS framework

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

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

xiv) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework, the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

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

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

xvii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Ministers' Citizen

Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/..Directions or guidance on specific aspects of Committee/LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Joint Committee Framework

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

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

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

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

Applying WHSSC Standing Orders

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

xxii) Full details of any non-compliance with these WHSSC SOs, including an

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

Variation and amendment of WHSSC Standing Orders

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

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

Interpretation

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

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

Relationship with LHB Standing Orders

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

The role of the Committee Secretary

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

Secretary acts as the guardian of good governance within the Joint Committee:

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

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

Section: B – WHSSC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions[7]

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

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

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

1.1.4 The Joint Committee's role is to:

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

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

contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;

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

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

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

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

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

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

1.2 Membership of the Joint Committee[8]

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

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

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

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

Chief Executives

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

Officer Members [known as WHSST Directors]

1.2.4 A total of 4, appointed by the Joint Committee, consisting of a Director of Specialised and Tertiary Services[11]; a Medical Director of Specialised and Tertiary Services; a Finance Director of Specialised and Tertiary Services, and a Nurse Director of Specialised and Tertiary Services. These officer members may have other responsibilities as determined by the Joint Committee and set out in the scheme of delegation to officers. These officer members comprise the Management Team.

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

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

Associate Members

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

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

In attendance

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

Use of the term 'Independent Members'

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

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

- Chair
- Vice-Chair
- Non-Officer Members

unless otherwise stated.

1.3 Member Responsibilities and Accountability

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

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

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

The Chair

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

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

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

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

The Vice-Chair

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

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

Non-Officer Members

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

WHSST Director of Specialised and Tertiary Services

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

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

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

1.4 Appointment and tenure of Joint Committee members

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

1.4.2 The ***Vice-Chair*** and two other ***Independent Members*** shall be appointed by the Joint Committee from existing Independent Members of the seven

12 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 3, Regulation 13
13 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 7

Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than 4 years, in line with that individual's term of office on any LHB Board. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term[14].

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

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

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

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

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

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

2.0.1 The Joint Committee is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally

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

accountable in respect of the exercise of the functions carried out on their behalf. The Joint Committee shall also be held to account by the Welsh Government through the NHS performance management system.

2.0.2 The Board of the host LHB will not be responsible or accountable for the planning, funding and securing of specialised services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the WHSST acts in accordance with its administrative policies and procedures.

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

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

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

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

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

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

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

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

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

3.1 Chair's action on urgent matters

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

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

3.2 Delegation to joint sub-Committees and others

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

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

3.3 Delegation to Officers

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

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

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

and agreed by the Joint Committee.

4. JOINT SUB-COMMITTEES

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

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

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

- Quality and Safety
- Audit

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

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

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

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;

- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

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

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

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

4.1 Other Groups

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

4.2 Reporting activity to the Joint Committee

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

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

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

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

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

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

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

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

5.1 Reporting activity

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

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

established.

6. MEETINGS

6.1 Putting Citizens first

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

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

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

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

6.2 Working with Llais

6.2.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs in relation to the engagement and involvement of Llais in their operations.

6.2.2 The 2020 Act places a statutory duty on LHBs to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.2.3 The 2020 Act also places a statutory duty on LHBs to make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. LHBs must also have regard to the Code of Practice on access to premises when it comes into effect in June 2023.

6.2.4 The LHBs and Joint Committee will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning and commissioning services.

6.2.5 The Joint Committee shall make arrangements ensure arrangements are in place to engage and co-operate liaise with representatives of Llais as appropriate.

6.3 Annual Plan of Committee Business

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

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

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

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

6.4 Calling Meetings

6.4.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual

committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

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

6.5 Preparing for Meetings

Setting the agenda

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

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

Notifying and equipping Joint Committee members

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

6.5.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This

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

will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

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

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

Notifying the public and others

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

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

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

6.6 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

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

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

> *That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].*

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

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

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

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

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

6.6.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement

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

and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

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

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

Quorum

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

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

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

6.6.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee

member or their deputy disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

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

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

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

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

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

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

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

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

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

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

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

Voting

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

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

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

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

6.7 Record of Proceedings

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

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

6.8 Confidentiality

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

(including Gifts and Hospitality) Policy or legislation such as the Freedom of Information Act 2000, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

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

7.1 Declaring and recording Joint Committee members' interests

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

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

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

7.1.4 The register will be held by the Committee Secretary, and will be updated

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

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

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

7.2 Dealing with Members' interests during Joint Committee meetings

7.2.1 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides specialised and tertiary services.

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

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

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint

Committee's discussion and decision, including voting.

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

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

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

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

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

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

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

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

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

these definitions.

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

7.3 Dealing with officers' interests

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

7.4 Reviewing how Interests are handled

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

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

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

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

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

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

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

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

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

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

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

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

7.6 Sponsorship

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

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the WHSSC Values and Standards of Behaviour (including Gifts and

Hospitality) Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

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

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

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

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

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

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

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

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

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

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

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

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

8.1 The role of Internal Audit in providing independent internal assurance

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

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

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

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

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

- The ongoing development of its governance arrangements, including its structures and processes;

- Its Committee Development Programme, as part of an overall Organisation Development framework; and

- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

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

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

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

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

9. DEMONSTRATING ACCOUNTABILITY

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

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

healthcare professionals.

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

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

9.1 Support to the Joint Committee

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

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

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

10. REVIEW OF STANDING ORDERS

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

Annex 1

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

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

SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

Introduction

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

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

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

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

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

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

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

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

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

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

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

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

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

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

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

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

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

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

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

The Joint Committee

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

The Lead Director

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

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

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

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

The Committee Secretary

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

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

The Audit Committee

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

Individuals to who powers have been delegated

Individuals will be personally responsible for:

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

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

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

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

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

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

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[23]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with WHSSC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are detailed below:
3	FULL	GENERAL	Approve the Joint Committee's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards: ▪ WHSSC SOs ; ▪ WHSSC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to sub-Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING	Ratify any urgent decisions taken by the Chair and the Lead Director in accordance

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

		ARRANGEMENTS	with WHSSC Standing Order requirements
6	NO – Nominated Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Committee Secretary on any non-compliance with WHSSC Standing Orders, making proposals to the Joint Committee on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with WHSSC Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework
9	NO - Chair on behalf of Joint Committee, Vice-chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. From Audit Committee or Committee Secretary.
10	FULL	STRATEGY & PLANNING	Determine the long term strategic plan for the development of specialised services and tertiary services in Wales, in conjunction with Welsh Ministers.
11	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan

			▪ The development and delivery of patient and population centred specialised and tertiary services for the population of Wales ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
12	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
13	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
14	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework and strategy for performance management.
15	FULL	STRATEGY AND PLANNING	Approve the LHBs framework and strategy for risk and assurance
16	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with Putting Things Right and health and safety requirements.
17	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Joint Committee, including standards/requirements determined by Welsh Government, regulators, professional bodies/others, e.g., National Institute of Health and Care Excellence (NICE)
18	FULL	STRATEGY & PLANNING	Approve the Joint Committee's patient, public, staff, partnership and stakeholder engagement and co-production.
19	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Joint Committee determines

			it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
20	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment, appraisal, discipline and dismissal of the officer members of the Joint Committee (Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions.
21	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Joint Committee level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Committee Secretary.
22	FULL	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
23	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Joint Committee's top level organisation structure and Joint Committee policies
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-Committees, including any joint sub-Committees directly accountable to the Joint Committee
25	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the Joint Committee
26	FULL	ORGANISATION STRUCTURE &	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups

		STAFFING	
27	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the Joint Committee
28	FULL – except where Chapter 6 specifies appropriate to delegate to Officers.	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
29	FULL – except where Chapter 6 specifies appropriate to delegate to Officers.	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Lead Director and officers
30	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Joint Committee
31	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Lead Director set out in the WHSSC SFIs
32	FULL	PERFORMANCE & ASSURANCE	Approve the Joint Committee's audit and assurance arrangements

33	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Joint Committee's WHSST Directors on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
34	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee's sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans
35	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate)
36	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Joint Committee's Chief Internal Auditor and approve action required, including improvement plans
37	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Joint Committee's external auditor and approve action required, including improvement plans
38	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Joint Committee's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
39	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required.
40	FULL	REPORTING	Receive, approve and ensure the publication of Joint Committee reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

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

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

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

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

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

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

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

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

[24] As defined in Standing Orders.

SCHEME OF DELEGATION TO WHSST DIRECTORS AND OFFICERS

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

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
Agreeing and signing Health Care Agreements and Contracts with service providers for health care services	Lead Director Director of Finance (Deputy)
Approval to commission Specialist healthcare services	Lead Director
Information Governance arrangements	Committee Secretary (in conjunction with the host LHB)
Management of Concerns	Director of Nursing & Quality Assurance
Health and Safety arrangements	Lead Director/ Committee Secretary (in conjunction with the host LHB)
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with government directions.	Chair/ Lead Director Director of Finance (Deputy)
Issuing tenders and post tender negotiations.	Lead Director Director of Finance (Deputy)
Legal advice	Committee Secretary

Action on litigation	Lead Director/ Committee Secretary
Operation of detailed financial matters, including bank accounts and banking procedures	Director of Finance (in conjunction with the host LHB Director of Finance)
Workforce	Committee Secretary
Public consultation	Lead Director
Manage central reserves and contingencies	Director of Finance
Management and control of stocks other than pharmacy stocks	Lead Director
Management and control of computer systems and facilities	Committee Secretary
Monitor and achievement of management cost targets	Lead Director
Recording of payments under the losses and compensation regulations	Director of Finance
Individual Patient Funding Requests	Director of Nursing & Quality Assurance
Approve and ensure the publication of non-statutory Annual Report	Lead Director
Welsh Kidney Network (WKN)	Programme Director

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

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

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

Joint Committee framework

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

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

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

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

NHS Wales framework

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

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

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

Management Group

Quality & Patient Safety Committee

Integrated Governance Committee

Welsh Kidney Network (WKN)

Annex 4

ADVISORY GROUPS AND EXPERT PANELS TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

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

Schedule 4.2

MODEL STANDING ORDERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

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

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing SOs Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Emergency Ambulance Services Committee's (the EASC or the Joint Committee) proceedings and business.

These EASC Standing Orders (EASC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014 No.566 (w.67)) and LHB Standing Order 3 into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

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

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

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/ .

Contents

Section: A – Introduction

Statutory framework

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

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

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

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

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

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

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

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

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

x) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour); and,
- The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The guidance outlines the responsibilities of Local Health Board when commissioning services for their population. EASC shall ensure they consider these responsibilities in the discharge of their duties.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

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

NHS framework

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

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

xiv) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

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

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

xvii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Minister's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

xviii) Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Joint Committee Framework

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

- These EASC Standing Orders (SOs) and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation.
- The EASC SFIs - these are based on the Welsh Health Specialised Services Committee SFIs and were presented to the Joint Committee in March 2023.
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A hosting agreement between the Joint Committee and the host LHB in relation to the provision of administrative and any other services to be provided to the Joint Committee.

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

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

Applying EASC Standing Orders

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

xxiii) Full details of any non-compliance with these EASC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit and Risk Committee at Cwm Taf Morgannwg University Health Board CTMUHB to formally consider the matter and make proposals to the Joint Committee on any action to be taken.

All Joint Committee members and Joint Committee officers have a duty to report any non-compliance to the Committee Secretary as soon as they are

aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with EASC SOs is a disciplinary matter.**

Variation and amendment of EASC Standing Orders

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

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

Interpretation

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

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

Relationship with LHB Standing Orders

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

The role of the Committee Secretary

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

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, Joint Committee Sub Groups and Advisory Groups;
- Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities

in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the Joint Committee's compliance with the law, EASC SOs and the framework set by the LHBs and Welsh Ministers.

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

Section: B – EASC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions

1.1.1 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the commissioning of emergency ambulance and non-emergency patient transport services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales.

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

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

1.1.4 The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of emergency ambulance services and non-emergency patient transport services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging ways of working and commission the best quality emergency ambulance and non-emergency patient transport services;
- Produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of emergency ambulance and non-emergency patient transport services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the EASC Team) in accordance with any specific directions set by the Welsh Ministers;
- Establish mechanisms for managing the commissioning risks;
- Establish mechanisms to monitor, evaluate and publish the outcomes of emergency ambulance and non-emergency patient transport services and take appropriate action.

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

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

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

1.2 Membership of the Joint Committee

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

Chief Officers or nominated representative

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

Officer Member

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

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

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

Associate Members

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

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

In attendance

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

1.3 Member Responsibilities and Accountability

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

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

The Chair

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

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

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

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

The Vice-Chair

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

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

Officer Members

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

1.4 Appointment and tenure of Joint Committee members

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

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

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

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

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

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

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

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

2.0.2 The Board of the host LHB will not be responsible or accountable for the planning, funding and securing of emergency ambulance or non-emergency patient transport services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the EASC Team acts in accordance with its administrative policies and procedures.

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

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

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

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

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

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

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

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

3.1 Chair's action on urgent matters

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

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

3.2 Delegation to Joint Committee Sub-Committees and Others

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

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

3.3 Delegation to Officers

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

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

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

4. JOINT COMMITTEE SUB-COMMITTEES AND SUB-GROUPS

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

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

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

- Quality and Safety
- Audit

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

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

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

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;

- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

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

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

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

4.1 Other Groups

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

4.2 Reporting activity to the Joint Committee

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

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

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

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

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

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

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

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

5.1 Reporting activity

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

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

6. MEETINGS

6.1 Putting Citizens first

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

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

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

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

6.2 Working with Llais

6.2.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs and Trusts in relation to the engagement and involvement of Llais in their operations.

6.2.2 The 2020 Act places a statutory duty on LHBs and Trusts to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

6.2.3 The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.2.4 The 2020 Act also places a statutory duty on LHBs and NHS Trusts to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. LHBs and Trusts must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

6.2.5 The Code of Practice on Access to Premises and Engagement with Individuals can be found at

https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

6.2.6 The LHBs, Welsh Ambulance Services NHS Trust and Joint Committee will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning, developing, considering proposals for service change and commissioning services.

6.2.7 The Joint Committee shall ensure arrangements are in place to engage and co-operate with representatives of Llais as appropriate.

6.3 Annual Plan of Committee Business

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

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

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

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

6.4 Calling Meetings

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

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

6.5 Preparing for Meetings

Setting the agenda

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

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

Notifying and equipping Joint Committee members

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

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

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

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

Notifying the public and others

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

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

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

6.6 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

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

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

> *'That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].'*

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

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

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

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

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

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

Chairing Joint Committee Meetings

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

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

Quorum

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

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

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

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

Dealing with Motions

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

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

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

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

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

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

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Joint Committee member may not be heard further;

- The Joint Committee decides upon the motion before them;
- An ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

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

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

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

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

Voting

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

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

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

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

6.7 Record of Proceedings

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

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

6.8 Confidentiality

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

7. VALUES AND STANDARDS OF BEHAVIOUR

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

The Values and Standards of Behaviour document is the same as the host body Cwm Taf Morgannwg University Health Board (CTMUHB).

7.1 Declaring and recording Joint Committee members' interests

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

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

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

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

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

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

7.2 Dealing with Members' interests during Joint Committee meetings

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

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

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

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting. This may be appropriate, for example where experience of using a digital system (not procurement)*;*

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

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

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

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

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

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

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

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

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

7.3 Dealing with officers' interests

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

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

7.4 Reviewing how Interests are handled

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

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

7.5.1 The Values and Standards of Behaviour Framework - CTMUHB Standards of Behaviour Policy (incorporating declarations of interest, gifts, hospitality, sponsorship and honoraria) adopted by the Joint Committee prohibits Joint Committee members and EASC Team officers receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

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

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

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;
- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Joint Committee;
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);
- **Frequency:** Acceptance of frequent or regular invitations particularly

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

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

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

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

7.6 Sponsorship

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

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the CTMUHB Standards of Behaviour Policy (incorporating declarations of interest, gifts, hospitality, sponsorship and honoraria) and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

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

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

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

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value would not usually need to be recorded, e.g., seasonal items such as diaries/calendars with normally fall within this category.
- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

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

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

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

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

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

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

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

8.1 The role of Internal Audit in providing independent internal assurance

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

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

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

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

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

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

8.3 External Assurance

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

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

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

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

9. DEMONSTRATING ACCOUNTABILITY

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

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

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

9.0.3 The Joint Committee shall ensure that within the Emergency Ambulance Services Committee Team (EASC T), individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

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

- Overseeing the process of nomination and appointment to the Joint Committee;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others;
- Ensuring the provision of secretariat support for Joint Committee meetings;

- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;
- Ensuring an effective relationship between the Joint Committee and its host LHB; and
- Facilitating effective reporting to each LHB

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

10. REVIEW OF STANDING ORDERS

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

Annex 1

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

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

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

Introduction

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

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

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

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

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

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

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

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

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

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

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

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

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

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

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

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

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

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

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

The Joint Committee

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

The Chief Ambulance Services Commissioner

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

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

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

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

The Committee Secretary

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

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

The Audit and Risk Committee

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

Individuals to who powers have been delegated

Individuals will be personally responsible for:

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

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

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

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

The Quality and Safety Committee

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

Individuals to who powers have been delegated

Individuals will be personally responsible for:

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

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

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

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

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

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

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[4]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with EASC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are: • Collaborative Commissioning Framework Agreement(s) • EAS Integrated Medium Term Plan
3	FULL	GENERAL	Approve the Joint Committee's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards: ▪ EASC SOs ; ▪ EASC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to sub-Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

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

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Ambulance Services Commissioner in accordance with EASC Standing Order requirements
6	NO – Nominated Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Committee Secretary on any non-compliance with EASC Standing Orders, making proposals to the Joint Committee on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with EASC Standing Orders, and where required ratify in public session any instances of failure to comply with EASC SOs
8	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework – CTMUHB Standards of Behaviour policy adopted
9	NO – Chair on behalf of Joint Committee/Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. From Audit Committee or Committee Secretary
10	FULL	STRATEGY & PLANNING	Determine the long term strategic plan, for the development of emergency ambulance services and non-patient transport services in Wales, in conjunction with the Welsh Ministers.
11	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Commissioning Plan and Population Health Needs Assessment ▪ The development and delivery of emergency ambulance and non-emergency patient Transport services for the population of Wales ▪ Improving quality and patient safety outcomes

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
			▪ Workforce and Organisational Development Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
12	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
13	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
14	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework and strategy for performance management.
15	FULL	STRATEGY & PLANNING	Approve the Joint Committee's framework and strategy for risk and assurance.
16	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Joint Committee, including standards/requirements determined by Welsh Government, regulators, professional bodies/others, e.g., National Institute for Health and Care Excellence (NICE)
17	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Joint Committee determines it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
18	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of officer member of the Joint Committee employed by the host Local Health board (Chief Ambulance Commissioner) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions.

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
19	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Joint Committee level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Committee Secretary.
20	FULL	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
21	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-groups, including any joint sub-groups directly accountable to the Joint Committee
22	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Joint Committee sub-groups, or Group set up by the Joint Committee
23	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups
24	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Joint Committee sub-groups, and groups established by the Joint Committee
25	FULL – except where Chapter 6 specifies appropriate to delegate to Officers.	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Ambulance Services Commissioner and officers

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
26	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Joint Committee
27	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Ambulance Services Commissioner set out in the EASC SFIs
28	FULL	PERFORMANCE & ASSURANCE	Approve the Joint Committee's audit and assurance arrangements
29	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Joint Committee's EASC Team on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
30	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee sub-groups, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans
31	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-groups (as appropriate)
32	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Joint Committee's Chief Internal Auditor and approve action required, including improvement plans
33	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Joint Committee's external auditor and approve action required, including improvement plans
34	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Joint Committee's performance against the Health and Care Quality Standards 2023 and the arrangements for approving required action, including improvement plans

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
35	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required.
36	FULL	REPORTING	Receive, approve and ensure the publication of Joint Committee reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

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

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

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

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

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

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

- Audit and Risk Committee (Cwm Taf Morgannwg University Health Board)
- Quality and Safety Committee (Cwm Taf Morgannwg University Health Board
- EASC Management Group
- Non-emergency patient transport services (NEPTS)
- Emergency medical retrieval and transfer services (EMRTS Cymru)

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

[5] As defined in Standing Orders

SCHEME OF DELEGATION TO EMERGENCY AMBULANCE SERVICES TEAM AND OFFICERS

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

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

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
WAST payments monthly	Chief Ambulance Services Commissioner (CASC) and Director of Finance
Information Governance arrangements	Committee Secretary (in line with CTMUHB as host LHB)
Management of concerns	Committee Secretary (in line with CTMUHB as host LHB)
Health and safety arrangements	Lead Director / Committee Secretary (in line with CTMUHB as host LHB)
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with Government directions	CASC / Chair EASC / Director of Finance/ Committee Secretary
Issuing tenders and post tender negotiations	CASC / Lead Director / Director of Finance
Legal Advice	Committee Secretary (in line with CTMUHB)
Action on litigation	Lead Director / Committee Secretary (in line with CTMUHB as host LHB)

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
Operation of detailed financial matters including bank accounts and banking procedures	Director of Finance (with host LHB Director of Finance)
Workforce	Committee Secretary (in line with CTMUHB as host LHB)
Public Consultation	CASC
Manage central reserves and contingencies	Director of Finance
Manage and control of stocks other than pharmacy stocks	Committee Secretary (in line with CTMUHB as host LHB)
Monitor and achievement of management cost targets	CASC
Recording of payments under the losses and compensation regulations	Director of Finance

This scheme only relates to matters delegated by the Joint Committee to the Chief Ambulance Services Commissioner and other members of the EASC Team together with certain other specific matters referred to in EASC SFIs.

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

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

Joint Committee framework

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

- **EASC SFIs**
- **Scheme of Delegation**
- **Values and Standards of Behaviour Framework - CTMUHB Standards of Behaviour Policy (incorporating declarations of interest, gifts, hospitality, sponsorship and honoraria).**
- **Risk Register**
- **Key policy documents**

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

These documents may be accessed by:

EASC Website https://easc.nhs.wales/

NHS Wales framework

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

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

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

Sub Groups	Terms of Reference
EASC Management Group	 EASC Management Group TOR approvec
Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) Delivery Assurance Group (DAG)	 EMRTS DAG Terms of Reference approve
Non-Emergency Patient Transport Service Delivery Assurance Group (NEPTS DAG)	 NEPTS DAG Terms of Reference approve

Annex 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

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

Terms of Reference to be included when required. No advisory groups or expert panels at time of approval – September 2023

Appendix 5

Table of Amendments for the Standing Orders of the Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC)

Page Number	Section	Original	Changed to	Comment
Welsh Health Specialised Services Committee (WHSSC)				
4	Contents table 6.2	Working with Community Health Councils	Working with Llais	Update to Partner
7 + 8	Statutory Framework part x)		**The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for: • Ensuring NHS bodies and ministers think about the quality of health services when making decisions (the Duty of Quality); • Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour); • The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and	New text

Page Number	Section	Original	Changed to	Comment
			• The appointment of statutory vice-chairs for NHS Trusts. The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023. Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance. The guidance outlines the responsibilities of Local Health Board when commissioning services for their population. WHSSC shall ensure they consider these responsibilities in the discharge of their duties. The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/nhs-duty-candour	
8	NHS Framework Part xiv)	These include the NHS Values and Standards of Behaviour Framework; the 'Doing Well, Doing Better: Standards for Health Services in Wales' (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the	These include the NHS Values and Standards of Behaviour Framework, the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.	Change of reference of framework

Page Number	Section	Original	Changed to	Comment
		NHS planning and performance management systems		
23 + 24	6.2	6.2 Working with Community Health Councils 6.2.1 The Joint Committee shall make arrangements to ensure arrangements are in place to liaise with CHC members as appropriate.	6.2 Working with Llais 6.2.1 Part 4 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (the 2020 Act) places a range of duties on LHBs in relation to the engagement and involvement of Llais in their operations. 6.2.2 The 2020 Act places a statutory duty on LHBs to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered. The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf 6.2.3 The 2020 Act also places a statutory duty on LHBs to make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. LHBs must also have regard to the Code of Practice on access to premises when it comes into effect in June 2023.	Additional text regarding working in partnership

Page Number	Section	Original	Changed to	Comment
			6.2.4 The LHBs and Joint Committee will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning and commissioning services. 6.2.5 The Joint Committee shall make arrangements ensure arrangements are in place to engage and co-operate liaise with representatives of Llais as appropriate.	
Emergency Ambulance Services Committee (EASC)				
4	Contents Table		6.2 Working with Llais	New section
7	Statutory Framework part x)		The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (the 2020 Act) makes provision for: • Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality); • Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour); and, • The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for	New text

Page Number	Section	Original	Changed to	Comment
			people across health and social care in respect of complaints about services. The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023. Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance. The guidance outlines the responsibilities of Local Health Board when commissioning services for their population. EASC shall ensure they consider these responsibilities in the discharge of their duties. The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023	
8	NHS Framework Part xiv)	These include the NHS Values and Standards of Behaviour Framework; the 'Doing Well, Doing Better: Standards for Health Services in Wales' (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems	These include the NHS Values and Standards of Behaviour Framework, the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.	Change of reference of framework

Page Number	Section	Original	Changed to	Comment
9	Joint Committee Framework Part xix)	• These EASC Standing Orders (SOs) and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation (The Cwm Taf University LHB Scheme of Delegation has been adopted for use by the Committee in November 2016) to others; • The EASC SFIs (The Cwm Taf Standing Financial Instructions have been adopted for use by the Committee in November 2016);	• These EASC Standing Orders (SOs) and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation. • The EASC SFIs - these are based on the Welsh Health Specialised Services Committee SFIs and were presented to the Joint Committee in March 2023.	Remove text and update reference to SFIs
21 + 22	6.2		6.2 Working with Llais 6.2.1 Part 4 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (the 2020 Act) places a range of duties on LHBs and Trusts in relation to the engagement and involvement of Llais in their operations. 6.2.2 The 2020 Act places a statutory duty on LHBs and Trusts to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered. 6.2.3 The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-	New section regarding working in partnership

Page Number	Section	Original	Changed to	Comment
			representations-made-by-the-citizen-voice-body.pdf 6.2.4 The 2020 Act also places a statutory duty on LHBs and NHS Trusts to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. LHBs and Trusts must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant). 6.2.5 The Code of Practice on Access to Premises and Engagement with Individuals can be found at https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people 6.2.6 The LHBs, Welsh Ambulance Services NHS Trust and Joint Committee will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning, developing, considering proposals for service change and commissioning services. 6.2.7 The Joint Committee shall ensure arrangements are in place to engage and co-	

Page Number	Section	Original	Changed to	Comment
			operate with representatives of Llais as appropriate.	
30	7.0.1	The Values and Standards of Behaviour document is the same as the Welsh Health Specialised Services Joint Committee.	The Values and Standards of Behaviour document is the same as the host body Cwm Taf Morgannwg University Health Board (CTMUHB).	Update
33	7.4.1	The Joint Committee's Audit Committee	The Joint Committee's (CTMUHBs) Audit and Risk Committee	Update reference
33	7.5.1	The Values and Standards of Behaviour Framework [the insert title of EASC policy/and or procedure] adopted by the Joint Committee	The Values and Standards of Behaviour Framework - CTMUHB Standards of Behaviour Policy (incorporating declarations of interest, gifts, hospitality, sponsorship and honoraria) adopted by the Joint Committee	Update reference
48	SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE Item 8	Approve the Joint Committee's Values and Standards of Behaviour framework [EASC to insert title of relevant policy]	Approve the Joint Committee's Values and Standards of Behaviour framework – CTMUHB Standards of Behaviour policy adopted	Update reference
49	SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE Item 34	Receive assurance regarding the Joint Committee's performance against the Health and Care Standards for Wales	Receive assurance regarding the Joint Committee's performance against the Health and Care Quality Standards 2023	Update reference

<table>
<tr><th>Page Number</th><th>Section</th><th>Original</th><th>Changed to</th><th>Comment</th></tr>
<tr><td>51</td><td>DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS</td><td>[sub-Committees and sub-Groups to be inserted]</td><td>The Joint Committee has delegated a range of its powers to the following sub-Committees and others:
• Audit and Risk Committee (Cwm Taf Morgannwg University Health Board)
• Quality and Safety Committee (Cwm Taf Morgannwg University Health Board
• EASC Management Group
• Non-emergency patient transport services (NEPTS)
• Emergency medical retrieval and transfer services (EMRTS Cymru)</td><td>Insertion of relevant Committees and Groups</td></tr>
<tr><td>52 + 53</td><td>SCHEME OF DELEGATION TO EMERGENCY AMBULANCE SERVICES TEAM AND OFFICERS</td><td><table><tr><th>DELEGATED MATTER</th><th>RESPONSIBLE OFFICER(S)</th></tr><tr><td>[Joint Committee to determine]</td><td>[Joint Committee to determine]</td></tr></table></td><td><table><tr><th>DELEGATED MATTER</th><th>RESPONSIBLE OFFICER(S)</th></tr><tr><td>WAST payments monthly</td><td>Chief Ambulance Services Commissioner (CASC) and Director of Finance</td></tr><tr><td>Information Governance arrangements</td><td>Committee Secretary (in line with CTMUHB as host LHB)</td></tr><tr><td>Management of concerns</td><td>Committee Secretary (in line with CTMUHB as host LHB)</td></tr><tr><td>Health and safety arrangements</td><td>Lead Director / Committee Secretary (in line with CTMUHB as host LHB)</td></tr></table></td><td>Insertion of relevant Delegated Matters and Responsible Officers into Table</td></tr>
</table>

Page Number	Section	Original	Changed to		Comment
			Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with Government directions	CASC / Chair EASC / Director of Finance/ Committee Secretary	
			Issuing tenders and post tender negotiations	CASC / Lead Director / Director of Finance	
			Legal Advice	Committee Secretary (in line with CTMUHB)	
			Action on litigation	Lead Director / Committee Secretary (in line with CTMUHB as host LHB)	
			Operation of detailed financial matters including bank accounts and banking procedures	Director of Finance (with host LHB Director of Finance)	
			Workforce	Committee Secretary (in line with CTMUHB as host LHB)	
			Public Consultation	CASC	
			Manage central reserves and contingencies	Director of Finance	

<table>
<tr><th>Page Number</th><th>Section</th><th>Original</th><th>Changed to</th><th>Comment</th></tr>
<tr><td></td><td></td><td></td><td><table>
<tr><td>Manage and control of stocks other than pharmacy stocks</td><td>Committee Secretary (in line with CTMUHB as host LHB)</td></tr>
<tr><td>Monitor and achievement of management cost targets</td><td>CASC</td></tr>
<tr><td>Recording of payments under the losses and compensation regulations</td><td>Director of Finance</td></tr>
</table></td><td></td></tr>
<tr><td>53</td><td>SCHEME OF DELEGATION TO EMERGENCY AMBULANCE SERVICES TEAM AND OFFICERS</td><td>In November 2016, the Joint Committee agreed to use the host body’s Standing Financial Instructions (Cwm Taf) and Scheme of Delegation</td><td></td><td>Delete text</td></tr>
<tr><td>55</td><td>Annex 2 KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS</td><td>Values and Standards of Behaviour Framework</td><td>Values and Standards of Behaviour Framework - CTMUHB Standards of Behaviour Policy (incorporating declarations of interest, gifts, hospitality, sponsorship and honoraria).</td><td>Include reference</td></tr>
</table>

Page Number	Section	Original	Changed to	Comment
56	Annex 3 JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS	Sub Groups [To be inserted]	Sub Groups EASC Management Group Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) Delivery Assurance Group (DAG) Non-Emergency Patient Transport Service Delivery Assurance Group (NEPTS DAG)	Terms of Reference for sub groups inserted
57	Annex 4 ADVISORY GROUPS AND EXPERT PANELS	Terms of Reference to be included when available	No advisory groups or expert panels at time of approval – September 2023	Update

<table>
<tr><td>Teitl adroddiad:
Report title:</td><td colspan="4">Review of Health Board Scheme of Reserved Delegation</td></tr>
<tr><td>Adrodd i:
Report to:</td><td colspan="4">Audit Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:
Date of Meeting:</td><td colspan="4">Thursday, 16 November 2023</td></tr>
<tr><td>Crynodeb Gweithredol:
Executive Summary:</td><td colspan="4">Following on from the updates that have been made to the Standing Orders and Standing Financial Instructions (SFIs) for the Health Board, a review has also been carried out into the responsibilities of the Board, the Board’s Committees, the Executive Team and Directors and other officers and employees of the Health Board.

Tables A, B and B2 of the Scheme of Reserved Delegation (SoRD) have been updated to reflect the changes from the 2023 Standing Financial Instructions and the review.

The Health Board are being asked to incorporate and adopt the latest version of the Scheme of Reserved Delegation as appropriate.</td></tr>
<tr><td>Argymhellion:
Recommendations:</td><td colspan="4">The Audit Committee is asked to take assurance from the report and support the incorporation and adoption of the revised Scheme of Reserved Delegation by the Board on 30 November 2023.</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="4">Russell Caldicott, Interim Executive Director of Finance</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="4">Andrea Hughes, Interim Finance Director – Operational Finance and Neil Williams, Senior Finance Manager</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td colspan="2">I’w Nodi
For Noting
☐</td><td>I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:
Assurance level:</td><td>Arwyddocaol
Significant
☒
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
</table>

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	There are no associated strategy implications.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Scheme of Delegation is a key component of financial and operational governance within the Standing Financial Instructions of the Health Board
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	None identified as necessary
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	None identified as necessary
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF 2.3 and 2.7 As per the requirement for the achievement of meeting Statutory Financial Duties in accordance with the adoption of Standing Orders for the Health Board
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Appropriate levels of control and delegation will be implemented over budget management and expenditure
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Relevant staff are obliged to be aware of the delegated responsibilities and limits and to adhere to them in undertaking financial proceedings for the Health Board
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF 2.3 and 2.7 As per the requirement for the achievement of meeting Statutory Financial Duties in accordance with the adoption of Standing Orders for the Health Board

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: ***Next Steps:*** To bring the draft Scheme of Reserved Delegation to Board on 30 November 2023 for approval, and following approval, to publish and implement the new model across the Health Board	
Rhestr o Atodiadau: **List of Appendices:** Appendix 1: Proposed Table A - Scheme of Delegated Matters for BCUHB Appendix 2: Table of amendments for proposed SoRD Appendix 3: Proposed Table A - Scheme of Delegated Matters for BCUHB with tracked changes Appendix 4: Proposed Tables B and B2 of Delegated Limits Appendix 5: Tables B and B2 of Delegated Limits approved by Board in August 2022	

Audit Committee 16 November 2023

Review of Scheme of Reserved Delegation for BCUHB

1. Introduction and Background

The Health Board must approve and adopt Standing Orders (SOs) that inform its "ways of working". The whole suite of Standing Orders include:

- Model Standing Orders
- a set of Standing Financial Instructions (SFIs)
- a Scheme of Decisions reserved to the Board;
- a Scheme of Delegations to officers and others; and
- a range of other framework documents set out the arrangements within which the Board, its Committees, Advisory Groups and staff make decisions and carry out their activities.

The Model Standing Orders were presented to Audit Committee and Board in September 2023. The Standing Financial Instructions are presented to Audit Committee at this meeting for review along with these Scheme of Reserved Delegation setting out the Delegated Matters, Responsible Lead and delegated financial limits.

2. Considerations for the Audit Committee

There is a requirement to keep Matters delegated to Board, Committees, the Executive Team and other Directors and Service leads updated and under review to ensure they remain accurate and current. This forms part of the framework that the Health Board must adopt in line with the Standing Orders.

An in depth review of the Scheme of Reserved Delegation (SoRD) has been undertaken since June 2023. Proposed changes to delegated responsibilities have been widely consulted with members of the Executive Team, other relevant Directors, Chief Finance Officers (linking in with their Directorates), the Local Counter Fraud Service and Internal Audit. Integrated Health Communities (IHCs) and Divisions have reviewed their local structures and positions within their service areas for input and consistency with the proposed SoRD.

The Audit Committee has a role to make sure that there are effective arrangements in place in relation to setting the Scheme of Reserved Delegation (SoRD). The charitable funds element will also be presented to the Charitable Funds Committee on 27 November 2023.

The formal incorporation and adoption of the SoRD would be received by the Board for approval at its meeting on 30 November 2023.

All Integrated Health Communities (IHCs) and Divisions must have a local Standard Operating Procedure (SOP) linking activities to the delegated limits set out in Table B2 at a granular level of application within their service area. For example, the Central IHC Ward Manager's £500 general expenditure limit applies to the approval of travel & subsistence, bank staff and staff overtime expenditure.

Appendix 1 – Proposed Table A Scheme of Reserved Delegation (SoRD) contains the final draft schedule of Delegated Matters and responsible Leads to be adopted by the Health Board.

Appendix 2 – Table of amendments for Table A Scheme of Reserved Delegation (SoRD) from the previous version approved by Board.

Appendix 3 – Proposed Table A Scheme of Reserved Delegation (SoRD) contains the draft schedule of Delegated Matters with tracked changes from the previous version approved by Board

Appendix 4 – Proposed Tables B and B2 of Delegated Limits details the responsibilities, approval requirements and financial limits of the draft SoRD to be adopted by the Health Board

Appendix 5 – Tables B and B2 of Delegated Limits approved by Board in August 2022

3. Key changes in the Review of the Standing Orders

The Delegated Matters are carried over from the previous version of the SoRD, with some minor changes and additions, but the delegated responsibility has been reviewed and updated as necessary for each Delegated Matter. These have also been cross-referenced to the Standing Orders and Standing Financial Instructions to ensure they are consistent and are delegated accordingly.

Tables B and B2 have been updated to revise the delegated limits for the roles listed. The Healthcare Agreements column has been extended from the previous version from one column to four columns to distinguish between the different types of agreements and the applicable approval limits and requirements.

Table B2 has also been extended to include the roles which were previously only included in the Operational SoRDs of each service area, setting delegated limits for roles beyond Director level for the services and divisions. Where possible, job roles have been consolidated into bandings of delegated limits to minimise the number of entries in the table.

4. Recommendations

The Audit Committee is asked to take assurance from the report and support the Adoption and Incorporation of the Scheme of Reserved Delegation as part of the Standing Orders and Standing Financial Instructions of the Health Board.

SECTION 2: SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OPERATIONAL BUDGET MANAGERS

The LHB Standing Orders and Standing Financial Instructions specify certain key responsibilities of the Chief Executive, the Executive Director of Finance and other officers.

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

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

Delegated Matter	Table Reference No.
REVIEW OF FIRE PRECAUTIONS	34
HEALTH & SAFETY	35
MEDICINES INSPECTORATE REGULATIONS	36
ENVIRONMENTAL REGULATIONS	37
LEGAL & RISK PAYMENTS	38
INVESTIGATION OF FRAUD/CORRUPTION OR FINANCIAL IRREGULARITIES	39
COMMERCIAL SPONSORSHIP	40
COSTS/NOTIONAL RENT/THIRD PARTY DEVELOPER/IMPROVEMENT GRANTS	41
FREEDOM OF INFORMATION	42
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Schedule 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS

Table A – Scheme of Delegation to Officers

Board Member Responsible: in line with the Standing Orders, delegated approval to the relevant Board Member, Board Committee or Executive Director. Where there is more than one Executive Director named the applicable responsibility is in relation to their individual service area.

Specific Delegation Where Applicable: The intention within the Operating Model is to delegate to the Operational Divisions wherever possible, however some Matters are either delegated through a Director, Associate or Assistant then to the Operational Division, or they are not delegated beyond this secondary level. This column sets out the delegation flow where relevant. Where there is more than one 'Accountable Lead' named the applicable responsibility is in relation to their individual service area.

Operational Responsibility: – where Matters are delegated to the Operational Divisions, the generic term "*Service Director*" has been used to identify the Accountable Lead, for example IHC Director, Director of Mental Health, Cancer, and Support Functions. It is also recognised that these Matters are delegated within Health Board Policy and where relevant are directly supported by Finance, People Services and other Support Functions.

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
1. Standing Orders / Standing Financial Instructions			
a) Final authority in interpretation of Standing Orders	Chair	Not Delegated	Not Delegated
b) Notifying Directors, employees and agents of their responsibilities within the Standing Orders (Board Secretary) and Standing Financial Instructions (Executive Director of Finance) and ensuring that they understand the responsibilities	Executive Director of Finance / Board Secretary	Direct to Operational Services	Service Director** (**Generic Title used for the 'Accountable Lead' across IHC, Pan BCU, Regional Directors and Support Functions)
c) Responsibility for the security of the LHB's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial Instructions and financial procedures	Executive Director of Finance	Direct to Operational Services	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
d) Ensuring Standing Orders are compatible with Welsh Government requirements re building and engineering contracts	Chief Executive	Executive Director of Finance	Not Delegated
2. Meetings			
a) Calling meetings of the LHB	Chair	Board Secretary	Not Delegated
b) Chair all LHB Board meetings and associated responsibilities	Chair or Vice Chair in Chair's absence	Not Delegated	Not Delegated
3. Financial Planning/Budgetary Responsibility			All Matters locally supported by CFO / FD
a) Setting: Submit Three Year Plan and Annual Operating Plan to the LHB Board	Chief Executive	Executive Director of Transformation, Strategic Planning & Commissioning	Not Delegated
Submit budgets to the LHB Board	Chief Executive	Executive Director of Finance	Not Delegated
Submit to Board financial estimates and forecasts	Chief Executive	Executive Director of Finance	Not Delegated
b) Implementing financial policies, plans and procedures, providing advice and co-ordinating any corrective action necessary	Executive Director of Finance	Finance Director: Operational Finance	Service Director
c) Issuing Budgets	Executive Director of Finance	Finance Director: Operational Finance	Service Director
d) Monitoring: Monitor performance against budget	Executive Director of Finance	Executive and Associate Directors	Service Director
Submit monitoring returns (WHC requires approval by both CEO and EDoF, if not available these are delegated to their deputies)	Chief Executive and Executive Director of Finance	Finance Director: Operational Finance and Deputy Chief Executive	Not Delegated
Effective budgetary control and a balanced budget	Executive Director of Finance	Executive and Associate Directors	Service Director
Preparation of annual accounts and returns	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Identifying and implementing cost improvements and income generation initiatives	Executive Director of Finance	Executive and Associate Directors	Service Director
e) Authorisation of Virement It is not possible for any officer other than the Executive Director of Finance to vire from non-recurring headings to recurring budgets or from capital to revenue/revenue to capital. Virement between different budget holders (Service Directors) requires the agreement of both parties.	Executive Director of Finance	Please refer to Table B – Delegated Limits	Service Director
f) Maintaining an effective system of internal financial control	Chief Executive	Executive Director of Finance	Service Director
g) Delivery of financial training to budget holders (Directors)	Executive Director of Finance	Finance Director: Operational Finance	Service Director
4. Bank/PGO Accounts (Excluding Charitable Fund Accounts)			
a) Operation: Managing banking arrangements and operation of bank accounts	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
Opening bank accounts	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
Authorisation of transfers between LHB bank accounts	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
Authorisation of: -PGO/GBS Schedules -BACS Schedules -Automated cheque schedules -Manual cheques	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated to Service Directors. NOTING that Senior Finance Staff (CFO / FD) authorise contract / SLA / RIF payments
5. Non Pay Expenditure			
For details of Delegated Limits refer to Table B			
a) Completion of an Operational Scheme of Delegation and Authorisation by each Budget Holder ensuring maintenance of a list of officers authorised to place requisitions/orders (including emergency verbal orders) and record receipts within the E-Financials Business Suite.	Chief Executive	Executive and Associate Directors	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
b) Obtain the best value for money when requisitioning goods/services	Executive Director of Finance	Executive and Associate Directors	Service Director
c) Ensuring expenditure is within budget	Chief Executive	Executive and Associate Directors	Service Director
d) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive	Executive Director of Finance	Service Director
e) Orders exceeding 12 month period	Executive Director of Finance	Finance Director: Operational Finance	Service Director
f) Prompt payment of accounts	Executive Director of Finance	Direct to Operational Services	Service Director
g) Financial Limits	Executive Director of Finance	Direct to Operational Services → Refer to Table B for Delegated Limits	Service Director Per Table B
h) Maintenance of sufficient records to explain the LHB's transactions and report on the LHB's financial position	Executive Director of Finance	Finance Director: Operational Finance	Service Director
i) Provision of electronic signature / approval within the E-Financials Business Suite in accordance with each Budget Holder's Operational Scheme of Delegation and Authorisation	Executive Director of Finance	Finance Director: Operational Finance	Service Director
6. Stores and Receipt of Goods			
a) Responsibility for the systems of financial control over all stores including receipt of goods and returns	Executive Director of Finance	Direct to Operational Services	Service Director
b) Responsibility for the control of stores and of goods, issues and returns: (excluding pharmaceutical stock: see below)	Chief Executive	Executive Director of Finance	Service Director
Pharmaceutical Stores	Chief Executive	Chief Pharmacist	Service Director Via Head of Medicines Management
c) Stocktaking arrangements	Executive Director of Finance	Direct to Operational Services	Service Director
7. Capital Investment Management For details of Delegated Limits for Delegated Matter 7d), please refer to Table B – Leases.			

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
In accordance with Welsh Government guidance:			
a) Programme:			
Preparation of Capital Investment Programme	Chief Executive	Executive Director of Transformation, Strategic Planning & Commissioning	Service Director
Completion and signing off of a business case for approval	Chief Executive	Executive Director of Finance	Service Director
Appointment of Project Directors	Chief Executive	Executive Director of Finance with support from relevant Directors	Not Delegated
Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Executive Director of Finance	Executive and Associate Directors.	Service Director
Issuing of guidance on management of capital schemes	Executive Director of Transformation, Strategic Planning & Commissioning and Executive Director of Finance	Executive and Associate Directors.	Not Delegated
b) Contracting – Selection of 3rd party developers, architects, quantity surveyors, consultant engineers and other professional advisors within EC regulations and LHB tender procedures	Chief Executive	Executive Director of Finance	Not Delegated
c) Private Finance – Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector	Chief Executive	Executive Director of Finance	Not Delegated
d) Leases – Granting and termination of leases	Chief Executive	Executive Director of Finance	Not Delegated
e) Financial control and audit- Arrangements are in place to review building and engineering contracts and property transactions comply with Welsh Government guidance.	Chief Executive	Executive Director of Finance	Not Delegated
8. Quotations, Tendering & Contract Procedures For details of Delegated Limits, please refer to Table B – Quotations/Tenders.			All Matters locally supported by CFO / FD
a) Services:			

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Direct to Operational Services	Service Director
Nominate officers to oversee and manage the contract on behalf of the LHB	Chief Executive	Direct to Operational Services	Service Director
b) Quotations – Total value of the contract over its entire period:			
Seeking quotations up to £5,000 in value	Chief Executive	Executive Director of Finance	Service Director
Obtaining minimum of 3 written quotations for goods/services of value between £5,000 and £25,000	Chief Executive	Executive Director of Finance	Service Director
c) Competitive Tenders – Total value of the contract over its entire period:			
Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and the OJEU threshold (in compliance with EU Procurement Directives and UK Procurement Regulations as appropriate)	Chief Executive	Executive Director of Finance	Service Director
Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of the OJEU threshold (in compliance with EU Procurement Directives and UK Procurement Regulations as appropriate)	Chief Executive	Executive Director of Finance	Service Director
Receipt and custody of tenders prior to opening	Executive Director of Finance	Direct to Operational Services	Service Director
Opening Tenders and Quotations	Executive Director of Finance	Direct to Operational Services	Service Director
Decide if late tenders should be considered	Executive Director of Finance	Direct to Operational Services	Service Director
d) Waiving the requirement to request quotes or tenders – subject to Schedule 2.1 Standing Financial Instructions Section 11.133 – Formally reported to the Audit Committee	Chief Executive	Executive Director of Finance or Chief Executive if above £25,000, The Chief Executive and Director of Finance cannot approve their own waiver and must seek approval from one other Executive Director	Service Director All Single Tender Waivers (STW's) must be approved by NWSSP and by the Executive Director of Finance **before** any commitment is made.
9. Fixed Assets			
a) Maintenance of asset register	Chief Executive	Executive Director of Finance	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
b) Apply accounting policies (including depreciation and revaluations) in accordance with Welsh Government requirements	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
c) Responsibility for fixed assets – Land & Buildings	Chief Executive	Executive Director of Finance	Director of Capital and Estates
d) Responsibility for all other fixed assets (Plant, Machinery, Transport, IT assets including software, Furniture & Fittings)	Chief Executive	Executive Director of Finance	Director of Capital and Estates, Chief Digital and Information Officer and Deputy CEO with support from relevant Directors.
e) Responsibility for security of LHB assets including notifying discrepancies to the Director of Finance and reporting losses in accordance with LHB procedures	Chief Executive	Executive Director of Finance, with support from relevant Directors.	Service Director
10. Personnel & Pay			All Matters locally supported by CFO / FD / People
a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts in accordance with the "Policy for the Safe Recruitment and Selection Practices" together with accompanying guidance, particularly the need for pre-employment checks.	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
b) Approve the commencement of employment prior to all pre-employment checks being completed.	Executive Director of Workforce & OD	Associate Director People Services	Service Director
c) Authority to fill funded post on the establishment with permanent staff.	Executive Director of Workforce & OD	Deputy Director Workforce & OD / Associate Director of People Services (IHC / PAN BCU / Support Services)	Service Director
d) The granting of additional increments to staff within budget in accordance with Terms & Conditions of Service	Executive Director of Workforce & OD	Executive Directors with advice from Associate Director of People Services	Service Director
e) All requests for upgrading/ regrading/ major skill mix changes shall be dealt with in accordance with LHB Procedure	Executive Director of Workforce & OD	Executive Directors with advice from Associate Director of people Services	Service Director
f) Authority to agree acting up salaries for staff other than Executive Directors, within budget (Approval of acting up salaries for interim Executive Directors to	Chief Executive to agree acting up	Executive Directors lead for acting up salaries up to Band 9 or equivalent.	Service Director Up to Band 9 or equivalent only.

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
be retained by Remuneration & Terms of Service Committee)	arrangements of Band 9 and above (Excluding Executive Directors)		
g) Establishments:			
Locum/additional staff to the agreed establishment **with** specifically allocated finance	Executive Director of Workforce & OD / Executive Director of Finance	Direct to Operational Services	Service Director
Locum/additional staff to the agreed establishment **without** specifically allocated finance.	Chief Executive	Executive Director of Finance and Executive Director of Workforce & OD	Service Director (via ECR & Budget Virement)
Variation to the funded establishment	Chief Executive	Executive Director of Workforce & OD and Executive Director of Finance	Service Director (Via ECR & Budget Virement)
h) Pay			
Authority to complete standing data forms effecting pay, new starters, changes and leavers. Responsibility to ensure forms are processed in timely manner to prevent errors occurring.	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Authority to complete and authorise timesheets and payroll returns	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Authority to authorise overtime	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Authority to authorise travel & subsistence expenses	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Maintenance of a list of managers authorised to sign payroll and travel expense documentation. (and via e-expense systems)	Executive Director of Workforce & OD	Deputy Director of Workforce & OD	Service Director
Responsibility for the recovery of any overpayments	Executive Director of Finance	Finance Director: Operational Finance	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
i) Leave			
Approval of annual leave in accordance with LHB policy	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Carry-over of annual leave in exceptional circumstances up to a maximum of 5 days	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Compassionate leave	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Special leave arrangements (to be applied in accordance with All Wales Policy)	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Leave without pay	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Medical Staff Leave of Absence – paid and unpaid	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Consultants Special Leave	Executive Medical Director	Direct to Operational Services	Service Director
Time off in lieu	Executive Director of Workforce and OD	Direct to Operational Services	Service Director
Maternity / Paternity Leave – paid and unpaid	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
j) Annualised hours/flexible working hours system- maintenance of adequate records	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
k) Sick Leave			
Extension of sick leave on half pay up to three months	Executive Director of Workforce & OD	Direct to Operational Services in conjunction with Associate Director of People Services	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Return to work part-time on full pay to assist recovery	Executive Director of Workforce & OD	Direct to Operational Services in conjunction with Associate Director of People Services	Service Director
Extension of sick leave on full pay	Executive Director of Workforce & OD	Direct to Operational Services in conjunction with Associate Director of People Services	Service Director
l) Study Leave			
Study leave outside the UK (non-medical staff excluding clinical staff)	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Medical staff study leave (UK)	Executive Medical Director / Executive Director of Workforce & OD	Direct to Operational Services	Service Director
Consultant Medical Staff Leave (UK)	Executive Medical Director	Direct to Operational Services	Service Director
All Medical and non-Medical Clinical Staff study leave outside the UK (as per relevant professional lead)	Executive Medical Director / Executive Director of Nursing & Midwifery / Executive Director of Therapies & Health Science / Executive Director of Operations	Direct to Operational Services	Service Director
All other study leave (UK)	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
m) Removal Expenses			
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Executive Director of Workforce & OD	Direct to Operational Services → In accordance with BCUHB policy / approval from the	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
		Executive Director of Workforce & OD	
n) Respect & Resolution Procedure	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
o) Professional Misconduct/Competence- Medical and Dental Staff	Executive Medical Director / Executive Director of Workforce & OD	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
p) Suspension of Doctors employed directly by the LHB	Executive Medical Director	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
q) Formal actions as required under The Performers List	Chief Executive	Executive Medical Director supported by Executive Director of Workforce & OD and Executive Director of Operations	Not Delegated to Operational Divisions, cover for Executive Medical Director provided through the Deputy Responsible Officer or Deputy Medical Director
r) Requests for new posts to be authorised as car users	Executive Director of Finance	Direct to Operational Services	Service Director
s) Renewal of Fixed Term Contract	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
t) Voluntary Early Release Scheme	Remuneration and Terms of Service Committee (supported by Executive Director of Workforce & OD)	Executive Director of Workforce & OD, with Executive Director of Finance for sign off of financial viability	Not Delegated
u) Settlement on termination of employment	Remuneration and Terms of Service Committee (supported by Executive	Executive Director of Workforce & OD with approval from Welsh Government where the payment is Ex-gratia and exceeds the	Not Delegated. Service Directors to operate within Policy as set through the

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
	Director of Workforce & OD)	delegated limit of £50,000	Executive Director of Workforce & OD
v) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from Workforce & OD Department	Executive Director of Workforce & OD	Associate Director of People Services	Service Director for local implementation: Ultimate Approval is via NHS Pensions Agency
w) Disciplinary Procedure (excluding Executive Directors)	Executive Director of Workforce & OD	Executive Directors	Service Director
11. Engagement of Staff Not On the Establishment			
For details of Delegated Limits, please refer to Table B			All Matters locally supported by CFO / FD / People
a) Non clinical Consultancy Staff	Executive Director of Finance	Direct to Operational Services	Service Director
b) Medical Locum staff	Executive Medical Director	Direct to Operational Services	Service Director
c) Booking of Agency Nursing Staff	Executive Director of Nursing & Midwifery	Direct to Operational Services	Service Director
d) Booking of Bank Staff:			
Nursing	Executive Director of Nursing & Midwifery	Direct to Operational Services	Service Director
Other	Executive Director of Workforce & OD	Direct to Operational Services	Service Director
12. Charitable Funds Held on Trust	Overall the Health Board Charitable Funds are managed through Awyr Las and through the Charitable Funds Committee and its formal Trustee status		
For details of Delegated Limits, Please refer to Table B			All Matters locally supported by CFO / FD
a) Management:			

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Funds held on Trust are managed appropriately	Executive Director of Finance	Direct to Operational Services	Service Director
b) Maintenance of authorised signatory list of Authorised Fund Holders	Executive Director of Finance	Direct to Operational Services	Service Director
c) Expenditure	Executive Director of Finance	Direct to Operational Services → Refer to Table B – Delegated limits	Service Director
d) Fundraising Appeals – Preparation/Monitoring/Reporting progress and performance	Director of Communications and Partnerships	Fundraising manager	Service Director Via Awyr Las
e) Operation of Bank Accounts:			
Managing banking arrangements and operation of bank accounts	Executive Director of Finance in conjunction with Corporate Trustees	Not Delegated	Not Delegated
Opening bank accounts	Corporate Trustee	Executive Director of Finance	Not Delegated
f) Investments – Policy and Arrangements	Executive Director of Finance in conjunction with Corporate Trustees	Not Delegated	Not Delegated
g) Authority to accept the discharge of a donor's estate	Executive Director of Finance	Not Delegated	Via Awyr Las
13. Primary Care Patient Services/ Healthcare Agreements For details of Delegated Limits, please refer to Table B – Healthcare Agreements			**SEE TABLE B FOR SPECIFIC SENIOR POSTS & £ LIMITS**
a) Contract negotiation and provision of service agreements	Chief Executive	Executive Director of Finance / Executive Director of Operations	System Oversight
b) Reporting actual and forecast contract income	Executive Director of Finance	Finance Director: Operational Finance	System Oversight (supported by Finance)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
c) Pricing of all contracts and SLAs	Executive Director of Finance	Executive Director of Finance with relevant Director (including Associate Director of Healthcare Contracting)	Not Delegated
d) Signing agreements	Chief Executive	Chief Executive or Executive Director of Finance in Chief Executive's absence / Executive Director of Operations for all primary care related agreements	Service Director (see Table B for specific limits and arrangements)
14. Income Systems, Fees and Charges			All Matters locally supported by CFO / FD
a) Private Patients, Overseas Visitors, Income Generation and other patient related services	Executive Director of Finance	Associate Director of Healthcare Contracting	Service Director
b) Pricing of NHS agreements	Executive Director of Finance	Associate Director of Healthcare Contracting	Not Delegated
c) Informing the Director of Finance of monies due to the LHB	Executive Director of Finance	Direct to Operational Services	Service Director
d) Recovery of debt	Executive Director of Finance	Finance Director: Operational Finance.	Not Delegated
e) Security of cash and other negotiable instruments	Executive Director of Finance	Finance Director: Operational Finance.	Service Director
f) Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due	Executive Director of Finance	Finance Director: Operational Finance	Service Director
g) Non patient care income	Executive Director of Finance	Finance Director: Operational Finance.	Service Director
15. Disposal and Condemnations Disposal of all property and land requires formal approval by the Minister for Health and Social Services			

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
a) Issuing procedure for the disposal of assets obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	Executive Director of Finance	Not Delegated	Not Delegated
b) Notification to Executive Director of Finance prior to disposal	Executive Director of Finance	Director of Capital and Estates	Service Director
16. Losses, Write-offs & Compensation			
The delegated limits stated below, as specified within Welsh Government's Losses and Special Payments Guidance in Manual for Accounts Chapter 6, relate to the requirement to obtain written approval from the Welsh Government H&SSG Director of Finance for write-off of losses or special payments above these limits. Audit Committee to regularly receive Schedule of Losses and Special Payments.			
a) Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response plan and informing the Board, External Auditor and Counter Fraud Operational Services of frauds.	Executive Director of Finance	Finance Director: Operational Finance.	Service Director For Implementation and compliance with BCU Procedure
b) Losses of cash due to theft, fraud, overpayment of salaries, fees, allowances & other causes up to £50,000	Chief Executive	Executive Director of Finance	Not Delegated
c) Fruitless payments (including abandoned Capital Schemes) up to £250,000	Chief Executive	Executive Director of Finance	Not Delegated
d) Bad debts and claims abandoned: Private patients; overseas visitors & other cases up to £50,000	Chief Executive	Executive Director of Finance	Not Delegated
e) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other up to £50,000	Chief Executive	Executive Director of Finance	Not Delegated
f) For personal and public liability claims, under the Legal & Risk scheme, authorisation from Legal & Risk is required before admissions may be made and monetary compensation offered. (Ex-gratia settlements offered by the LHB are by definition not payments based upon legal liability and are, therefore, not reimbursable under the WRP scheme)	Chief Executive	Executive Medical Director supported by the relevant Director after seeking appropriate legal advice, up to a max £500,000	Deputy Director of Quality Governance
g) Compensation payments made under legal obligation:	Chief Executive	Executive Director of Finance or Executive Medical Director	Deputy Director of Quality Governance

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
h) Extra contractual payments to contractors up to £50,000	Chief Executive	Executive Director of Finance with reporting to the Audit Committee	Not Delegated
16.1 Ex-Gratia Payments: The delegated limits stated below, as specified within Welsh Government's Losses and Special Payments Guidance in the Manual for Accounts Chapter 6, relate to the requirement to obtain written approval from the Welsh Government H&SSG Director of Finance for write-off of losses or special payments above these limits. Audit Committee to regularly receive Schedule of Losses and Special Payments.			
a) Patients and staff for loss of personal effects up to £50,000	Chief Executive	Executive Director of Finance- Refer to Finance Policy on Losses and Special Payments	Service Directors to Implement: financial approval remains within Finance Department per Policy
b) For clinical negligence up to £250,000 including plaintiff's costs (negotiated settlements following legal advice)*.	Chief Executive	Executive Director of Finance / Executive Medical Director	Deputy Director of Quality Governance
c) For clinical negligence over £250,000 and up to £1,000,000 including plaintiff's costs (negotiated settlements following legal advice)*.	Chair Board	Chief Executive / Executive Director of Finance / Executive Medical Director	Deputy Director of Quality Governance
d) For personal injury claims involving negligence up to £250,000 including plaintiff's costs (where legal advice obtained and relevant guidance has been applied) *	Board	Chief Executive / Executive Director of Finance / Executive Medical Director	Deputy Director of Quality Governance
e) For personal injury claims involving negligence over £250,000 and up to £1,000,000 (where legal advice obtained and relevant guidance has been applied) *	Board	Chief Executive / Executive Director of Finance / Executive Medical Director	Deputy Director of Quality Governance
f) Other, except cases for maladministration where there was no financial loss by claimant, up to £50,000	Chief Executive	Executive Director of Finance / Executive Medical Director	Deputy Director of Quality Governance
* For all clinical negligence and personal injury cases (including Court cases) the use of structured settlements should be considered involving costs to the NHS of £250,000 or more **– All structured settlements require approval from the Welsh Government H&SSG Director of Finance**	Board	Chief Executive / Executive Director of Finance / Executive Medical Director	Deputy Director of Quality Governance

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
17. Procedure to follow after reporting of incidents to the Police (refer to Standing Operating Process in relation to reporting requirement to Security Advisors)			
a) Where a criminal offence is suspected	Executive Director of Finance and Executive Director of Workforce & OD	Direct to Operational Services	Service Director For Implementation and compliance
b) Criminal offence of a sexual or violent nature	Executive Director of Workforce & OD	Direct to Operational Services	Service Director For implementation and compliance
c) Arson or theft	Executive Director of Finance and Executive Director of Workforce & OD	Direct to Operational Services	Service Director for implementation and compliance
d) Other	Chief Executive and Executive Director of Finance and Executive Director of Workforce & OD	Direct to Operational Services → dependent upon the nature of the suspected offence	Service Director for implementation nd compliance
18. Financial Procedures			
a) Maintenance & Update of LHB Financial Procedures	Executive Director of Finance	Finance Director : Operational Finance	Not Delegated
19. Audit Arrangements			
a) Review, appraise and support in accordance with Public Sector Internal Audit Standards for NHS Wales and best practice	Chair of the Audit Committee	Board Secretary / Head of Internal Audit	Not Delegated
b) Provide an independent and objective view on internal control and probity	Board Secretary	Head of Internal Audit / Audit Wales	Not Delegated
c) Ensure Cost-effective external audit	Chair of Audit Committee	Executive Director of Finance	Not Delegated
d) Ensure an adequate internal audit service	Chief Executive	Board Secretary	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
e) Implement recommendations	Board Secretary	Direct to Operational Services	Service Director
20. Legal Proceedings			
a) Engagement of LHB's Solicitors	Chief Executive	Board Secretary for all Board related matters / Executive Director of Workforce & OD for all employment related matters / Executive Director of Finance for all estate related matters / Executive Medical Director, Executive Director of Transformation, Strategic Planning & Commissioning and Executive Director of Operations for all Primary Care related matters. Deputy Director of Quality Governance for claims, inquest, MHA, COP and general healthcare legal matters.	Service Director (Associate Director People Services for employment matters). Out of Hours approval via Gold On-Call.
b) Approve and sign all documents which will be necessary in legal proceedings	Chief Executive	Executive Medical Director or any Executive Director of the Board or an Officer formally nominated by the Chief Executive / Deputy Director of Quality Governance for claims, inquest, MHA, COP and general healthcare legal matters.	Not Delegated
c) Sign on behalf of the LHB any agreement or document not requested to be executed as a deed	Chief Executive	Any Executive Director of the Board or an officer formally nominated by the Chief Executive	Not Delegated
21. Insurance Policies (incorporating Risk Management)	Chief Executive	Executive Director of Finance and Executive Medical Director	Not Delegated except for Welsh Risk Pool which is delegated to the Deputy Director of Quality Governance

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
22. Clinical Audit	Chief Executive	Executive Medical Director	Not Delegated
23. Patients' Property (in conjunction with financial advice)			
For details of Delegated Limits, please refer to Table B – Petty Cash/Patients Monies			
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Direct to Operational Services	Service Director
b) Prepare detailed written instructions for the administration of patients' property	Executive Director of Finance	Direct to Operational Services	Service Director
c) Informing staff of their duties in respect of patients' property	Executive Director of Finance	Direct to Operational Services	Service Director
d) Issuing property valued >£5,000 only on production of a probate letter of administration	Executive Director of Finance	Finance Director : Operational Finance	Not Delegated
24. Putting Things Right Regulations (in line with WRP Policy & Guidance)			
a) Overall responsibility for ensuring that all concerns (as defined in PTR Regulations) are dealt with effectively	Chief Executive	Executive Director of Nursing & Midwifery / Deputy Director of Quality Governance	Service Director Patient Safety Team, and Patient and Carer Experience/Complaints Team for implementation
b) Responsibility for ensuring complaints are investigated thoroughly, and learning is embedded.	Chief Executive	Executive Director of Nursing & Midwifery / Deputy Director of Quality Governance	Service Director and Patient and Carer Experience/Complaints Team for implementation
c) Medical – Legal Complaints Co-ordination of their management	Chief Executive	Executive Director of Nursing & Midwifery / Deputy Director of Quality Governance	Service Director For implementation
25. Seal			
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Board Secretary	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
b) Attestation of seal in accordance with Standing Orders	Chief Executive and Chair	Board Secretary	Not Delegated
c) Signing and sealing documents in accordance with Standing Orders	Chief Executive and Chair	Board Secretary	Not Delegated
26. Gifts and Hospitality			
a) Keeping of gifts and hospitality register	Chief Executive	Board Secretary	Service Director for implementation and compliance
27. Declaration of Interests			
a) Maintaining a register of interests	Chief Executive	Board Secretary	Service Director for implementation and compliance
28. Informatics and the Data Protection Act			
a) Review of LHB's compliance with the Data Protection Act	Chief Executive	Chief Digital and Information Officer	Data Protection Officer
b) Responsibility for Informatics policy and strategy	Chief Executive	Chief Digital and Information Officer	Service Director
c) Responsibility for ensuring that adequate management (audit) trails exist in Informatics systems	Chief Executive	Chief Digital and Information Officer	Service Director
29. Records			
a) Review LHB's compliance with the Retention of Records Act and guidance	Chief Executive	Chief Digital and Information officer / Executive Medical Director	Not Delegated
b) Approval for the destruction of records	Chief Executive	Director of Digital / Executive Medical Director	Service Director / Assistant Director of Compliance and Business Management
c) Ensuring the form and adequacy of the financial records of all departments	Executive Director of Finance	Finance Director: Operational Finance	Service Director
30. Authorisation of New Drugs	Chief Executive	Executive Medical Director on the advice of the appropriate professional bodies (Clinical approval via	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
		NICE Implementation Group and Drugs and Therapy Group for onward financial approval by Senior Leadership Team, see Table B for delegated limits)	
31. Authorisation of Research Projects (individuals responsible for their own declaration of interest to UKPI and BCUHB)	Executive Medical Director	Director of Research & Development	Service Director
32. Authorisation of Clinical Trials	Chief Executive	Executive Medical Director	Service Director
33. Infectious Diseases & Notifiable Outbreaks – outbreak control / public health monitoring and surveillance / provision of public health advice	Chief Executive	Executive Director of Public Health	Not Delegated
34. Review of Fire Precautions	Chief Executive	Executive Director of Finance	Not Delegated
35. Health & Safety			
Review of all statutory compliance legislation and Health and Safety requirements (including associated mandatory staff awareness training).	Chief Executive	Executive Director of Workforce & OD	Not Delegated
36. Medicines Inspectorate Regulations			
Review Regulations Compliance	Chief Executive	Executive Medical Director supported by Chief Pharmacist	Service Director via Head of Medicines Management
37. Environmental Regulations			
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Executive Director of Finance	Director of Capital and Estates	Not Delegated
38. Legal & Risk Payments	Chief Executive	Executive Medical Director / Executive Director of Finance /	Not Delegated **See Table B**

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
		Deputy Director of Quality Governance	
39. Investigation of Fraud, Bribery and Corruption or Financial Irregularities	Executive Director of Finance	Lead Local Counter Fraud Specialist	Not Delegated
40. Commercial Sponsorship			
Agreement to proposal in accordance with BCU HB procedures	Chief Executive	Executive Director of Finance	Not Delegated
41. Cost/Notional Rent/Third Party Developer/Improvement Grants			All Matters locally supported by CFO / FD
Approval of all schedules of payments	Chief Executive	Executive Director of Operations	Service Director
Submission to Welsh Government for all new GP premises or major extensions in accordance with BCU HB Primary Care Estates Strategy	Chief Executive	Executive Director of Operations	Not Delegated
42. Freedom of Information	Chief Executive	Chief Digital and Information officer	Assistant Director of Compliance and Business Management
43. Compliance Lead Roles:			
a) Caldicott Guardian	Chief Executive	Executive Medical Director	Deputy Medical Director
b) Data Protection Officer	Chief Executive	Data Protection Officer	Head of Information Governance
c) Senior Information Risk Owner	Chief Executive	Chief Digital Information Officer	Not Delegated
44. Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)	Chief Executive	Executive Director of Operations	Not Delegated
45. National Health Services (Wales) Act 2006 Section 33 Agreements: Arrangements between NHS Bodies and Local Authorities	Chief Executive	Executive Director of Finance	Service Director (CFO / FD Supported) **See also Table B**

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
46. Statutory compliance with respective Legislation	Chief Executive	Board Secretary	Service Director for implementation
47. National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 (Statutory Instrument 2005: 3039) Appointment of all Medical and Dental Consultant posts. Consultant posts within Public Health that are open to both medically qualified and those qualified in other disciplines other than medicine should follow this process, even though they fall outside of the requirements of the Statutory Instrument.	Board	Chair of ACC's	Not Delegated
48. All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR)	Chief Executive	WHSSC IPFR Panel £300,000 to £1,000,000; Chief Executive up to £299,999; Chair and Vice Chair of Health Board IPFR Panel together sign up to £125,000	Not Delegated
*** The IPFR Panel cannot make policy decisions for the health board. Any policy proposals arising from their considerations and decisions must be reported to the Health Board Quality, Safety & Experience Committee**			
49. Human Tissue Act 20014	Chief Executive	Executive Medical Director	Service Director for implementation
50. Ionising Radiation (Medical Exposure) Regulations 2017	Chief Executive	Executive Director of Therapies & Health Sciences / Executive Medical Director	Service Director for implementation
51. Nurse Staffing Levels Act (Wales) 2016	Chief Executive	Executive Director of Nursing & Midwifery	Service Director for implementation
52. Welsh Language Standard Reporting	Chief Executive	Executive Director of Public Health	Service Director for implementation
53. Controlled Drugs Accountable Officer	Chief Executive	Chief Pharmacist	Not Delegated
54. Upholding Professional Standards in Wales (UPSW): **Responsible Officer**	Executive Medical Director (SRO)	Deputy Medical Director (Deputy Responsible Officer)	Service Director for implementation

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Appointing a Designated Board Member	Health Board Chair	Remuneration & Terms of Service Committee	Not Delegated

Appendix

Table of Amendments for Scheme of Reservation and Delegation of Powers – Table A, Scheme of Delegation to Officers

Page Number	Section	Original	Changed to	Comment
1	Contents Table	UNALLOCATED 5		Deleted as not required
2	Contents Table	CARBON REDUCTION COMMITMENT ORDER 50		Deleted as not required
3	Board Member Responsible		Where there is more than one Executive Director named the applicable responsibility is in relation to their individual service area.	Additional text
3	Specific Delegation Where Applicable		Where there is more than one 'Accountable Lead' named the applicable responsibility is in relation to their individual service area	Additional text
3	1b)	Notifying Directors, employees and agents of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Notifying Directors, employees and agents of their responsibilities within the Standing Orders (Board Secretary) and Standing Financial Instructions (Executive Director of Finance) and ensuring that they understand the responsibilities	Additional text
4	3d) Submit monitoring returns	Submit monitoring returns	Submit monitoring returns (WHC requires approval by both CEO and EDoF, if not available these are delegated to their deputies)	Additional text
		Chief Executive	Chief Executive and Executive Director of Finance	Additional delegated responsibility
		Executive Director of Finance	Finance Director: Operational Finance and Deputy Chief Executive	Additional delegated responsibility
4	3d) Preparation of annual accounts and returns	Executive Director of Finance	Finance Director: Operational Finance	Change in delegated responsibility
6	5a)	Executive Director of Finance	Chief Executive	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
6	5f)	Executive Director of Finance	Direct to Operational Services	Change in delegated responsibility
		Not Delegated	Service Director	Change in delegated responsibility
6	6b) Responsibility for the control of stores and of goods, issues and returns	Executive Director of Finance	Chief Executive	Change in delegated responsibility
		Direct to Operational Services	Executive Director of Finance	Change in delegated responsibility
6	6b) Pharmaceutical Stores	Executive Medical Director	Chief Executive	Change in delegated responsibility
7	7a) Preparation of Capital Investment Programme	Executive Director of Finance	Executive Director of Transformation, Strategic Planning & Commissioning	Change in delegated responsibility
7	7a) Completion and signing off of a business case for approval	Executive Director of Finance	Chief Executive	Change in delegated responsibility
		Director of Finance: operations	Executive Director of Finance	Change in delegated responsibility
7	7a) Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Executive Director of Finance with support from relevant Directors	Executive and Associate Directors.	Change in delegated responsibility
7	7a) Issuing of guidance on management of capital schemes	Executive Director of Finance	Executive Director of Transformation, Strategic Planning & Commissioning and Executive Director of Finance	Additional delegated responsibility
		Executive Director of Finance with support from relevant Directors	Executive and Associate Directors	Change in delegated responsibility
8	8b) Seeking quotations up to £5,000 in value	Executive Director of Finance	Chief Executive	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
		Direct to Operational Services	Executive Director of Finance	Change in delegated responsibility
8	8b) Obtaining minimum of 3 written quotations for goods/services of value between £5,000 and £25,000	Chief Executive, Executive Director of Finance	Chief Executive	Change in delegated responsibility
		Direct to Operational Services	Executive Director of Finance	Change in delegated responsibility
8	8c)	Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and the OJEU threshold (in compliance with EC Directives as appropriate)	Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and the OJEU threshold (in compliance with EU Procurement Directives and UK Procurement Regulations as appropriate)	Updated legislation
8	8c) Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and the OJEU threshold (in compliance with EU Procurement Directives and UK Procurement Regulations as appropriate)	Executive Director of Finance	Chief Executive	Change in delegated responsibility
		Direct to Operational Services	Executive Director of Finance	Change in delegated responsibility
8	8c)	Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of the OJEU threshold (in compliance with EC Directives as appropriate)	Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of the OJEU threshold (in compliance with EU Procurement Directives and UK Procurement Regulations EC Directives as appropriate)	Updated legislation
	8c) Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of the OJEU threshold (in compliance with EU Procurement Directives and	Executive Director of Finance	Chief Executive	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
	UK Procurement Regulations as appropriate)			
		Direct to Operational Services	Executive Director of Finance	Change in delegated responsibility
9	8d)	Waiving the requirement to request quotes or tenders – subject to SFI Schedule Pars 4.2 & 4.3 – Formally reported to the Audit Committee	Waiving the requirement to request quotes or tenders – subject to Schedule 2.1 Standing Financial Instructions Section 11.133 – Formally reported to the Audit Committee	Updated legislation
		Executive Director of Finance	Chief Executive	Change in delegated responsibility
		Finance Director: Operational Finance (escalation to the Executive Director of Finance or Chief Executive if necessary) The Chief Executive and Director of Finance cannot approve their own waiver and must seek approval from one other Executive Director	Executive Director of Finance or Chief Executive if above £25,000, The Chief Executive and Director of Finance cannot approve their own waiver and must seek approval from one other Executive Director	Change in policy
		All Single Tender Waivers (STW's) must be approved by NWSSP and by the Operational Finance Director **before** any commitment is made.	All Single Tender Waivers (STW's) must be approved by NWSSP and by the Executive Director of Finance **before** any commitment is made.	Change in policy
9	9a)	Executive Director of Finance	Chief Executive	Change in delegated responsibility
		Finance Director: Operational Finance	Executive Director of Finance	Change in delegated responsibility
9	9b)	Calculate and pay capital charges in accordance with Welsh Government requirements	Apply accounting policies (including depreciation and revaluations) in accordance with Welsh Government requirements	Change in policy
9	9c)	Executive Director of Finance	Chief Executive	Change in delegated responsibility
		Director of Estates	Executive Director of Finance	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
		Not Delegated	Director of Estates	Change in delegated responsibility
9	9d)	Executive Director of Finance	Chief Executive	Change in delegated responsibility
		Director of Estates and Director of Digital, Deputy CEO with support from relevant Directors	Executive Director of Finance	Change in delegated responsibility
		Service Director	Director of Estates, Chief Digital and Information Officer and Deputy CEO with support from relevant Directors.	Change in delegated responsibility
10	10g) Variation to the funded establishment	Executive Director of Workforce & OD / Executive Director of Finance	Chief Executive	Change in delegated responsibility
		Direct to Operational Services with budget virement approval in line with Executive Director of Finance policy	Executive Director of Workforce & OD and Executive Director of Finance	Change in delegated responsibility
10	10h)	Authority to complete standing data forms effecting pay, new starters, changes and leavers.	Authority to complete standing data forms effecting pay, new starters, changes and leavers. Responsibility to ensure forms are processed in timely manner to prevent errors occurring.	Additional text
10	10h)		Responsibility for the recovery of any overpayments	Additional delegated matter
10	10h) Responsibility for the recovery of any overpayments		Executive Director of Finance Finance Director: Operational Finance Service Director	Delegated responsibility for new matter
12	10l) Medical staff study leave (UK)	Executive Medical Director / Executive Director of Workforce & OD / Executive Director of Integrated Clinical Delivery	Medical Director / Executive Director of Workforce & OD	Change in delegated responsibility
12	10l) All Medical and non-Medical Clinical Staff study leave outside the UK	All Medical and non-Medical Clinical Staff study leave outside the UK	All Medical and non-Medical Clinical Staff study leave outside the UK (as per relevant professional lead)	Additional text
		Executive Director of Integrated Clinical Delivery	Executive Director of Operations	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
13	10q)	Executive Director of Integrated Clinical Delivery	Executive Director of Operations	Change in delegated responsibility
13	10u)	Executive Director of Workforce & OD	Remuneration and Terms of Service Committee (supported by Executive Director of Workforce & OD)	Change in delegated responsibility
15	12b)	Executive Director of Finance	Direct to Operational Services	Change in delegated responsibility
15	12e)	Executive Director of Finance	Not Delegated	Change in delegated responsibility
15	12f)	Executive Director of Finance	Not Delegated	Change in delegated responsibility
15	12g)	Executive Director of Finance	Not Delegated	Change in delegated responsibility
15	13a)	Executive Director of Finance / Executive Director of Integrated Clinical Delivery	Chief Executive	Change in delegated responsibility
		Executive Director of Integrated Clinical Delivery	Executive Director of Operations	Change in delegated responsibility
16	13c)	Executive Director of Finance with relevant Director	Executive Director of Finance with relevant Director (including Associate Director of Healthcare Contracting)	Change in delegated responsibility
16	13d)	Executive Director of Integrated Clinical Delivery for all primary care related agreements	Executive Director of Operations for all primary care related agreements	Change in delegated responsibility
16	14a)	Executive Director of Finance	Associate Director of Healthcare Contracting	Change in delegated responsibility
16	14b)	Executive Director of Finance	Associate Director of Healthcare Contracting	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
17	15a)	Executive Director of Finance	Not Delegated	Change in delegated responsibility
17	15b)	Direct to Operational Services	Director of Capital & Estates	Change in delegated responsibility
17	16		The delegated limits stated below, as specified within Welsh Government's Losses and Special Payments Guidance in Manual for Accounts Chapter 6, relate to the requirement to obtain written approval from the Welsh Government H&SSG Director of Finance for write-off of losses or special payments above these limits. Audit Committee to regularly receive Schedule of Losses and Special Payments.	Additional text
17	16a)	Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response plan and informing the Counter Fraud Operational Services of frauds.	Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response plan and informing the Board, External Auditor and Counter Fraud Operational Services of frauds.	Additional text
17	16f)	Executive Director of Nursing & Midwifery supported by the relevant Director after seeking appropriate legal advice, up to a max £150,000	Executive Medical Director supported by the relevant Director after seeking appropriate legal advice, up to a max £500,000	Change in delegated responsibility and increase in amount
17	16g)	Chief Executive, Executive Director of Finance or Executive Director of Nursing & Midwifery	Executive Director of Finance or Executive Medical Director	Change in delegated responsibility
18	16.1		The delegated limits stated below, as specified within Welsh Government's Losses and Special Payments Guidance in the Manual for Accounts Chapter 6, relate to the requirement to obtain written approval from the Welsh Government H&SSG Director of Finance for write-off of losses or special payments above these limits. Audit Committee to regularly receive Schedule of Losses and Special Payments.	Additional text

Page Number	Section	Original	Changed to	Comment
18	16.1b)	For clinical negligence up to £250,000 (negotiated settlements)*.	For clinical negligence up to £250,000 including plaintiff's costs (negotiated settlements following legal advice)*.	Additional text
		Executive Director of Finance / Executive Director of Nursing & Midwifery	Executive Director of Finance / Executive Medical Director	Change in delegated responsibility
		Not delegated	Deputy Director of Quality Governance	Change in delegated responsibility
18	16.1c)	For clinical negligence over £250,000 and up to £1,000,000 (negotiated settlements)*.	For clinical negligence over £250,000 and up to £1,000,000 including plaintiff's costs (negotiated settlements following legal advice)*.	Additional text
		Chief Executive / Executive Director of Finance / Executive Director of Nursing & Midwifery	Chief Executive / Executive Director of Finance / Executive Medical Director	Change in delegated responsibility
		Not delegated	Deputy Director of Quality Governance	Change in delegated responsibility
18	16.1d)	For personal injury claims involving negligence where legal advice obtained and guidance applied up to £250,000 including plaintiff's costs	For personal injury claims involving negligence up to £250,000 including plaintiff's costs (where legal advice obtained and relevant guidance has been applied) *	Additional text
		Chief Executive / Executive Director of Finance / Executive Director of Workforce & OD / Executive Director of Nursing & Midwifery	Chief Executive / Executive Director of Finance / Executive Medical Director	Change in delegated responsibility
		Not delegated	Deputy Director of Quality Governance	Change in delegated responsibility
18	16.1e)	For personal injury claims involving negligence where legal advice obtained and guidance applied up to £1,000,000 *	For personal injury claims involving negligence over £250,000 and up to £1,000,000 (where legal advice obtained and relevant guidance has been applied) *	Additional text
		Chief Executive / Executive Director of Finance / Executive Director of Nursing & Midwifery	Chief Executive / Executive Director of Finance / Executive Medical Director	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
18	16.1e)	Not delegated	Deputy Director of Quality Governance	Change in delegated responsibility
18	16.1f)	Executive Director of Finance / Executive Director of Nursing & Midwifery	Executive Director of Finance / Executive Medical Director	Change in delegated responsibility
		Not delegated	Deputy Director of Quality Governance	Change in delegated responsibility
18	16.1*	All structured settlements require approval from the Welsh Government	All structured settlements require approval from the Welsh Government H&SSG Director of Finance	Additional text
		Chief Executive / Executive Director of Finance / Executive Director of Nursing & Midwifery	Executive / Executive Director of Finance / Executive Medical Director	Change in delegated responsibility
		Not delegated	Deputy Director of Quality Governance	Change in delegated responsibility
19	17	Procedure to follow after reporting of incidents to the Police	Procedure to follow after reporting of incidents to the Police (refer to Standing Operating Process in relation to reporting requirement to Security Advisors)	Additional text
19	17a)	Executive Director of Finance	Executive Director of Finance and Executive Director of Workforce & OD	Change in delegated responsibility
19	17c)	Executive Director of Finance	Executive Director of Finance and Executive Director of Workforce & OD	Change in delegated responsibility
19	17d)	Chief Executive	Chief Executive and Executive Director of Finance and Executive Director of Workforce & OD	Change in delegated responsibility
19	19a)	Review, appraise and support in accordance with Internal Audit Standards for NHS Wales and best practice	Review, appraise and support in accordance with Public Sector Internal Audit Standards for NHS Wales and best practice	Additional text

Page Number	Section	Original	Changed to	Comment
20	20a)	Board Secretary for all Board related matters / Executive Director of Workforce & OD for all employment related matters / Executive Director of Finance for all estate related matters / Executive Director of Integrated Clinical Delivery for all Primary Care related matters. Associate Director of Quality for claims, inquest, MHA and COP matters.	Board Secretary for all Board related matters / Executive Director of Workforce & OD for all employment related matters / Executive Director of Finance for all estate related matters / Executive Medical Director, Executive Director of Transformation, Strategic Planning & Commissioning and Executive Director of Operations for all Primary Care related matters. Deputy Director of Quality Governance for claims, inquest, MHA, COP and general healthcare legal matters.	Change in delegated responsibility
20	20b)	Any Executive Director of the Board or an Officer formally nominated by the Chief Executive / Associate Director of Quality Governance for claims, inquest, MHA and COP matters.	Executive Medical Director or any Executive Director of the Board or an Officer formally nominated by the Chief Executive / Deputy Director of Quality Governance for claims, inquest, MHA, COP and general healthcare legal matters.	Change in delegated responsibility
20	21	Insurance Policies and Risk Management	Insurance Policies (incorporating and Risk Management)	Change in title
		Not Delegated	Not Delegated except for Welsh Risk Pool which is delegated to the Deputy Director of Quality Governance	Change in delegated responsibility
21	23a)	Executive Director of Nursing & Midwifery	Chief Executive	Change in delegated responsibility
21	23b)	Executive Director of Nursing & Midwifery	Executive Director of Finance	Change in delegated responsibility
21	23c)	Executive Director of Nursing & Midwifery	Executive Director of Finance	Change in delegated responsibility
21	24a)	Executive Director of Nursing & Midwifery / Associate Director of Quality Governance (PTR Deputy Responsible Officer and Senior investigations Officer)	Executive Director of Nursing & Midwifery / Deputy Director of Quality Governance	Change in delegated responsibility
		Service Director	Service Director Patient Safety Team, and Patient and Carer Experience/Complaints Team for implementation	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
21	24b)	Executive Director of Nursing & Midwifery / Associate Director of Quality Governance (PTR Deputy Responsible Officer and Senior investigations Officer)	Executive Director of Nursing & Midwifery / Deputy Director of Quality Governance	Change in delegated responsibility
		Service Director	Service Director Patient Safety Team, and Patient and Carer Experience/Complaints Team for implementation	Change in delegated responsibility
21	24c)	Executive Director of Nursing & Midwifery / Associate Director of Quality Governance (PTR Deputy Responsible Officer and Senior investigations Officer)	Executive Director of Nursing & Midwifery / Deputy Director of Quality Governance	Change in delegated responsibility
22	25c)		Signing and sealing documents in accordance with Standing Orders	New delegated matter
			Chief Executive and Chair Board Secretary Not Delegated	Delegated responsibility
22	28a)	Director of Digital	Chief Digital and Information Officer	Change in delegated responsibility
		Not delegated	Data Protection Officer	Change in delegated responsibility
22	28b)	Executive Medical Director	Chief Executive	Change in delegated responsibility
22	28b)	Director of Digital	Chief Digital and Information Officer	Change in delegated responsibility
		Not delegated	Service Director	Change in delegated responsibility
22	28c)	Executive Medical Director	Chief Executive	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
		Director of Digital	Chief Digital and Information Officer	Change in delegated responsibility
		Not delegated	Service Director	Change in delegated responsibility
22	29a)	Director of Digital	Chief Digital and Information Officer	Change in delegated responsibility
22	29b)	Service Director	Service Director / Assistant Director of Compliance and Business Management	Change in delegated responsibility
22	30	Executive Medical Director on the advice of the appropriate professional bodies	Executive Medical Director on the advice of the appropriate professional bodies (Clinical approval via NICE Implementation Group and Drugs and Therapy Group for onward financial approval by Senior Leadership Team, see Table B for delegated limits)	Change in delegated responsibility
23	31	Authorisation of Research Projects	Authorisation of Research Projects (individuals responsible for their own declaration of interest to UKPI and BCUHB)	Additional text
23	35	Review of all statutory compliance legislation and Health and Safety requirements	Review of all statutory compliance legislation and Health and Safety requirements (including associated mandatory staff awareness training).	Additional text
23	38	Executive Director of Nursing & Midwifery / Executive Director of Finance	Executive Medical Director / Executive Director of Finance / Deputy Director of Quality Governance	Change in delegated responsibility
24	39	Investigation of Fraud /Corruption or Financial Irregularities	Investigation of Fraud, Bribery and Corruption or Financial Irregularities	Additional text
24	41	Executive Director of Integrated Clinical Delivery	Executive Director of Operations	Change in delegated responsibility
24	42	Director of Digital	Chief Digital and Information Officer	Change in delegated responsibility
		Service Director	Assistant Director of Compliance and Business Management	Change in delegated responsibility

Page Number	Section	Original	Changed to	Comment
24	43a)	Executive Medical Director	Chief Executive	Change in delegated responsibility
		Not delegated	Deputy Medical Director	Change in delegated responsibility
24	43b)	Director of Digital	Data Protection Officer	Change in delegated responsibility
		Not delegated	Head of Information Governance	Change in delegated responsibility
24	43c)	Executive Director of Finance	Chief Digital Information Officer	Change in delegated responsibility
24	44	Executive Director of Integrated Clinical Delivery	Executive Director of Operations	Change in delegated responsibility
25	49	Carbon Reduction Commitment Order Agency Registration		No longer required as delegated matter

SECTION 2: SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OPERATIONAL BUDGET MANAGERS

The LHB Standing Orders and Standing Financial Instructions specify certain key responsibilities of the Chief Executive, the Executive Director of Finance and other officers.

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

Delegated Matter	Table Reference No.
STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS	1
MEETINGS	2
FINANCIAL PLANNING/BUDGETARY RESPONSIBILITY	3
BANK/PGO ACCOUNTS (EXCLUDING CHARITABLE FUND ACCOUNTS)	4
~~UNALLOCATED~~	~~5~~
NON PAY EXPENDITURE	5~~6~~
STORES AND RECEIPT OF GOODS	6~~7~~
CAPITAL INVESTMENT MANAGEMENT	7~~8~~
QUOTATIONS, TENDERING & CONTRACT PROCEDURES	8~~9~~
FIXED ASSETS	9~~10~~
PERSONNEL & PAY	10~~11~~
ENGAGEMENT OF STAFF (NOT ON THE ESTABLISHMENT)	11~~12~~
CHARITABLE FUNDS HELD ON TRUST	12~~13~~
PRIMARY CARE PATIENT SERVICES/HEALTHCARE AGREEMENTS	13~~14~~
INCOME SYSTEMS, FEES & CHARGES	14~~15~~
DISPOSAL AND CONDEMNATIONS	15~~16~~
LOSSES, WRITE-OFFS & COMPENSATION AND EX-GRATIA PAYMENTS	16~~17~~
REPORTING INCIDENTS TO THE POLICE	17~~18~~
FINANCIAL PROCEDURES	18~~19~~
AUDIT ARRANGEMENTS	19~~20~~
LEGAL PROCEEDINGS	20~~21~~
INSURANCE POLICIES AND RISK MANAGEMENT	21~~22~~
CLINICAL AUDIT	22~~23~~
PATIENTS' PROPERTY	23~~24~~
PATIENTS' & RELATIVES' COMPLAINTS	24~~25~~
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Schedule 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS

Table A – Scheme of Delegation to Officers

Board Member Responsible: in line with the Standing Orders, delegated approval to the relevant Board Member, Board Committee or Executive Director. Where there is more than one Executive Director named the applicable responsibility is in relation to their individual service area.

Specific Delegation Where Applicable: The intention within the Operating Model is to delegate to the Operational Divisions wherever possible, however some Matters are either delegated through a Director, Associate or Assistant then to the Operational Division, or they are not delegated beyond this secondary level. This column sets out the delegation flow where relevant. Where there is more than one 'Accountable Lead' named the applicable responsibility is in relation to their individual service area.

Operational Responsibility: – where Matters are delegated to the Operational Divisions, the generic term "*Service Director*" has been used to identify the Accountable Lead, for example IHC Director, Director of Mental Health, Cancer, and Support Functions. It is also recognised that these Matters are delegated within Health Board Policy and where relevant are directly supported by Finance, People Services and other Support Functions.

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
1. Standing Orders / Standing Financial Instructions			
a) Final authority in interpretation of Standing Orders	Chair	Not Delegated	Not Delegated
b) Notifying Directors, employees and agents of their responsibilities within the Standing Orders (Board Secretary) and Standing Financial Instructions (Executive Director of Finance) and ensuring that they understand the responsibilities	Executive Director of Finance / Board Secretary	Direct to Operational Services ➔	Service Director** (**Generic Title used for the 'Accountable Lead' across IHC, Pan BCU, Regional Directors and Support Functions)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
c) Responsibility for the security of the LHB's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial Instructions and financial procedures	Executive Director of Finance	Direct to Operational Services ~~→~~	Service Director
d) Ensuring Standing Orders are compatible with Welsh Government requirements re building and engineering contracts	Chief Executive	Executive Director of Finance	Not Delegated
2. Meetings			
a) Calling meetings of the LHB	Chair	Board Secretary	Not Delegated
b) Chair all LHB Board meetings and associated responsibilities	Chair or Vice Chair in Chair's absence	Not Delegated	Not Delegated
3. Financial Planning/Budgetary Responsibility			All Matters locally supported by CFO / FD
a) Setting: Submit Three Year Plan and Annual Operating Plan to the LHB Board	Chief Executive	Executive Director of Transformation, Strategic Planning & Commissioning ~~Executive Director of Transformation and Planning~~	Not Delegated
Submit budgets to the LHB Board	Chief Executive	Executive Director of Finance	Not Delegated
Submit to Board financial estimates and forecasts	Chief Executive	Executive Director of Finance	Not Delegated
b) Implementing financial policies, plans and procedures, providing advice and co-ordinating any corrective action necessary	Executive Director of Finance	Finance Director: Operational Finance	Service Director
c) Issuing Budgets	Executive Director of Finance	Finance Director: Operational Finance	Service Director
d) Monitoring: Monitor performance against budget	Executive Director of Finance	Executive and Associate Directors	Service Director
Submit monitoring returns (WHC requires approval by both CEO and EDoF, if not available these are delegated to their deputies)	Chief Executive and Executive Director of Finance	Finance Director: Operational Finance and Deputy Chief Executive ~~Executive Director of Finance~~	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Effective budgetary control and a balanced budget	Executive Director of Finance	Executive and Associate Directors	Service Director
Preparation of annual accounts and returns	Executive Director of Finance	~~Executive Director of Finance~~ Finance Director: Operational Finance	Not Delegated
Identifying and implementing cost improvements and income generation initiatives	Executive Director of Finance	Executive and Associate Directors	Service Director
e) Authorisation of Virement It is not possible for any officer other than the Executive Director of Finance to vire from non-recurring headings to recurring budgets or from capital to revenue/revenue to capital. Virement between different budget holders (Service Directors) requires the agreement of both parties.	Executive Director of Finance	Please refer to Table B – Delegated Limits	Service Director
f) Maintaining an effective system of internal financial control	Chief Executive	Executive Director of Finance	Service Director
g) Delivery of financial training to budget holders (Directors)	Executive Director of Finance	Finance Director: Operational Finance	Service Director
4. Bank/PGO Accounts (Excluding Charitable Fund Accounts)			
a) Operation: Managing banking arrangements and operation of bank accounts	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
Opening bank accounts	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
Authorisation of transfers between LHB bank accounts	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
Authorisation of: -PGO/GBS Schedules -BACS Schedules -Automated cheque schedules -Manual cheques	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated to Service Directors. NOTING that Senior Finance Staff (CFO / FD) authorise contract / SLA / RIF payments
5. Non Pay Expenditure			
For details of Delegated Limits refer to Table B			

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
a) Completion of an Operational Scheme of Delegation and Authorisation by each Budget Holder ensuring maintenance of a list of officers authorised to place requisitions/orders (including emergency verbal orders) and record receipts within the E-Financials Business Suite.	~~Executive Director of Finance~~Chief Executive	Executive and Associate Directors	Service Director
b) Obtain the best value for money when requisitioning goods/services	Executive Director of Finance	Executive and Associate Directors	Service Director
c) Ensuring expenditure is within budget	Chief Executive	Executive and Associate Directors	Service Director
d) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive	Executive Director of Finance	Service Director
e) Orders exceeding 12 month period	Executive Director of Finance	Finance Director: Operational Finance	Service Director
f) Prompt payment of accounts	Executive Director of Finance	Direct to Operational Services ~~Executive Director of Finance~~	Service Director ~~Not Delegated~~
g) Financial Limits	Executive Director of Finance	Direct to Operational Services → Refer to Table B for Delegated Limits	Service Director Per Table B
h) Maintenance of sufficient records to explain the LHB's transactions and report on the LHB's financial position	Executive Director of Finance	Finance Director: Operational Finance	Service Director
i) Provision of electronic signature / approval within the E-Financials Business Suite in accordance with each Budget Holder's Operational Scheme of Delegation and Authorisation	Executive Director of Finance	Finance Director: Operational Finance	Service Director
6. Stores and Receipt of Goods			
a) Responsibility for the systems of financial control over all stores including receipt of goods and returns	Executive Director of Finance	Direct to Operational Services ~~→~~	Service Director
b) Responsibility for the control of stores and of goods, issues and returns: (excluding pharmaceutical stock: see below)	~~Executive Director of Finance~~Chief Executive	~~Direct to Operational Services →~~Executive Director of Finance	Service Director
Pharmaceutical Stores	Chief Executive ~~Executive Medical Director~~	Chief Pharmacist	Service Director Via Head of Medicines Management

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
c) Stocktaking arrangements	Executive Director of Finance	Direct to Operational Services ~~→~~	Service Director
7. Capital Investment Management For details of Delegated Limits for Delegated Matter 7~~8~~d), please refer to Table B – Leases. In accordance with Welsh Government guidance:			
a) Programme:			
Preparation of Capital Investment Programme	Chief Executive	~~Executive Director of Finance~~Executive Director of Transformation, Strategic Planning & Commissioning	Service Director
Completion and signing off of a business case for approval	Chief Executive ~~Executive Director of Finance~~	Executive Director of Finance ~~Director of Finance; Operations~~	Service Director
Appointment of Project Directors	Chief Executive	Executive Director of Finance with support from relevant Directors	Not Delegated
Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Executive Director of Finance	Executive and Associate ~~Director of Finance with support from relevant~~ Directors.	Service Director
Issuing of guidance on management of capital schemes	Executive Director of Transformation, Strategic Planning & Commissioning and Executive Director of Finance	Executive and Associate ~~Director of Finance with support from relevant~~ Directors.	Not Delegated
b) Contracting – Selection of 3rd party developers, architects, quantity surveyors, consultant engineers and other professional advisors within EC regulations and LHB tender procedures	Chief Executive	Executive Director of Finance	Not Delegated
c) Private Finance – Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector	Chief Executive	Executive Director of Finance	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
d) Leases – Granting and termination of leases	Chief Executive	Executive Director of Finance	Not DelegatedRefer to Table B
e) Financial control and audit-Arrangements are in place to review building and engineering contracts and property transactions comply with Welsh Government guidance.	Chief Executive	Executive Director of Finance	Not Delegated
8. Quotations, Tendering & Contract Procedures For details of Delegated Limits, please refer to Table B – Quotations/Tenders.			All Matters locally supported by CFO / FD
a) Services:			
Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Direct to Operational Services →	Service Director
Nominate officers to oversee and manage the contract on behalf of the LHB	Chief Executive	Direct to Operational Services →	Service Director
b) Quotations – Total value of the contract over its entire period:			
Seeking quotations up to £5,000 in value	Chief Executive Executive Director of Finance (per SFI 11.7.1)	Executive Director of FinanceDirect to Operational Services → Refer to Table B for delegated limits	Service Director
Obtaining minimum of 3 written quotations for goods/services of value between £5,000 and £25,000	Chief Executive Executive Director of Finance (per SFI 11.1.2)	Executive Director of FinanceDirect to Operational Services → Refer to Table B for delegated limits	Service Director
c) Competitive Tenders – Total value of the contract over its entire period:			
Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and the OJEU threshold (in compliance with EU ProcurementC Directives and UK Procurement Regulations as appropriate)	Chief ExecutiveExecutive Director of Finance	Executive Director of FinanceDirect to Operational Services → Refer to Table B for delegated limits	Service Director
Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of the OJEU threshold (in compliance with EU Procurement Directives and UK Procurement Regulations EC Directives as appropriate)	Chief ExecutiveExecutive Director of Finance	Executive Director of FinanceDirect to Operational Services → Refer to Table B for delegated limits	Service Director
Receipt and custody of tenders prior to opening	Executive Director of Finance	Direct to Operational Services → Refer to Table B for delegated limits	Service Director
Opening Tenders and Quotations	Executive Director of Finance	Direct to Operational Services → Refer to Table B for delegated limits	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Decide if late tenders should be considered	Executive Director of Finance	Direct to Operational Services ~~→ Refer to Table B for delegated limits~~	Service Director
d) Waiving the requirement to request quotes or tenders – subject to ~~SFI~~ Schedule 2.1 Standing Financial Instructions Section 11.13~~Para. 4.2 & 4.~~3 – Formally reported to the Audit Committee	Chief Executive ~~Executive Director of Finance~~	~~Finance Director: Operational Finance (escalation to the~~ Executive Director of Finance or Chief Executive if above £25,000~~necessary,~~) The Chief Executive and Director of Finance cannot approve their own waiver and must seek approval from ~~-~~one other Executive Director~~s~~	Service Director All Single Tender Waivers (STW's) must be approved by NWSSP and by the ~~Operational Finance~~ Executive Director of Finance **before** any commitment is made.
9. Fixed Assets			
a) Maintenance of asset register	~~Executive Director of Finance~~Chief Executive	Executive Director of Finance ~~Finance Director (Operational Finance)~~	Service Director
b) Apply accounting policies (including ~~Calculate and pay capital charges~~depreciation and revaluations) in accordance with Welsh Government requirements	Executive Director of Finance	Finance Director: ~~(~~Operational Finance~~)~~	Not Delegated
c) Responsibility for fixed assets – Land & Buildings	Chief Executive ~~Executive Director of Finance~~	~~-~~Executive Director of Finance~~Director of Estates~~	~~Not Delegated~~ Director of Capital & Estates
d) Responsibility for all other fixed assets (Plant, Machinery, Transport, IT assets including software, Furniture & Fittings)	Chief Executive ~~Executive Director of Finance~~	~~-~~Executive Director of Finance ~~Director of Estates and Director of Digital, Deputy CEO with support from relevant Directors.~~	~~Service Director~~ Director of Capital & Estates, Chief Digital & Information Officer and Deputy CEO with support from relevant Directors.
e) Responsibility for security of LHB assets including notifying discrepancies to the Director of Finance and reporting losses in accordance with LHB procedures	Chief Executive	Executive Director of Finance, with support from relevant Directors.	Service Director
10. Personnel & Pay			All Matters locally supported by CFO / FD / People
a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts in	Executive Director of	Direct to Operational Services ~~→~~	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
accordance with the "Policy for the Safe Recruitment and Selection Practices" together with accompanying guidance, particularly the need for pre-employment checks.	Workforce & OD		
b) Approve the commencement of employment prior to all pre-employment checks being completed.	Executive Director of Workforce & OD	Associate Director People Services	Service Director
c) Authority to fill funded post on the establishment with permanent staff.	Executive Director of Workforce & OD	Deputy Director Workforce & OD / Associate Director of People Services (IHC / PAN BCU / Support Services)	Service Director
d) The granting of additional increments to staff within budget in accordance with Terms & Conditions of Service	Executive Director of Workforce & OD	Executive Directors with advice from Associate Director of Ppeople Services	Service Director
e) All requests for upgrading/ regrading/ major skill mix changes shall be dealt with in accordance with LHB Procedure	Executive Director of Workforce & OD	Executive Directors with advice from Associate Director of people Services	Service Director
f) Authority to agree acting up salaries for staff other than Executive Directors, within budget (Approval of acting up salaries for interim Executive Directors to be retained by Remuneration & Terms of Service Committee)	Chief Executive to agree acting up arrangements of Band 9 and above (Excluding Executive Directors)	Executive Directors lead for acting up salaries up to Band 9 or equivalent.	Service Director Up to Band 9 or equivalent only.
g) Establishments:			
Locum/additional staff to the agreed establishment **with** specifically allocated finance	Executive Director of Workforce & OD / Executive Director of Finance	Direct to Operational Services ~~→~~	Service Director
Locum/additional staff to the agreed establishment **without** specifically allocated finance.	Chief Executive	Executive Director of Finance and Executive Director of Workforce & OD	Service Director (via ECR & Budget Virement)
Variation to the funded establishment	Chief Executive ~~Executive Director of Workforce & OD and~~	Executive Director of Workforce & OD and Executive Director of Finance ~~Direct to Operational Services →~~	Service Director (Via ECR & Budget Virement)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
	~~Executive Director of Finance~~	~~with Budget Virement approval in line with Executive Director of Finance Policy~~	
h) Pay			
Authority to complete standing data forms effecting pay, new starters, changes and leavers. Responsibility to ensure forms are processed in timely manner to prevent errors occurring.	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
Authority to complete and authorise timesheets and payroll returns	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
Authority to authorise overtime	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
Authority to authorise travel & subsistence expenses	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
Maintenance of a list of managers authorised to sign payroll and travel expense documentation. (and via e-expense systems)	Executive Director of Workforce & OD	Deputy Director of Workforce & OD	Service Director
Responsibility for the recovery of any overpayments	Executive Director of Finance	Finance Director: Operational Finance	Service Director
i) Leave			
Approval of annual leave in accordance with LHB policy	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
Carry-over of annual leave in exceptional circumstances up to a maximum of 5 days	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
Compassionate leave	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
Special leave arrangements (to be applied in accordance with All Wales Policy)	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Leave without pay	Executive Director of Workforce & OD	Direct to Operational Services ➔	Service Director
Medical Staff Leave of Absence – paid and unpaid	Executive Director of Workforce & OD	Direct to Operational Services ➔	Service Director
Consultants Special Leave	Executive Medical Director	Direct to Operational Services ➔	Service Director
Time off in lieu	Executive Director of Workforce and OD	Direct to Operational Services ➔	Service Director
Maternity / Paternity Leave – paid and unpaid	Executive Director of Workforce & OD	Direct to Operational Services ➔	Service Director
j) Annualised hours/flexible working hours system- maintenance of adequate records	Executive Director of Workforce & OD	Direct to Operational Services ➔	Service Director
k) Sick Leave			
Extension of sick leave on half pay up to three months	Executive Director of Workforce & OD	Direct to Operational Services ➔ in conjunction with Associate Director of People Services	Service Director
Return to work part-time on full pay to assist recovery	Executive Director of Workforce & OD	Direct to Operational Services ➔ in conjunction with Associate Director of People Services	Service Director
Extension of sick leave on full pay	Executive Director of Workforce & OD	Direct to Operational Services ➔ in conjunction with Associate Director of People Services	Service Director
l) Study Leave			
Study leave outside the UK (non-medical staff excluding clinical staff)	Executive Director of Workforce & OD	Direct to Operational Services ➔	Service Director
Medical staff study leave (UK)	Executive Medical Director / Executive	Direct to Operational Services ➔	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
	Director of Workforce & OD ~~/ Executive Director of Integrated Clinical Delivery~~		
Consultant Medical Staff Leave (UK)	Executive Medical Director	Direct to Operational Services ~~→~~	Service Director
All Medical and non-Medical Clinical Staff study leave outside the UK (as per relevant professional lead)	Executive Medical Director / Executive Director of Nursing & Midwifery / Executive Director of Therapies & Health Science / Executive Director of ~~Integrated Clinical Delivery~~ Operations	Direct to Operational Services ~~→~~	Service Director
All other study leave (UK)	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
m) Removal Expenses			
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Executive Director of Workforce & OD	Direct to Operational Services → In accordance with BCUHB policy / approval from the Executive Director of Workforce & OD	Service Director
n) Respect & Resolution Procedure	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
o) Professional Misconduct/Competence-Medical and Dental Staff	Executive Medical Director / Executive Director of Workforce & OD	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
p) Suspension of Doctors employed directly by the LHB	Executive Medical Director	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
q) Formal actions as required under The Performers List	Chief Executive	Executive Medical Director supported by Executive Director of Workforce & OD and Executive Director of Operations~~Integrated Clinical Delivery~~	Not Delegated to Operational Divisions, cover for Executive Medical Director provided through the Deputy Responsible Officer ~~RO~~ or Deputy Medical Director
r) Requests for new posts to be authorised as car users	Executive Director of Finance	Direct to Operational Services ~~→~~	Service Director
s) Renewal of Fixed Term Contract	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
t) Voluntary Early Release Scheme	Remuneration and Terms of Service Committee (supported by Executive Director of Workforce & OD)	Executive Director of Workforce & OD, with Executive Director of Finance for sign off of financial viability	Not Delegated
u) Settlement on termination of employment	Remuneration and Terms of Service Committee (supported by Executive Director of Workforce & OD)~~Executive Director of Workforce & OD~~	Executive Director of Workforce & OD with approval from Welsh Government where the payment is Ex-gratia and exceeds the delegated limit of £50,000	Not Delegated. Service Directors to operate within Policy as set through the Executive Director of Workforce & OD
v) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from Workforce & OD Department	Executive Director of Workforce & OD	Associate Director of People Services	Service Director for local implementation~~-~~: Ultimate Approval is via NHS Pensions Agency

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
w) Disciplinary Procedure (excluding Executive Directors)	Executive Director of Workforce & OD	Executive Directors	Service Director
11. Engagement of Staff Not On the Establishment			
For details of Delegated Limits, please refer to Table B			All Matters locally supported by CFO / FD / People
a) Non clinical Consultancy Staff	Executive Director of Finance	Direct to Operational Services ~~→~~	Service Director
b) Medical Locum staff	Executive Medical Director	Direct to Operational Services ~~→~~	Service Director
c) Booking of Agency Nursing Staff	Executive Director of Nursing & Midwifery	Direct to Operational Services ~~→~~	Service Director
d) Booking of Bank Staff:			
Nursing	Executive Director of Nursing & Midwifery	Direct to Operational Services ~~→~~	Service Director
Other	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director
12. Charitable Funds Held on Trust	Overall the Health Board Charitable Funds are managed through Awyr Las and through the Charitable Funds Committee and its formal Trustee status		
For details of Delegated Limits, Please refer to Table B			All Matters locally supported by CFO / FD
a) Management: Funds held on Trust are managed appropriately	Executive Director of Finance	Direct to Operational Services ~~→~~	Service Director
b) Maintenance of authorised signatory list of Authorised Fund Holders	Executive Director of Finance	Direct to Operational Services ~~Executive Director of Finance~~	Service Director
c) Expenditure	Executive Director of Finance	Direct to Operational Services → Refer to Table B – Delegated limits	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
d) Fundraising Appeals – Preparation/Monitoring/Reporting progress and performance	Director of Communications and Partnerships	Fundraising manager~~,~~	Service Director Via Awyr Las
e) Operation of Bank Accounts:			
Managing banking arrangements and operation of bank accounts	Executive Director of Finance in conjunction with Corporate Trustees	Not Delegated~~Executive Director of Finance~~	Not Delegated
Opening bank accounts	~~-~~Corporate Trustee	Executive Director of Finance	Not Delegated
f) Investments – Policy and Arrangements	Executive Director of Finance in conjunction with Corporate Trustees	Not Delegated~~Executive Director of Finance~~	Not Delegated
g) Authority to accept the discharge of a donor's estate	Executive Director of Finance	Not Delegated~~Executive Director of Finance~~	~~Not Delegated~~ Via Awyr Las
13. Primary Care Patient Services/ Healthcare Agreements For details of Delegated Limits, please refer to Table B – Healthcare Agreements			**SEE TABLE B FOR SPECIFIC SENIOR POSTS & £ LIMITS**
a) Contract negotiation and provision of service agreements	~~Executive Director of Finance / Executive Director of Integrated Clinical Delivery~~Chief Executive	Executive Director of Finance / Executive Director of Operations~~Integrated Clinical Delivery~~	System Oversight
b) Reporting actual and forecast contract income	Executive Director of Finance	Finance Director: Operational Finance	System Oversight (supported by Finance)
c) Pricing of all contracts and SLAs	Executive Director of Finance	Executive Director of Finance with relevant Director (including Associate Director of Healthcare Contracting)	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
d) Signing agreements	Chief Executive	Chief Executive or Executive Director of Finance in Chief Executive's absence / Executive Director of Operations ~~Integrated Clinical Delivery~~ for all primary care related agreements	Service Director (see Table B for specific limits and arrangements)
14. Income Systems, Fees and Charges			All Matters locally supported by CFO / FD
a) Private Patients, Overseas Visitors, Income Generation and other patient related services	Executive Director of Finance	Associate Director of Healthcare Contracting~~Executive Director of Finance~~	Service Director
b) Pricing of NHS agreements	Executive Director of Finance	Associate Director of Healthcare Contracting~~Assistant Directors of Finance~~	Not Delegated
c) Informing the Director of Finance of monies due to the LHB	Executive Director of Finance	Direct to Operational Services ~~→~~	Service Director
d) Recovery of debt	Executive Director of Finance	Finance Director: Operational Finance.	Not Delegated
e) Security of cash and other negotiable instruments	Executive Director of Finance	Finance Director: Operational Finance.	Service Director
f) Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due	Executive Director of Finance	Finance Director: Operational Finance	Service Director
g) Non patient care income	Executive Director of Finance	Finance Director: Operational Finance.	Service Director
15. Disposal and Condemnations Disposal of all property and land requires formal approval by the Minister for Health and Social Services			
a) Issuing procedure for the disposal of assets obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	Executive Director of Finance	Not Delegated ~~Executive Director of Finance~~	Not Delegated
b) Notification to Executive Director of Finance prior to disposal	Executive Director of Finance	Director of Capital & Estates ~~Direct to Operational Services →~~	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
16. Losses, Write-offs & Compensation			
The delegated limits stated below, as specified within Welsh Government's Losses and Special Payments Guidance in Manual for Accounts Chapter 6, relate to the requirement to obtain written approval from the Welsh Government H&SSG Director of Finance for write-off of losses or special payments above these limits. Audit Committee to regularly receive Schedule of Losses and Special Payments.			
a) Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response plan and informing the Board, External Auditor and Counter Fraud Operational Services of frauds.	Executive Director of Finance	Finance Director: Operational Finance.	Service Director For Implementation and compliance with BCU Procedure
b) Losses of cash due to theft, fraud, overpayment of salaries, fees, allowances & other causes up to £50,000	Chief Executive	Executive Director of Finance	Not Delegated
c) Fruitless payments (including abandoned Capital Schemes) up to £250,000	Chief Executive	Executive Director of Finance	Not Delegated
d) Bad debts and claims abandoned: Private patients; overseas visitors & other cases up to £50,000	Chief Executive	Executive Director of Finance	Not Delegated
e) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other up to £50,000	Chief Executive	Executive Director of Finance	Not Delegated
f) For personal and public liability claims, under the Legal & Risk scheme, authorisation from Legal & Risk is required before admissions may be made and monetary compensation offered. (Ex-gratia settlements offered by the LHB are by definition not payments based upon legal liability and are, therefore, not reimbursable under the WRP scheme)	Chief Executive	~~Executive Director of Nursing & Midwifery~~ Executive Medical Director supported by the relevant Director after seeking appropriate legal advice, up to a max £~~1~~500,000	Deputy Director of Quality Governance~~Service Director For Implementation and compliance with BCU Procedure~~
g) Compensation payments made under legal obligation:	Chief Executive	~~Chief Executive,~~ Executive Director of Finance or Executive Medical Director ~~of Nursing & Midwifery~~	Deputy Director of Quality Governance ~~Not Delegated~~
h) Extra contractual payments to contractors – u~~U~~p to £50,000 ~~as specified within the Losses and Special Payments Manual of Guidance~~	Chief Executive	Executive Director of Finance with reporting to the Audit Committee	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
16.1 Ex-Gratia Payments: (The delegated limits stated below, as specified within Welsh Government's Losses and Special Payments Guidance in the Manual for Accounts Chapter 6, relate to the requirement to obtain written approval from the Welsh Government H&SSG Director of Finance for write-off of losses or special payments above these limits ~~per Manual for Accounts Chapter 6).~~ Audit Committee to regularly receive Schedule of Losses and Special Payments.			
a) Patients and staff for loss of personal effects up to £50,000 ~~Above £50k to Welsh Government~~	Chief Executive	Executive Director of Finance- Refer to Finance Policy on Losses and Special Payments	Service Directors to Implement: financial approval remains within Finance Department per Policy
b) For clinical negligence up to £250,000 including plaintiff's costs (negotiated settlements following legal advice)*. ~~Report to Board > £50,000 (Table B)~~	Chief Executive	Executive Director of Finance / Executive Medical Director ~~of Nursing & Midwifery~~	Deputy Director of Quality Governance ~~Not Delegated~~
~~b)~~c) For clinical negligence over £250,000 and up to £1,000,000 including plaintiff's costs * (negotiated settlements following legal advice)*. ~~Report to Board> £50,000 (see Table B)~~	Chair Board	Chief Executive / Executive Director of Finance / Executive Medical Director~~Executive Director of Nursing & Midwifery~~	Deputy Director of Quality Governance ~~Not Delegated~~
~~c)~~d) For personal injury claims involving negligence up to £250,000 including plaintiff's costs (where legal advice obtained and relevant guidance has been applied) ~~up to £250,000 (including plaintiff's costs)~~* ~~Report to Board > £50,000~~	Board	Chief Executive / Executive Director of Finance /~~Executive Director of Workforce & OD/~~ Executive Medical Director~~Executive Director of Nursing & Midwifery~~	Deputy Director of Quality Governance ~~Not Delegated~~
~~d)~~e) For personal injury claims involving negligence over £250,000 and up to £1,000,000 (where legal advice obtained and relevant guidance has been applied) ~~up to £1,000,000*~~ ~~(>£1m to Welsh Government)~~ ~~Report to Board > £50,000*~~	Board	Chief Executive / Executive Director of Finance / Executive Medical Director~~Executive Director of Nursing & Midwifery~~	Deputy Director of Quality Governance ~~Not Delegated~~
~~e)~~f) Other, except cases for maladministration where there was no financial loss by claimant, up to £50,000 ~~Above £50k to Welsh Government~~	Chief Executive	Executive Director of Finance / Executive Medical Director~~Executive Director of Nursing & Midwifery~~	Deputy Director of Quality Governance ~~Not Delegated~~

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
* For all clinical negligence and personal injury cases (including Court cases) the use of structured settlements should be considered involving costs to the NHS of £250,000 or more **– All structured settlements require approval from the Welsh Government H&SSG Director of Finance**	Board	Chief Executive / Executive Director of Finance / Executive Medical Director~~Executive Director of Nursing & Midwifery~~	Deputy Director of Quality Governance ~~Not Delegated~~
17. Procedure to follow after reporting of incidents to the Police (refer to Standing Operating Process in relation to reporting requirement to Security Advisors)			
a) Where a criminal offence is suspected	Executive Director of Finance and Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director For Implementation and compliance
b) Criminal offence of a sexual or violent nature	Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director For implementation and compliance
c) Arson or theft	Executive Director of Finance and Executive Director of Workforce & OD	Direct to Operational Services ~~→~~	Service Director for implementation and compliance
d) Other	Chief Executive and Executive Director of Finance and Executive Director of Workforce & OD	Direct to Operational Services → dependent upon the nature of the suspected offence	Service Director for implementation nd compliance
18. Financial Procedures			
a) Maintenance & Update of LHB Financial Procedures	Executive Director of Finance	Finance Director : Operational Finance	Not Delegated
19. Audit Arrangements			
a) Review, appraise and support in accordance with Public Sector Internal Audit S~~s~~tandards for NHS Wales and best practice	Chair of the Audit Committee	Board Secretary / Head of Internal Audit	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
b) Provide an independent and objective view on internal control and probity	Board Secretary	Head of Internal Audit / Audit Wales	Not Delegated
c) Ensure Cost-effective external audit	Chair of Audit Committee	Executive Director of Finance	Not Delegated
d) Ensure an adequate internal audit service	Chief Executive	Board Secretary	Not Delegated
e) Implement recommendations	Board Secretary	Direct to Operational Services ~~→~~	Service Director
20. Legal Proceedings			
a) Engagement of LHB's Solicitors	Chief Executive	Board Secretary for all Board related matters / Executive Director of Workforce & OD for all employment related matters / Executive Director of Finance for all estate related matters / Executive Medical Director, Executive Director of Transformation, Strategic Planning & Commissioning and Executive Director of Operations~~Integrated Clinical Delivery~~ for all Primary Care related matters. Deputy~~Associate~~ Director of Quality Governance for claims, inquest, MHA, ~~and~~ COP and general healthcare legal matters.	Service Director (Associate Director People Services for employment matters). Out of Hours approval via Gold On-Call.
b) Approve and sign all documents which will be necessary in legal proceedings	Chief Executive	Executive Medical Director or a~~A~~ny Executive Director of the Board or an O~~o~~fficer formally nominated by the Chief Executive /~~.~~ Deputy~~Associate~~ Director of Quality Governance for claims, inquest, MHA, ~~and~~ COP and general healthcare legal matters.	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
c) Sign on behalf of the LHB any agreement or document not requested to be executed as a deed	Chief Executive	Any Executive Director of the Board or an officer formally nominated by the Chief Executive	Not Delegated
21. Insurance Policies (incorporating~~and~~ Risk Management)	Chief Executive	Executive Director of Finance and Executive Medical Director	Not Delegated except for Welsh Risk Pool which is delegated to the Deputy Director of Quality Governance ~~(Service Director For **Implementation)**~~
22. Clinical Audit	Chief Executive	Executive Medical Director	Not Delegated
23. Patients' Property (in conjunction with financial advice)			
For details of Delegated Limits, please refer to Table B – Petty Cash/Patients Monies			
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission	~~Executive Director of Nursing & Midwifery~~Chief Executive	Direct to Operational Services ~~→~~	Service Director
b) Prepare detailed written instructions for the administration of patients' property	Executive Director of ~~Nursing & Midwifery~~Finance	Direct to Operational Services ~~→~~	Service Director
c) Informing staff of their duties in respect of patients' property	Executive Director of ~~Nursing & Midwifery~~Finance	Direct to Operational Services ~~→~~	Service Director
d) Issuing property valued >£5,000 only on production of a probate letter of administration	Executive Director of Finance	Finance Director : Operational Finance	Not Delegated
24. Putting Things Right Regulations (in line with WRP Policy & Guidance)			
a) Overall responsibility for ensuring that all concerns (as defined in PTR Regulations) are dealt with effectively	Chief Executive	Executive Director of Nursing & Midwifery /~~Associate~~ Deputy Director of Quality Governance~~(PTR~~	Service Director Patient Safety Team, and Patient and Carer Experience/Compla

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
		~~Deputy Responsible Officer and Senior Investigations Officer)~~	ints Team f~~F~~or iImplementation
b) Responsibility for ensuring complaints are investigated thoroughly, and learning is embedded.	Chief Executive	Executive Director of Nursing & Midwifery~~. /~~ ~~Associate~~ Deputy Director of Quality Governance ~~(PTR Deputy Responsible Officer and Senior Investigations Officer)~~	Service Director and Patient and Carer Experience/Complaints Team f~~F~~or implementation
c) Medical – Legal Complaints Co-ordination of their management	Chief Executive	Executive Director of Nursing & Midwifery /~~.~~ Deputy Director of Quality ~~Associate Director of Quality~~ Governance ~~(PTR Deputy Responsible Officer and Senior Investigations Officer)~~	Service Director For implementation
25. Seal			
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Board Secretary	Not Delegated
b) Attestation of seal in accordance with Standing Orders	Chief Executive and~~/~~ Chair	Board Secretary	Not Delegated
c) Signing and sealing documents in accordance with Standing Orders	Chief Executive and Chair	Board Secretary	Not Delegated
26. Gifts and Hospitality			
a) Keeping of gifts and hospitality register	Chief Executive	Board Secretary	Service Director for implementation and compliance
27. Declaration of Interests			
a) Maintaining a register of interests	Chief Executive	Board Secretary	Service Director for implementation and compliance
28. Informatics and the Data Protection Act			
a) Review of LHB's compliance with the Data Protection Act	Chief Executive	Chief Digital and Information officer ~~Director of Digital~~	Data Protection Officer ~~Not Delegated~~
b) Responsibility for Informatics policy and strategy	Chief Executive~~Exec~~	Chief Digital and Information officer	Service Director ~~Not Delegated~~

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
	~~utive Medical Director~~	~~Director of Digital~~	
c) Responsibility for ensuring that adequate management (audit) trails exist in Informatics systems	Chief Executive~~Executive Medical Director~~	Chief Digital and Information officer~~Director of Digital~~	Service Director ~~Not Delegated~~
29. Records			
a) Review LHB's compliance with the Retention of Records Act and guidance	Chief Executive	Chief Digital and Information officer ~~Director of Digital~~ / Executive Medical Director	Not Delegated
b) Approval for the destruction of records	Chief Executive	Director of Digital / Executive Medical Director	Service Director / Assistant Director of Compliance and Business Management
c) Ensuring the form and adequacy of the financial records of all departments	Executive Director of Finance	Finance Director: Operational Finance	Service Director
30. Authorisation of New Drugs	Chief Executive	Executive Medical Director on the advice of the appropriate professional bodies (Clinical approval via NICE Implementation Group and Drugs and Therapy Group for onward financial approval by Senior Leadership Team, see Table B for delegated limits)	Not Delegated
31. Authorisation of Research Projects (individuals responsible for their own declaration of interest to UKPI and BCUHB)	Executive Medical Director	Director of Research & Development	Service Director
32. Authorisation of Clinical Trials	Chief Executive	Executive Medical Director	Service Director
33. Infectious Diseases & Notifiable Outbreaks – outbreak control / public health monitoring and surveillance / provision of public health advice	Chief Executive	Executive Director of Public Health	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
34. Review of Fire Precautions	Chief Executive	Executive Director of Finance	Not Delegated
35. Health & Safety			
Review of all statutory compliance legislation and Health and Safety ~~requirements~~requirements ~~.~~ (including associated mandatory staff awareness training).	Chief Executive	Executive Director of Workforce & OD	Not Delegated
36. Medicines Inspectorate Regulations			
Review Regulations Compliance	Chief Executive	Executive Medical Director supported by Chief Pharmacist	Service Director via Head of Medicines Management
37. Environmental Regulations			
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Executive Director of Finance	Director of Capital & Estates	Not Delegated
38. Legal & Risk Payments	Chief Executive	Executive Medical Director ~~of Nursing & Midwifery~~ / Executive Director of Finance / Deputy Director of Quality Governance	Not Delegated **See Table B**
39. Investigation of Fraud, Bribery and ~~/~~Corruption or Financial Irregularities	Executive Director of Finance	Lead Local Counter Fraud Specialist	Not Delegated
40. Commercial Sponsorship			
Agreement to proposal in accordance with BCU HB procedures	Chief Executive	Executive Director of Finance	Not Delegated
41. Cost/Notional Rent/Third Party Developer/Improvement Grants			All Matters locally supported by CFO / FD
Approval of all schedules of payments	Chief Executive	Executive Director of Operations ~~Integrated Clinical Delivery~~	Service Director
Submission to Welsh Government for all new GP premises or major extensions in accordance with BCU HB Primary Care Estates Strategy	Chief Executive	Executive Director of Operations ~~Integrated Clinical Delivery~~	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
42. Freedom of Information	Chief Executive	Chief Digital and Information officer ~~Director of Digital~~	Assistant Director of Compliance and Business Management ~~Service Director~~
43. Compliance Lead Roles:			
a) Caldicott Guardian	Chief Executive ~~Executive Medical Director~~	Executive ~~Deputy~~ Medical Director	Deputy Medical Director ~~Not Delegated~~
b) Data Protection Officer		Data Protection Officer~~Director of Digital~~	
c) Senior Information Risk Owner	Chief Executive		Head of Information Governance ~~Not Delegated~~
	Chief Executive	Chief Digital Information Officer~~Executive Director of Finance~~	Not Delegated
44. Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)	Chief Executive	Executive Director of Operations ~~Integrated Clinical Delivery~~	Not Delegated
45. National Health Services (Wales) Act 2006 Section 33 Agreements: Arrangements between NHS Bodies and Local Authorities	Chief Executive	Executive Director of Finance	Service Director (CFO / FD Supported) **See also Table B**
46. Statutory compliance with respective Legislation	Chief Executive	Board Secretary	Service Director for implementation
47. National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 (Statutory Instrument 2005: 3039) Appointment of all Medical and Dental Consultant posts. Consultant posts within Public Health that are open to both medically qualified and those qualified in other disciplines other than medicine should follow this process, even though they fall outside of the requirements of the Statutory Instrument.	Board	Chair of ACC's	Not Delegated
48. All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR)	Chief Executive	WHSSC IPFR Panel £300,000 to £1,000,000; Chief Executive up to £299,999; Chair and	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
		Vice Chair of Health Board IPFR Panel together sign up to £125,000	
*** The IPFR Panel cannot make policy decisions for the health board. Any policy proposals arising from their considerations and decisions must be reported to the Health Board Quality, Safety & Experience Committee**			
~~**49. Carbon Reduction Commitment Order (Phase 2) Agency Registration**~~	~~Chief Executive~~	~~Executive Director of Finance~~	~~Not Delegated~~
~~50.~~49. **Human Tissue Act 20014**	Chief Executive	Executive Medical Director	Service Director for implementation
~~51.~~50. **Ionising Radiation (Medical Exposure) Regulations 2017**	Chief Executive	Executive Director of Therapies & Health Sciences / Executive Medical Director	Service Director for implementation
~~52.~~51. **Nurse Staffing Levels Act (Wales) 2016**	Chief Executive	Executive Director of Nursing & Midwifery	Service Director for implementation
~~53.~~52. **Welsh Language Standard Reporting**	Chief Executive	Executive Director of Public Health	Service Director for implementation
~~54.~~53. **Controlled Drugs Accountable Officer**	Chief Executive	Chief Pharmacist	Not Delegated
~~55.~~54. **Upholding Professional Standards in Wales (UPSW):** **Responsible Officer** **Appointing a Designated Board Member**	 Executive Medical Director (SRO) Health Board Chair	 Deputy Medical Director (Deputy Responsible Officer) Remuneration & Terms of Service Committee	 Service Director for implementation Not Delegated

Table B – Scheme of Financial Delegation

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

All purchases must ensure compliance with Standing Financial Instruction Schedule 1 - Procurement of Works, Goods and Services with regard to the required quotation or Tendering exercise.

The governance section (i.e. Board, Committees, Executive Team, etc.) should be reviewed initially to ascertain the approval route and requirements.

NHS Wales Shared Services Partnership (NWSSP) provide numerous support functions to the Health Board including procurement services as detailed in Section 11 of the Health Board's Standing Financial Instructions (SFIs). NWSSP Procurement Services maintain detailed policies and procedures that comply with the Health Board's SFIs and this Scheme of Reserved Delegation (SoRD).

All Integrated Health Communities (IHCs) and Divisions must have a local Standard Operating Procedure (SOP) linking activities to the delegated limits set out in Table B2 (see below) at a granular level of application within their service area. For example, the Central IHC Ward Manager's £500 general expenditure limit applies to the approval of travel & subsistence, bank staff and staff overtime expenditure.

Within Table B2 there are various job roles which have been consolidated into bandings of delegated limits. If there is uncertainty as to a delegated limit or which banding or level a specific job role relates to or is included within, then refer to the Division's SOP or discuss with the relevant Service Director or CFO.

References within Tables B and B2 of an approval limit "up to" includes the value stated, for example, "Up to £50k" includes expenditure of £50,000. Approval limits where it states "Below" does not include the value stated, for example, "Below £1m" means approval of amounts up to £999,999.

	Budget changes	General expenditure	Healthcare agreements (as per SFI S.12.2) WG Exemptions (see below)				Revenue and Capital (Business Case and Contractual Commitment approvals)				Specialist		Procurement waivers	Staffing			Charitable Funds	
Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors to apply scheme of delegation within their structures.																		
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams (Virements)	Higher of: Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Contracts between NHS Bodies (annual value)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	IPFR / CHC (PPAs and IPAs)	Building and engineering orders; related consultancy support (individual contractual commitment)	Medical devices; plant; machinery; related consultancy support (individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	All leases (granting or termination of leases; lifetime value) Includes Revenue Operating and IFRS16 Capital leases	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by ED of W&OD; VERS by RATS Committee)	New drugs (value based on annual costs after approval – see Table A)	All areas	New posts (additional funded establishment)	Agency and Waiting List Initiatives (all areas)		Locally held funds (total funding bid value)	General funds (total funding bid value)
				Framework	Not under any Framework	For IPFRs: See note 3				Property/Equipment/Managed Service Contracts etc.			See note 6	See note 5				See note 4	
Welsh Government (In advance of contract planning).		£1m+			£1m+	IPFR: £1m+	£1m+ For Capital, approval is via IFRS16 and Business Case process – ADL required for above £0.5m but below £1.0m				£1m+	£1m+ Board and WG						£1m+	£1m+
Board	£1m+	£1m+	Initial contract schedule approved via annual budget approval process. New contracts / variations £1m+ to be retrospectively reported with £10m+ approved in advance.	£1m+ for approval. All agreements to be reported periodically for noting	£1m+ for approval (including Primary Care). All agreements to be reported periodically for noting	£1m+ for approval. All agreements to be reported periodically for noting	£1m+	£1m+	£1m +	£1m + or any which need signing under seal (Reservation of Power, Number 33)	£0.5m+	Terminations £50k+ by WG See SFI (Section 17) and Table A (Section 16) as special rules apply for certain losses and ex-gratia payments.	£1m+					£1m+	£1m+
Performance, Finance and Information Governance Committee					All Primary Care		Below £1m	Below £1m	Below £1m	£250k+									
Audit Committee												All payments to be reported. Novel/contentious approval in advance		Retrospective reporting					
Executive Team			All for noting.	All for noting.	All for noting.	All for noting.				All for noting. Up to £250k for approval (following advice from CIG)			All for noting.						
Charitable Funds Committee (all Executives can authorise use of funds up to £5k)																		£5k+	
Senior Leadership Team													Up to £0.5m (see note 6)						

	Budget changes	General expenditure	Healthcare agreements (as per SFI S.12.2) WG Exemptions (see below)				Revenue and Capital (Business Case and Contractual Commitment approvals)				Specialist			Procurement waivers	Staffing			Charitable Funds	
Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors to apply scheme of delegation within their structures.																			
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams (Virements)	Higher of: Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Contracts between NHS Bodies (annual value)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	IPFR / CHC (PPAs and IPAs)	Building and engineering orders; related consultancy support (individual contractual commitment)	Medical devices; plant; machinery; related consultancy support (individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	All leases (granting or termination of leases; lifetime value) Includes Revenue Operating and IFRS16 Capital leases	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by ED of W&OD; VERS by RATS Committee)	New drugs (value based on annual costs after approval – see Table A)	All areas	New posts (additional funded establishment)	Agency and Waiting List Initiatives (all areas)		Locally held funds (total funding bid value)	General funds (total funding bid value)
				Framework	Not under any Framework	For IPFRs: See note 3				Property/Equipment/Managed Service Contracts etc.			See note 6	See note 5				See note 4	
Chief Executive (above these limits only following prior approval by Board)	Above £0.5m, below £1m	Above £0.5m, below £1m	New / contract variation below £10m.	Below £1m	Below £1m	All CHC PPAs. CHC IPAs: £1m+ (per annum) IPFR: Below £300k (£300k to £1m: WHSSC IPFR)	Above £0.5m, below £1m	Above £0.5m, below £1m	Above £0.5m, below £1m	Above £0.5m, below £1m	Above £250k, below £0.5m	Above £0.5m, below £1m	Above £0.5m, below £1m	£25k+	Approve new posts across HB			Below £1m	Below £1m
Deputy Chief Executive	Above £0.5m, below £1m	Above £0.5m, below £1m	New / contract variation below £10m.	Below £1m	Below £1m	All CHC PPAs	Above £0.5m, below £1m	Above £0.5m, below £1m	Above £0.5m, below £1m	Above £0.5m, below £1m	Above £250k, below £0.5m	Above £0.5m, below £1m	Above £0.5m, below £1m		Approve new posts across HB			Up to £0.5m	Up to £0.5m
Executive Director of Finance	Above £0.5m, below £1m	Above £0.5m, below £1m	New / contract variation below £10m.	Below £1m	Below £1m	IPAs: Above £0.5m, below £1m (per annum).	Above £0.5m, below £1m	Above £0.5m, below £1m	Above £0.5m, below £1m	Above £250k, below £0.5m	Above £250k, below £0.5m	Above £0.5m, below £1m	Above £0.5m, below £1m	Up to £25k	Approve new posts across HB			Up to £0.5m	Up to £0.5m
An Executive Director and Finance Director (2 to sign)		Up to £0.5m	New / contract variation up to £5m	Up to £0.5m	Up to £0.5m	IPAs: £250k to £0.5m (per annum)					Up to £250k			All Single Waivers (SWs) are created within the Services and approved by the relevant Service Director and Executive Director. Following Procurement review all SW's must be submitted for approval by the Executive Director of Finance (and Chief Executive if above £25k)					
Executive Directors (not listed separately below)	Within own delegated budget	Up to £300k									Up to £100k				Approve new posts within own structure.	Approve in advance in own structure.		Up to £5k	Up to £5k
Executive Medical Director	Within own delegated budget	Up to £300k				IPFR (Panel): Up to £125k			Up to £0.5m		Up to £100k	Up to £0.5m	Above £0.5m, below £1m		Approve new posts within own structure.	Approve in advance in own structure.		Up to £5k	Up to £5k
Executive Director of Transformation, Strategic Planning and Commissioning	Within own delegated budget	Up to £300k									Up to £100k				Approve new posts within own structure.	Approve in advance in own structure.		Up to £5k	Up to £5k
Executive Director of Public Health	Within own delegated budget	Up to £300k									Up to £100k				Approve new posts within own structure.	Approve in advance in own structure.		Up to £5k	Up to £5k

	Budget changes	General expenditure	Healthcare agreements (as per SFI S.12.2) WG Exemptions (see below)				Revenue and Capital (Business Case and Contractual Commitment approvals)				Specialist			Procurement waivers	Staffing			Charitable Funds	
Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors to apply scheme of delegation within their structures.																			
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams (Virements)	Higher of: Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Contracts between NHS Bodies (annual value)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	IPFR / CHC (PPAs and IPAs)	Building and engineering orders; related consultancy support (individual contractual commitment)	Medical devices; plant; machinery; related consultancy support (individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	All leases (granting or termination of leases; lifetime value) Includes Revenue Operating and IFRS16 Capital leases	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by ED of W&OD; VERS by RATS Committee)	New drugs (value based on annual costs after approval – see Table A)	All areas	New posts (additional funded establishment)	Agency and Waiting List Initiatives (all areas)		Locally held funds (total funding bid value)	General funds (total funding bid value)
				Framework	Not under any Framework	For IPFRs: See note 3				Property/Equipment/Managed Service Contracts etc.			See note 6	See note 5				See note 4	
Executive Director of Workforce & OD	Within own delegated budget	Up to £300k									Up to £100k	Terminations up to £50k (£50k+ for approval by WG)		All Single Waivers (SWs) are created within the Services and approved by the relevant Service Director and Executive Director. Following Procurement review all SW's must be submitted for approval by the Executive Director of Finance (and Chief Executive if above £25k)	Approve new posts across HB	Approve in advance in own structure.		Up to £5k	Up to £5k
Executive Director of Nursing & Midwifery	Within own delegated budget	Up to £300k									Up to £100k				Approve new posts within own structure.	Approve in advance in own structure.		Up to £5k	Up to £5k
Executive Director of Therapies & Health Sciences	Within own delegated budget	Up to £300k						Up to £150k			Up to £100k				Approve new posts within own structure.	Approve in advance in own structure.		Up to £5k	Up to £5k
Executive Director of Operations	Within own delegated budget	Up to £300k						Up to £150k			Up to £100k				Approve new posts within own structure.	Approve in advance in own structure.		Up to £5k	Up to £5k
Chief Digital and Information Officer	Within own delegated budget	Up to £250k							Up to £250k		Up to £100k				Approve new posts within own structure.	Approve in advance in own structure			
Director of Partnerships, Engagement & Communications	Within own delegated budget	Up to £250k									Up to £100k				Approve new posts within own structure.	Approve in advance in own structure			
Board Secretary	Within own delegated budget	Up to £250k									Up to £100k				Approve new posts within own structure.	Approve in advance in own structure.			
Service Directors (See Table B2 for divisional / departmental delegation levels)	Within own delegated budget	Up to £250k	New / contract variation up to £250k			CHC IPA: Up to £250k per annum (following approval at CHC panel)		Up to £250k		Up to £250k	Up to £100k				Approve new posts within own structure.	Within Delegated Budget		Up to £5k	

The above scheme only relates to matters delegated by the Board to the Chief Executive and Directors, together with certain other specific matters referred to in the Standing Financial Instructions. Each Director is responsible for delegation within their department, in line with Table B2 below.

	Budget changes	General expenditure	Healthcare agreements (as per SFI S.12.2) WG Exemptions (see below)				Revenue and Capital (Business Case and Contractual Commitment approvals)				Specialist			Procurement waivers	Staffing			Charitable Funds	
Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors to apply scheme of delegation within their structures.																			
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams (Virements)	Higher of: Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Contracts between NHS Bodies (annual value)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	IPFR / CHC (PPAs and IPAs)	Building and engineering orders; related consultancy support (individual contractual commitment)	Medical devices; plant; machinery; related consultancy support (individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	All leases (granting or termination of leases; lifetime value) Includes Revenue Operating and IFRS16 Capital leases	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by ED of W&OD; VERS by RATS Committee)	New drugs (value based on annual costs after approval – see Table A)	All areas	New posts (additional funded establishment)	Agency and Waiting List Initiatives (all areas)		Locally held funds (total funding bid value)	General funds (total funding bid value)
				Framework	Not under any Framework	For IPFRs: See note 3				Property/Equipment/Managed Service Contracts etc.			See note 6	See note 5				See note 4	

Table B2 – Scheme of Financial Delegation, Divisional Level Posts

Finance Directors	Up to £0.5m	Up to £250k	Up to £250k	Up to £250k	Up to £250k		Up to £0.5m	Up to £0.5m	Up to £0.5m	Up to £250k	Up to £100k	Up to £0.5m (Operational FD only)		Up to £250k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*		Up to £250k	Up to £250k
IHC Director, Director of Operations, MHLD, Divisional Directors and Pan-BCU equivalent (not mentioned separately below)	Within own delegated budget	Up to £250k	New / contract variation up to £250k	Up to £250k	Up to £250k	CHC IPA: Up to £250k per annum (following approval at CHC panel)		Up to £250k		Up to £250k	Up to £100k			Up to £250k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*		Up to £5k	
IHC Medical Director	Within own delegated budget	Up to £250k	Up to £250k					Up to £150k			Up to £100k			Up to £250k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*			
Associate Director of Healthcare Contracting		Up to £250k						Up to £250k			Up to £100k							Up to £5k	
Chief Finance Officer (CFO) / IHC Business Partner "note1"																			
Director: Nursing MHLD and Pan-BCU equivalent	Within own delegated budget	Up to £150k	Up to £150k					Up to £150k		Up to £150k	Up to £75k			Up to £150k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*		Up to £5k	
IHC Directors: Nursing / Pharmacy and Medicines Management / Allied Health Professionals / Hospitals	Within own delegated budget	Up to £150k	Up to £150k					Up to £150k			Up to £100k				Within delegated budget in own team	Within delegated budget*		Up to £5k	
IHC Assistant Directors: Nursing	Within own delegated budget	Up to £150k	Up to £150k								Up to £100k				Within delegated budget in own team	Within delegated budget*			

	Budget changes	General expenditure	Healthcare agreements (as per SFI S.12.2) WG Exemptions (see below)				Revenue and Capital (Business Case and Contractual Commitment approvals)				Specialist			Procurement waivers	Staffing			Charitable Funds	
Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors to apply scheme of delegation within their structures.																			
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams (Virements)	Higher of: Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Contracts between NHS Bodies (annual value)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	IPFR / CHC (PPAs and IPAs)	Building and engineering orders; related consultancy support (individual contractual commitment)	Medical devices; plant; machinery; related consultancy support (individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	All leases (granting or termination of leases; lifetime value) Includes Revenue Operating and IFRS16 Capital leases	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by ED of W&OD; VERS by RATS Committee)	New drugs (value based on annual costs after approval – see Table A)	All areas	New posts (additional funded establishment)	Agency and Waiting List Initiatives (all areas)		Locally held funds (total funding bid value)	General funds (total funding bid value)
				Framework	Not under any Framework	For IPFRs: See note 3				Property/Equipment/Managed Service Contracts etc.			See note 6	See note 5				See note 4	
Director of Capital and Estates	Within own delegated budget	Up to £150k					Up to £150k	Up to £100k		Up to £150k	Up to £50k			Up to £150k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*			
Director of Planning and Performance	Within own delegated budget	Up to £150k													Within delegated budget in own team	Within delegated budget*			
Head of Medicines Management / Therapies / Psychology	Within own delegated budget	Up to £150k	Up to £150k					Up to £150k		Up to £150k	Up to £75k			Up to £75k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*		Up to £5k	
Deputy Director (equivalent)	Within own delegated budget	Up to £150k	Up to £150k	Up to £150k	Up to £150k			Up to £150k		Up to £150k	Up to £75k			Up to £150k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*		Up to £5k	
Associate Directors (equivalent)	Within own delegated budget	Up to £150k	Up to £150k	Up to £150k	Up to £150k			Up to £150k		Up to £150k	Up to £75k			Up to £150k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*		Up to £5k	
Assistant Directors (equivalent)	Within own delegated budget	Up to £75k	Up to £75k	Up to £75k	Up to £75k		Up to £75k (Capital and Estates only)	Up to £75k		Up to £75k	Up to £75k			Up to £75k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*		Up to £5k	
Heads of Service / Specialty / Section (and equivalent)	Within own delegated budget	Up to £75k	Up to £75k					Up to £75k						Up to £75k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*			
Director of Performance / Programme Directors (and equivalent)		Up to £75k													Within delegated budget in own team	Within delegated budget*			
Directorate General Manager / Head of Nursing – Clinical Quality and CHC (only)	Within own delegated budget	Up to £75k												Up to £75k (further approval required from EDoF / CEO)					
Head of Healthcare Contracting - Finance		Up to £75k (Non-contracted activity payments only)																	

	Budget changes	General expenditure	Healthcare agreements (as per SFI S.12.2) WG Exemptions (see below)				Revenue and Capital (Business Case and Contractual Commitment approvals)				Specialist			Procurement waivers	Staffing			Charitable Funds	
Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors to apply scheme of delegation within their structures.																			
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams (Virements)	Higher of: Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Contracts between NHS Bodies (annual value)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	IPFR / CHC (PPAs and IPAs)	Building and engineering orders; related consultancy support (individual contractual commitment)	Medical devices; plant; machinery; related consultancy support (individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	All leases (granting or termination of leases; lifetime value) Includes Revenue Operating and IFRS16 Capital leases	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by ED of W&OD; VERS by RATS Committee)	New drugs (value based on annual costs after approval – see Table A)	All areas	New posts (additional funded establishment)	Agency and Waiting List Initiatives (all areas)		Locally held funds (total funding bid value)	General funds (total funding bid value)
				Framework	Not under any Framework	For IPFRs: See note 3				Property/Equipment/Managed Service Contracts etc.			See note 6	See note 5				See note 4	
Contracts Manager	Within own delegated budget	Up to £50k	Up to £50k					Up to £50k						Up to £30k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*			
Head of Operations	Within own delegated budget	Up to £50k													Within delegated budget in own team	Within delegated budget*			
Service Lead / Site or General Manager	Within own delegated budget	Up to £30k	Up to £30k					Up to £30k						Up to £30k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*			
Matron (Cancer services only)	Within own delegated budget	Up to £25k	Up to £25k					Up to £25k						Up to £25k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*			
Principal Finance Manager - Healthcare Contracts		Up to £30k (Non-contracted activity payments only)																	
Estates Operations / Property Managers / and Heads of Facilities / Hotel Services	Within own delegated budget	Up to £25k					Up to £25k	Up to £25k			Up to £10k				Within delegated budget in own team	Within delegated budget*			
Heads of Nursing / Deputy Directorate General Managers / CAMHS Programme Manager	Within own delegated budget	Up to £25k																	
Outpatient / IV Suite Sister (Cancer services only) / Haemophilia Manager	Within own delegated budget	Up to £20k	Up to £30k					Up to £30k						Up to £30k (further approval required from EDoF / CEO)	Within delegated budget in own team	Within delegated budget*			
Operations Managers (within IHCs)	Within own delegated budget	Up to £20k																	
Heads of Site / Deputy Heads of Nursing / Theatre Manager	Within own delegated budget	Up to £15k																	

	Budget changes	General expenditure	Healthcare agreements (as per SFI S.12.2) WG Exemptions (see below)				Revenue and Capital (Business Case and Contractual Commitment approvals)				Specialist			Procurement waivers	Staffing			Charitable Funds	
Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors to apply scheme of delegation within their structures.																			
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams (Virements)	Higher of: Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Contracts between NHS Bodies (annual value)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	IPFR / CHC (PPAs and IPAs)	Building and engineering orders; related consultancy support (individual contractual commitment)	Medical devices; plant; machinery; related consultancy support (individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	All leases (granting or termination of leases; lifetime value) Includes Revenue Operating and IFRS16 Capital leases	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by ED of W&OD; VERS by RATS Committee)	New drugs (value based on annual costs after approval – see Table A)	All areas	New posts (additional funded establishment)	Agency and Waiting List Initiatives (all areas)		Locally held funds (total funding bid value)	General funds (total funding bid value)
				Framework	Not under any Framework	For IPFRs: See note 3				Property/Equipment/Managed Service Contracts etc.			See note 6	See note 5				See note 4	
Senior Finance Manager - Healthcare Contracts		Up to £15k (Non-contracted activity payments only)																	
Heads of: Corporate Affairs / Office N&M / Information Governance / Risk Management	Within own delegated budget	Up to £10k																	
IHCs: Head of GPOOH / Heads of Therapies (individual specialties) / Assistant Director of Nursing	Within own delegated budget	Up to £10k																	
IHC Children's Services (excl. CAMHS Programme Manager)	Within own delegated budget	Up to £10k																	
Surgery Managers	Within own delegated budget	Up to £7k																	
Day Unit / Ward Sister (Cancer Services only)	Within own delegated budget	Up to £5k	Up to £30k					Up to £30k						Up to £30k	Within delegated budget in own team	Within delegated budget*			
Service User Managers / Admin Managers / Operations Managers (GPOOH) / Planning & Commissioning Managers / Cath Lab Manager / Lead Managers / Clinical Services Manager / Home Dialysis Team Leader / EMRTS Programme Manager / Team Leader – Theatres	Within own delegated budget	Up to £5k	Up to £5k												Within delegated budget in own team	Within delegated budget*			
Head of Financial Control / Business Systems		Up to £5k (note 2)					Up to £75k (note 2)					Up to £5k							

	Budget changes	General expenditure	Healthcare agreements (as per SFI S.12.2) WG Exemptions (see below)				Revenue and Capital (Business Case and Contractual Commitment approvals)				Specialist			Procurement waivers	Staffing			Charitable Funds	
Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors to apply scheme of delegation within their structures.																			
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams (Virements)	Higher of: Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Contracts between NHS Bodies (annual value)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	IPFR / CHC (PPAs and IPAs)	Building and engineering orders; related consultancy support (individual contractual commitment)	Medical devices; plant; machinery; related consultancy support (individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	All leases (granting or termination of leases; lifetime value) Includes Revenue Operating and IFRS16 Capital leases	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by ED of W&OD; VERS by RATS Committee)	New drugs (value based on annual costs after approval – see Table A)	All areas	New posts (additional funded establishment)	Agency and Waiting List Initiatives (all areas)		Locally held funds (total funding bid value)	General funds (total funding bid value)
				Framework	Not under any Framework	For IPFRs: See note 3				Property/Equipment/Managed Service Contracts etc.			See note 6	See note 5				See note 4	
Financial Accountant – Capital & Tax		Up to £5k (see note 2)					Up to £75k (pan BCU discretionary capital only)												
Senior Estates Officers / Deputy Heads of Site	Within own delegated budget	Up to £5k					Up to £5k	Up to £5k			Up to £10k								
IHC Primary Care: Deputy Director / Senior Co-ordinator / HoS / Practice Manager	Within own delegated budget	Up to £5k																	
IHC Pharmacy: Operations Manager / Head / Service Lead / Technician	Within own delegated budget	Up to £5k																	
Matrons – Acute Nursing / Community Services Operations Manager	Within own delegated budget	Up to £5k																	
Facilities Managers: Domestic / Catering / Hotel Services	Within own delegated budget	Up to £2k																	
Area Specialties Manager / Endoscopy Unit Manger / Deputy Team Leader – Theatres / CSSD Manager / IHC Sisters – Acute nursing	Within own delegated budget	Up to £2k																	
IHC Operations Managers / Matrons and DN Leads – Community Nursing / Other Managers (not specified)	Within own delegated budget	Up to £1k																	
Ward / MDT Manager	Within own delegated budget	Up to £1k																	
General Office Manager / Line Managers (not listed above) within Corporate Divisions		Up to £0.5k																	

	Budget changes	General expenditure	Healthcare agreements (as per SFI S.12.2) WG Exemptions (see below)				Revenue and Capital (Business Case and Contractual Commitment approvals)				Specialist		Procurement waivers	Staffing			Charitable Funds	
Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors to apply scheme of delegation within their structures.																		
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams (Virements)	Higher of: Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Contracts between NHS Bodies (annual value)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	Private / 3rd Sector / Grants / Primary Care / Local Authorities (total contract value over life of contract)	IPFR / CHC (PPAs and IPAs)	Building and engineering orders; related consultancy support (individual contractual commitment)	Medical devices; plant; machinery; related consultancy support (individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	All leases (granting or termination of leases; lifetime value) Includes Revenue Operating and IFRS16 Capital leases	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by ED of W&OD; VERS by RATS Committee)	New drugs (value based on annual costs after approval – see Table A)	All areas	New posts (additional funded establishment)	Agency and Waiting List Initiatives (all areas)		Locally held funds (total funding bid value)	General funds (total funding bid value)
				Framework	Not under any Framework	For IPFRs: See note 3				Property/Equipment/Managed Service Contracts etc.			See note 6	See note 5				See note 4
IHC / Mental Health CHC Panel						CHC IPA Up to £2k per week												
Assistant Director Planning and Performance							Up to £150k (Capital expenditure only)				Up to £50k							
Capital Programmes Manager							Up to £50k (pan BCU discretionary capital only)											
Assistant Financial Accountant - Financial Control		Up to £20k (see note 2)					Up to £20k (pan BCU discretionary capital only)											
Accounts Receivable Manager		Up to £5k (see note 2)																
Patients Monies Officer		Up to £5k (see note 2)																
Deputy Director of Quality Governance												Up to £150k			Within delegated budget in own team			
Head of Quality Governance												Up to £20k						
Principal Finance Manager - Charitable Funds																	Up to £50k	Up to £50k
Assistant Financial Accountant - Charitable Funds																	Up to £5k	Up to £5k
Authorised fund holder (Charitable Funds)																	Up to £5k	

* Agency and Waiting List Initiatives must generally be approved in advance. However, in exceptional circumstances when staff are required out of hours, they can be approved retrospectively.

Notes:

1. The CFO is a key role within the Financial Governance arrangements, however their role is to "review" and "ratify" Oracle Requisitions, Contracts, Establishment Control Requests, and other such financial instruments within the limits of their particular IHC / Division, not to "approve" them. Approval sits with the delegated Budget Manager. As such the CFOs financial limit within Oracle will technically be set at £0 to reflect this context. There may be specific items or instances where the CFO does need to "approve" and these will be listed separately.
2. General Expenditure category restrictions apply (see local Standard Operational Procedures (SOP) that link to the SoRD)
3. Where the approval relates to an Individual Patient Funding Request (IPFR) these are reviewed by a Panel made up of senior medical and clinical staff. The approval process is as per the All Wales Policy stated below:
    a. Chair and Vice Chair of Health Board IPFR Panel together sign up to £125,000
    b. Chief Executive up to £299,999
    c. WHSSC IPFR Panel £300,000 to £1,000,000

    All details will be reported at Senior Leadership Team meetings for noting.

4. The Health Board is the Corporate Trustee of the charity and it is considered for accounting standards compliance to have control of the Charity as a subsidiary. The Health Board has with the agreement of the Welsh Government, adopted the IAS 27 (10) exemption to consolidate the results of the Charity within the statutory accounts of the Health Board and instead these results will be consolidated at Welsh Government level. Charitable funds are used exclusively for charitable purposes and must satisfy both the objects of the registered charity and any restrictions of the specific income source or fund. All items of expenditure will need to be approved using the appropriate authorisation level and relevant processes and controls are in place for reviewing the expenditure and justification for spend to ensure all spend is eligible prior to it being incurred. The procedures for requisitioning and approving any expenditure for items or services using charitable funds is identical to that for the Health Board, therefore all procurement policies apply equally.
5. Final approval of procurement waivers is with the Executive Director of Finance (up to £25k) and Chief Executive (above £25k). In addition to the initial 'local' approval, the Executive Director with that area of responsibility must also approve prior to submission to NWSSP procurement.
6. For new drugs and the commitment to expenditure after year one of the treatment fund arrangements, the approval process is as follows:
    a. NICE Implementation Group, onwards to
    b. Drugs and Therapeutics Group, onwards to
    c. Senior Leadership Team (SLT) for approval up to £0.5m
    d. Board approval for £1m plus

Healthcare Agreements – Welsh Government Exemptions:

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;
- All eligible LHB contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;

- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

I. All NHS contracts; that is where one health services body contracts with another health service body.
II. Wales Public Sector Framework Agreements e.g. Frameworks established by National Procurement Services (NPS) or NWSSP (not exhaustive) via direct award or mini competition
III. Third Party Public Sector Framework Agreements e.g. Frameworks established by Crown Commercial Services, NHS supply chain (not exhaustive) via direct award. However approval will be required for award of contracts through mini competition or where the specification is modified from that stated within the Framework Agreement

Table B – Scheme of Financial Delegation

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

All purchases must ensure compliance with Standing Financial Instruction Schedule 1 - Procurement of Works, Goods and Services with regard to the required quotation or Tendering exercise.

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

	Budget changes	General expenditure	Healthcare agreements	Revenue and Capital (Business Case and Contractual Commitment approvals)			Specialist				Charitable Funds		Procurement waivers	Staffing	
	Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.														
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishment)	Agency and Waiting List Initiatives (all values)
Any 2 of CEO, Executive Director of Integrated Clinical Delivery and DoF (must include DoF)		Up to £0.5m	New or contract variation to £5.0m (to £1m for Private sector).					Up to £250k		Up to £0.5m			As escalated by DoF		
Executive Director of Finance	£0.5m to £1m	£0.5m to £1m	New / contract variation to £10.0m.	£0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£250k to £0.5m	£250k to £0.5m	£0.5m to £1.0m	£0.5m to £1.0m	Up to £5k	Up to £5k	As escalated by DoF	Can approve new posts across LHB	No requirement
Executive Directors, (not noted below)		Up to £300k						Up to £100k					All Single Tender Waivers are created within the Services and approved by the relevant Service Director, however all STW's must be approved by FD: OF and Executive Director of Finance or Chief Executive if escalated by FD: OF	Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director Transformation & Improvement	Within own delegated budget	Up to £300k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Medical Director	Within own delegated budget	Up to £300k				Up to £0.5m		Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Public Health	Within own delegated budget	Up to £300k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of W & OD	Within own delegated budget	Up to £300k						Up to £100k	Terminations up to £50k (>£50k = WG)					Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Nursing & Midwifery	Within own delegated budget	Up to £300k						Up to £100k	Up to £150k					Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Therapies & Health Sciences	Within own delegated budget	Up to £300k			Up to £150k			Up to £100k	Up to £150k					Can approve new posts within own structure.	Must approve in advance in own structure.
Director of Digital & CDIO	Within own delegated budget	Up to £250k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure

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

	Budget changes	General expenditure	Healthcare agreements	Capital			Specialist				Charitable Funds		Procurement waivers	Staffing	
		Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.													
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations only approved by Exec Director of W&OD; VERS require RATS Committee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)
Regional Directors / Systems Oversight Directors	Within own delegated budgets	Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med Mgt Group	Up to £5k			Can approve new posts within own team.	As escalated by Direct Reports*
Integrated Health Care Directors , Health Community Director of Operations, Director of Mental Health & Learning Disabilities	Within own delegated budget	Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med Mgt Group	Up to £5k			Can approve new posts within own team.	As escalated by Direct Reports*
Associate Directors	Within own delegated budget	Up to £150k			Up to £150k			Up to £150k			Up to £5k			Can approve new posts within own structure	Must approve in advance in own structure.
Assistant Directors	Within own delegated budget	Up to £75k	Up to £75k		Up to £75k			Up to £75k			Up to £5k			Can approve new posts within own structure	Must approve in advance in own structure.
Head of Investigations and Redress									Up to £20k					Can approve new posts within own structure	
Claims Managers									Up to £5k						
Authorised fund holder (Charitable Funds)											Up to £5k				
Medicines Management Group(s)										All new drugs and treatments					

* Agency and Waiting List Initiatives must generally be approved in advance. However, in exceptional circumstances when staff are required out of hours, they can be approved retrospectively.

This scheme only relates to matters delegated by the Board to the Chief Executive and Directors, together with certain other specific matters referred to in Standing Financial Instructions. Each Director is responsible for delegation within their department, in line with Table B2 below.

Updated Master SoRD ratified at January 2020 Board Meeting v22.0 DRAFT Master SoRD November 2021 LJ TW v0.03

Table B.2 – Scheme of Financial Delegation, Divisional Level Posts

Any expenditure approval must be within funding limits of approved budgets.
Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.
Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.

	Budget changes	**General expenditure**	**Healthcare agreements**	**Capital (Business Case and Contractual Commitment approvals)**			**Specialist**				**Charitable Funds**		**Procurement waivers**	**Staffing**	
	Budget Virements (cross-divisional virements need appropriate reciprocal approval)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values (authorised within local Delegation but ultimate Approval is with the DoF)	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)
IHC Director MHL and Pan-BCU equivalent	Up to the Delegated Budget limit	Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med Mgt Group	Up to £5k		Up to £250k	Within Delegated Budget.	Within Delegated Budget
Director of Operations, MHL and Pan-BCU equivalent	Up to the Delegated Budget limit	Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med MGT Group	Up to £5k		Up to £250k	Within Delegated Budget.	Within Delegated Budget
CFO / FD "note1"	Within Budget	Up to £200k	Up to £200k		Up to £200k			Up to £80k			Up to £5k		Up to £250k	Within Delegated Budget	Within Delegated Budget
Director: Nursing MHL and Pan-BCU equivalent	Up to the Delegated Budget limit	Up to £150k	Up to £150k		Up to £150k			Up to £75k			Up to £5k		Up to £150k	Within own Delegated Budget.	Within own Delegated Budget
Director: 'Doctor' MHL and Pan-BCU equivalent	Up to the Delegated Budget limit	Up to £150k	Up to £150k		Up to £150k			Up to £75k		Up to £100k, following Med MGT Group	Up to £5k		Up to £150k	Within own Delegated Budget.	Within own Delegated Budget
Head of Medicines Mgt	Up to Delegated Budget limit	Up to £150k (within Meds Mgt)	Up to £150k (within Meds Mgt)		Up to £150k			Up to £75k		Up to £100k, following Med Mgt Group	Up to £5k		Up to £75k	Within own Delegated Budget.	Within own Delegated Budget

Table B.2 – Scheme of Financial Delegation, Divisional Level Posts

Any expenditure approval must be within funding limits of approved budgets.
Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.
Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.

	Budget changes	**General expenditure**	**Healthcare agreements**	**Capital (Business Case and Contractual Commitment approvals)**			**Specialist**				**Charitable Funds**		**Procurement waivers**	**Staffing**	
	Budget Virements (cross-divisional virements need appropriate reciprocal approval)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values (authorised within local Delegation but ultimate Approval is with the DoF)	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)
Head of Therapies	Up to Delegated Budget limit	Up to £150k (within Therapies)	Up to £150k (Within Therapies)		Up to £150k			Up to £75k			Up to £5k		Up to £75k	Within own Delegated Budget.	Within own Delegated Budget
Deputy Director (equivalent)	Up to Delegated Budget limit	Up to £150k	Up to £150k		Up to £150k			Up to £75k			Up to £5k		Up to £150k	Within own Delegated Budget.	Within own Delegated Budget
Associate Directors (equivalent)	Up to Delegated Budget limit	Up to £150k	Up to £150k		Up to £150k			Up to £75k			Up to £5k		Up to £150k	Within own Delegated Budget.	Within own Delegated Budget
Assistant Directors (equivalent)	Up to Delegated Budget limit	Up to £75k	Up to £75k		Up to £75k			Up to £75k			Up to £5k		Up to £75k	Within own Delegated Budget.	Within own Delegated Budget
etc															
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****NOTES****

1. The CFO / FD (Job Title to be defied within the New OM) is a key role within the Financial Governance arrangements, however their role is to “review” and “ratify” Oracle Requisitions, Contracts, Establishment Control Requests, and other such financial instruments within the limits of their particular IHC / Division, not to “approve” them; Approval sits with the delegated Budget Manager. As such their financial limit within Oracle will technically be set at £0, to reflect this context. There may be specific items or instances where the CFO/FD does need to “approve” and these will be listed separately.

Teitl adroddiad: ***Report title:***	**Single Waivers (procurement) & Losses and Special Payments – Q4 2022/23**			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 November 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide an update for the fourth quarter of 2022/23 (January 23 to March 23) on conformance with the Health Board's Standing Orders (SOs), incorporating Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation of Powers (SoRD), in relation to Single Waivers and Losses payments. The period relating to April 23 to August 23, was presented to Audit Committee in September 23.			
Argymhellion: ***Recommendations:***	The Audit Committee is asked to: Note: • Single Tender Waivers & Single Quote Waivers implemented by the Health Board Jan 23 to Mar 23 Approve: • Losses and Special Payments Jan 23 to Mar 23			
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	Andrea J Hughes, Interim Finance Director – Operational Claire Beswick, Financial Accountant			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Together with the adoption of Standing Orders (SOs), Local Health Boards in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. The SFIs require Single Waivers and Losses and Special Payments, to be			

	reported to Audit Committee, with the later requiring approval.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Single Waivers highlight risk of failing to meet regulatory and legal requirements, and expected good practice. Losses and Special Payments have specific approval requirements as directed by WG
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Single Waivers highlight risk of failing to meet regulatory and legal requirements, and expected good practice and restrict the ability to evidence Value for Money. Links to BAF:2.3 Health Board Financial Deficit
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Links to BAF:2.3 Health Board Financial Deficit
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** **The report is for noting; and in relation to Losses and Special Payments, for approval.**	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Single Waivers (Tender and Quotes) for the period Jan 23 to Mar 23 2. Losses and Special Payments for the period Jan 23 to Mar 23	

***Appendix 1 :Single Tender Waivers* (for items of expenditure above £25,000)**

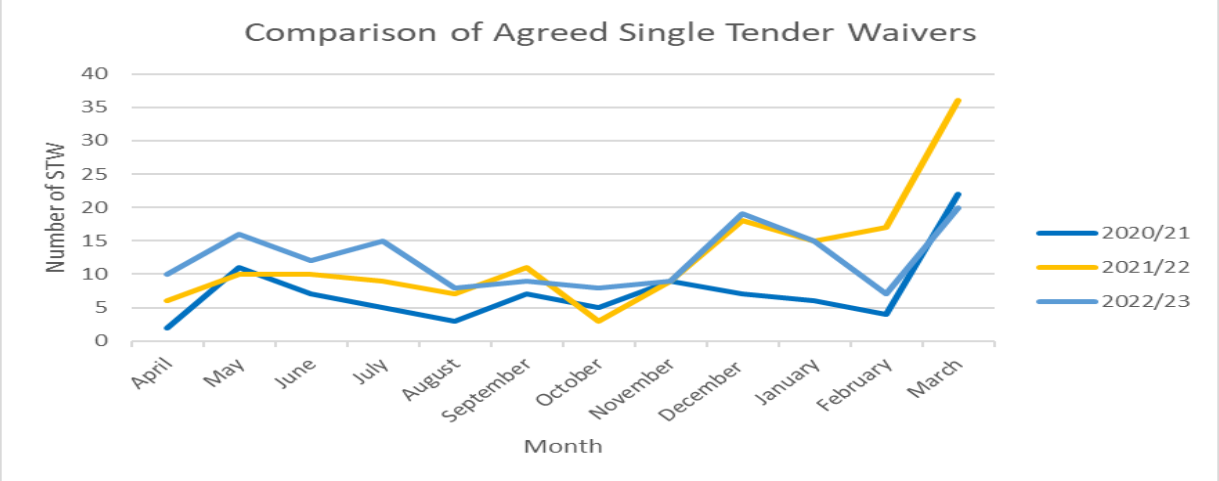
It is normal practice to request bids from multiple suppliers. Where this is not possible, a single tender waiver should be obtained and approved ahead of expenditure being committed. Allowable rationale for a single tender waiver are:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met, e.g. specific equipment required, or compliance with a warranty cover clause;
- A need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

The table below provides a summary of waiver activity for the period from 1st January – 31st March 2023 and year to date:

Single Tender Waivers	**2021/22 Q4**	**2022/2023 Q4**	**2021/22 YTD**	**2022/23 YTD**
Waivers Issued	72	59	150	167
Waivers Approved	68	42	151	148
Value of Approved Waivers	£10.7m	£2.4m	£18.7m	£9.3m
Waivers approval above EU Threshold	9	10	21	23
Cancelled Waivers	1	1	2	8

The chart below provides a summary of the approvals to waive tender requirements, which were received by Procurement for 2022/23, compared with 2020/21 and 2021/22. There has been an increase in quarterly approvals compared with 2021/22. All of the waivers were approved by Procurement.



The below table provides further information on the individual waivers approved in the period.

Breakdown of BCUHB Approved Single Tender Waivers >£25k: 1st January – 31st March 2023

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value £000s	Breached OJEU	Supported By Procurement
2022/2023-972	16/03/2023	IHC West (Secondary Care - YG)	MediTeam	Locum Consultant post to undertake clinical duties for RTT and USC capacity	Genuinely one provider	£192,000.00	YES	Accept
2022/2023-1050	31/01/2023	Corporate	Immedicare	Clinical Assessment and Support Services for Care Homes	Genuinely one provider	£91,980.00	NO	Accept
2022/2023-1080	24/01/2023	Corporate	KIM-Inspire	Continued delivery of Covid/Community Support Hubs	Other (please specify) - One off transitional payment from Welsh Government to allow this hub to continue to operate while Regional Partnership Boards develop their wider hubs programme and consider if they might play a future role as health and social care hubs, or not.	£50,000.00	NO	Accept
2022/2023-1082	24/01/2023	Corporate	Partneriaeth Ogwen	Continued delivery of Covid/Community Support Hubs	Other (please specify) - One off transitional payment from Welsh Government to allow this hub to continue to operate while Regional Partnership Boards develop their wider hubs programme and consider if they might play a future role as health and social care hubs, or not.	£34,816.00	YES	Accept
2022/2023-1083	24/01/2023	Corporate	Canolfan Fenter Congl Meinciau	Continued delivery of Covid/Community Support Hubs	Other (please specify) - One off transitional payment from Welsh Government to allow this hub to continue to operate while Regional Partnership Boards develop their wider hubs programme and consider if they might play a future role as health and social care hubs, or not.	£27,000.00	YES	Accept

2022/2023-1099	24/01/2023	Corporate	Can Cook/Well Fed	A subsidised mobile shop targeted at deprived communities experiencing food poverty in Wrexham and Flintshire. The additional funding will expand the service to four other local authority areas. Each authority will receive a mobile shop service for 3 mths in two different locations once a week. Selling subsidised groceries and 200 subsidised slow cooker meal packs and ready meals, aiming to provide healthy affordable food for three months during the cost of living crisis. The funding covers Staffing costs •Petrol •Cost of the ingredients for meals Translation of material/recipe cards Printing.	Genuinely one provider	£35,000.00	NO	Accept
2022/2023-1100	12/01/2023	Corporate	Can Cook/Eat Well	Delivers slow cooker classes to adults in schools in Flintshire. The classes involve the following: •The provision of a free slow cooker•4 weekly classes of preparing a slow cooker meal, providing two free family ingredient packs. The proposal is to expand these classes across all six local authority areas in north Wales. Each local authority will receive two classes each for 12 participants per class, which is crucial during the current cost of living crisis. funding covers:•Staff •Ingredients •The slow cookers The provision of bilingual recipe cards and recipe book	Genuinely one provider	£30,000.00	NO	Accept

2022/2023-1101	12/01/2023	Corporate	Wrexham County Borough Council	Each Local Authority will receive a £35,000 grant to administer to schools in the area to improve their ability to produce food on-site. Using funding on purchase fruit trees, fruit and vegetable plants and equipment to care for the plants and trees. The aim of the project is to increase access to healthy affordable food. The food produced will either be used for school or distributed to pupils and staff to improve their access to five fruit and vegetables per day. As this grant is only being made available to schools the local authority are the only organisations who can administer the funds.	Genuinely one provider	£35,000.00	NO	Accept
2022/2023-1102	12/01/2023	Corporate	Flintshire County Council	Each Local Authority will receive a £35,000 grant to administer to schools in the area to improve their ability to produce food on-site. Using funding on purchase fruit trees, fruit and vegetable plants and equipment to care for the plants and trees. The aim of the project is to increase access to healthy affordable food. The food produced will either be used for school or distributed to pupils and staff to improve their access to five fruit and vegetables per day. As this grant is only being made available to schools the local authority are the only organisations who can administer the funds.	Genuinely one provider	£35,000.00	NO	Accept

2022/2023-1103	12/01/2023	Corporate	Denbighshire County Council	Each Local Authority will receive a £35,000 grant to administer to schools in the area to improve their ability to produce food on-site. Using funding on purchase fruit trees, fruit and vegetable plants and equipment to care for the plants and trees. The aim of the project is to increase access to healthy affordable food. The food produced will either be used for school or distributed to pupils and staff to improve their access to five fruit and vegetables per day. As this grant is only being made available to schools the local authority are the only organisations who can administer the funds.	Genuinely one provider	£35,000.00	NO	Accept
2022/2023-1104	12/01/2023	Corporate	Conwy County Borough Council	Each Local Authority will receive a £35,000 grant to administer to schools in the area to improve their ability to produce food on-site. Using funding on purchase fruit trees, fruit and vegetable plants and equipment to care for the plants and trees. The aim of the project is to increase access to healthy affordable food. The food produced will either be used for school or distributed to pupils and staff to improve their access to five fruit and vegetables per day. As this grant is only being made available to schools the local authority are the only organisations who can administer the funds.	Genuinely one provider	£35,000.00	NO	Accept

2022/2023-1105	12/01/2023	Corporate	Cyngor Gwynedd Council	Each Local Authority in north Wales will receive a £35,000 grant to administer to schools in the area to improve their ability to produce food on-site. The funding will be used to purchase fruit trees, fruit and vegetable plants and equipment to care for the plants and trees. The aim of the project is to increase access to healthy affordable food. The food produced will either be used as part of the school food offer or will be distributed to pupils and staff to improve their access to five fruit and vegetables per day. As this grant is only being made available to schools the local authority are the only organisations who can administer the funds.	Genuinely one provider	£35,000.00	YES	Accept
2022/2023-1106	12/01/2023	Corporate	Isle of Anglesey County Council	Each Local Authority will receive a £35,000 grant to administer to schools in the area to improve their ability to produce food on-site. Using funding on purchase fruit trees, fruit and vegetable plants and equipment to care for the plants and trees. The aim of the project is to increase access to healthy affordable food. The food produced will either be used for school or distributed to pupils and staff to improve their access to five fruit and vegetables per day. As this grant is only being made available to schools the local authority are the only organisations who can administer the funds.	Genuinely one provider	£35,000.00	NO	Accept
2022/2023-1113	12/01/2023	Corporate	Hugh Irwin Associates	To provide expertise and support in developing the rapid actionable insight dashboard building on the existing prototype	Other (please specify) - The works is to complete development of a rapid actionable insight dashboard,	£59,500.00	NO	Accept

					which the previous supplier had developed to protopye status.			
2022/2023-1115	23/01/2023	Corporate	G M Thomas	Support of phase 1 schools and the 'roll-out' of phase 2 of PL informed Whole School Physical Activity Policy and associated support and mentoring. Please see quote for more information.	3 Physical Literacy consultants available across North Wales. One is excluded as they do not speak Welsh the other cannot fully commit to the amount of hours required to complete the project due to other permanent working commitments.	£16,850.00	NO	Accept
2022/2023-1119	16/02/2023	IHC East (Area East)	Wrexham Borough Council	Secondment extension for 12 months	SLA to support a 12 month extension of the secondment of 1.0wte Inspire CAMHS Transition youth worker to undertake joint working with adult mental health in line with S CAMHS to adult transition policy. WEF: 28.2.23 FOR 12 MONTHS	£51,823.20	NO	Accept
2022/2023-1124	26/01/2023	Capital	Touchpoint Medical UK	Automated medicine cabinets	Other (please specify) - Waiver required as this specific equipment is needed for standardisation with the rest of Pharmacy's cabinets	£128,760.00	YES	Accept
2022/2023-1126	16/03/2023	SecCare - Managed Clinical Support	Mediteam	Supporting Gogarth new admission / front door flow - part funded by COTE	Genuinely one provider	£111,600.00	NO	Accept
2022/2023-1129	10/02/2023	Corporate	Ararna	The aim of the commission is to provide expert facilitation to support delivery of 9 workshops designed to enable a place-based partnership approach to address health inequality, whilst ensuring integration with the ambitions of the Accelerated Cluster Development programme. A full description of the aims can be found in section 3 of the attached service specification	Compatibility Issue (eg. warranty cover clause or specific equipment)	£39,960.00	NO	Accept

2022/2023-1130	13/03/2023	IHC West (Secondary Care - YG)	Brownejacobson	Legal fees	Genuinely one provider	£150,000.00	YES	Accept
2022/2023-1132	09/02/2023	IHC Centre (Area Team - Central)	Aura Wales - Flintshire Area	The Exercise Professional support patients on a 1:1 basis with all aspects of activity advice for the patients in the East area. This year as the East Area Exercise Professional covers Flintshire, Denbighshire and Wrexham and due to increasing demand and waiting times we are increasing this funding to 0.9WTE (+£1000 - travel expenses). The additional funding comes from 2 sources - decreasing the funding to Central area from 0.5WTE to 0.3WTE as demand in Conwy alone is less and also saving made in the delays in recruiting to a Clinical Psychologist post 8b (0.4 WTE) - vacant since July 2021. In previous years, we have not completed a ewaiver but this year we were advised to complete this.	Follow on from previous waiver	£35,200.00	YES	Accept
2022/2023-1137	02/02/2023	Capital	Edan Medical	CTG central monitoring	Other (please specify) - Standardisation of CTG central monitoring across BCU, this system is currently in use in YGC.	£29,946.29	NO	Accept
2022/2023-1138	09/02/2023	IHC Centre (Area Team - Central)	Axia ASD Ltd	Neurodevelpoment Profiles	Interim arrangement pending tender	£34,000.00	NO	Accept
2022/2023-1148	16/02/2023	Corporate	North Wales Recovery Communities	Provision of a food share scheme and training programme for vulnerable individuals (e.g. with mental health issues, in rehab, at risk of homelessness).	Follow on from previous waiver	£50,000.00	YES	Accept

2022/2023-1149	16/02/2023	Sec Care - Managed Clinical Support	Leica Biosystems	Maintenance of the 3x CS-O Scanscope Digital Pathology Scanners	Maintenance	£36,338.76	NO	Accept
2022/2023-1153	20/03/2023	Secondary Care - Managed Clinical Support	Auditdata	Audit base is an integrated patient information system that links clinical test equipment, hearing aid fitting software, stock control of devices (e.g. hearing aids and earmouls) conventional patient administration and diary management	Genuinely one provider	£67,167.00	NO	Accept
2022/2023-1159	06/03/2023	Research & Development	Cepheid UK Ltd	Hire of equipment for iGBS3 trial. Equipment summary & cost breakdown in attached quote.	Compatibility Issue (eg. warranty cover clause or specific equipment)	£151,866.00	YES	Accept
2022/2023-1165	07/03/2023	Corporate	Scotia	Equipment for North Wales Endoscopy training centre.	Genuinely one provider	£32,665.00	NO	Accept
2022/2023-1167	08/03/2023	Sec Care - Managed Clinical Support	IBEX	Interim procurement of AI solution ahead of national procurement	Interim arrangement pending tender	£30,000.00	NO	Accept
2022/2023-1172	29/03/2023	IHC Centre (Area Team - Central)	Vale of Clwyd Mind	Extension of the Active Monitoring service in the four central clusters for 6 months. Vale of Clwyd Mind will manage the contract on behalf of Conwy Mind. The two organisations will deliver the service across Conwy & Denbighshire. A Service Specification is at Schedule 1 in the attached contracts. All Cluster Funded Schemes are being evaluated and an exit plan developed. During the 6 month extension, the service will be evaluated and a business plan prepared to source alternative funding for this type of provision,	Follow on from previous waiver	£100,865.60	YES	Accept
2022/2023-1176	21/03/2023	Mental Health & LD	Cepheid	4 year maintenance contract for specialist machines	Genuinely one provider	£36,342,00	NO	Accept

2022/2023-1177	29/03/2023	IHC Centre (Area Team - Central)	Vale of Clwyd Mind	Extension of the Mental Health Wellbeing Service in North Denbighshire for 12 months. A Service Specification is at Schedule 1 in the attached contracts. All Cluster Funded Schemes are being evaluated and an exit plan developed. During the 12-month extension, the service will be evaluated and a business plan prepared to source alternative funding for this type of provision, should it still be considered a necessary service at that time. A procurement / tendering exercise will take place during the year, for a service, commencing in 24/25 should the cluster wish to continue providing this type of service.	Follow on from previous waiver	£88,913.00	NO	Accept
2022/2023-1179	10/03/2023	IHC West (Area Team - West)	Medisure GPs	Locum GP cover on site on a regular and frequent basis until our existing recruitment campaigns become successful	Other (please specify) - Medacs have been unable to fulfil previous requests for GPs in the West including Tywyn. Other agencies do not provide GP cover. Geography is restrictive to key recruitment agencies.	£100,000.00	NO	Accept
2022/2023-1180	29/03/2023	IHC Centre (Area Team - Central)	Mental Health First Aid Wales Ltd	Youth Mental Health First Aid Instructor Training 5-day course: - Mental Health First Aid hold the license for this training.	Genuinely one provider	£29,808.00	NO	Accept
2022/2023-1185	20/03/2023	Secondary Care - Managed Clinical Support	Haemonetics	see attached - Blood stock management and traceability	Established transfusion process across BCU in which the service is reliant on to manage bloodstocks, preventative maintenance and traceability requirements not currently offered by any other company. Contract awarded annually due to delayed implementation of National LINC project	£60,587.00	NO	Accept

2022/2023-1192	29/03/2023	Corporate	Flintshire Local Voluntary Council	Provision of Social Prescribing Service in Flintshire. Our social prescribing partners currently manage large operational networks of providers so to contract individually with each provider or recreate the existing infrastructure with another partner at this stage would be difficult without creating a risk of disruption to service delivery. The impact of this may create avoidable harm during a period when the services are essential to support our communities, health, wellbeing, and reducing demand for health services.	Follow on from previous waiver	£46,000.00	NO	Accept
2022/2023-1193	29/03/2023	Corporate	Grwp Cynefin	Provision of Social Prescribing Service in Denbighshire. Our social prescribing partners currently manage large operational networks of providers so to contract individually with each provider or recreate the existing infrastructure with another partner at this stage would be difficult without creating a risk of disruption to service delivery. The impact of this may create avoidable harm during a period when the services are essential to support our communities, health, wellbeing, and reducing demand for health services.	Follow on from previous waiver	£51,000.00	NO	Accept

2022/2023-1194	29/03/2023	Corporate	Mantell Gwynedd	Provision of Social Prescribing Service in Gwynedd. Our social prescribing partners currently manage large operational networks of providers so to contract individually with each provider or recreate the existing infrastructure with another partner at this stage would be difficult without creating a risk of disruption to service delivery. The impact of this may create avoidable harm during a period when the services are essential to support our communities, health, wellbeing, and reducing demand for health services.	Follow on from previous waiver	£60,000.00	NO	Accept
2022/2023-1195	29/03/2023	Corporate	Rainbow Foundation (Penley, Wrexham)	Provision of Social Prescribing Service in Wrexham. Our social prescribing partners currently manage large operational networks of providers so to contract individually with each provider or recreate the existing infrastructure with another partner at this stage would be difficult without creating a risk of disruption to service delivery. The impact of this may create avoidable harm during a period when the services are essential to support our communities, health, wellbeing, and reducing demand for health services.	Follow on from previous waiver	£74,000.00	NO	Accept
2022/2023-1197	31/03/2023	Finance	CIPFA	Advisory work on technical/professional aspects	Specialist advice on confidential matters and technical/professional matters that CIPFA is expert in and the recognised lead professional body.	£36,750.00	NO	Accept

2022/2023-1201	29/03/2023	Corporate	North Wales Recovery Communities	Provision of a food share scheme and training programme for vulnerable individuals (e.g. with mental health issues, in rehab, at risk of homelessness) within a not for profit cafe facility on Bangor High Street. The Scheme is run through a multi-agency approach including the Housing association, Grwp Llandrillo, the substance misuse team the local council and homeless shelter. In addition, there is access to a food waste initiative, ensuring that surplus produce can be distributed community at low cost. To recreate the existing infrastructure with alternative partners and providers at this stage would be difficult without creating a risk of disruption to service delivery. The impact of this may create avoidable harm during a period when the services are essential to support our communities, health, wellbeing, and reducing demand for health services.	Follow on from previous waiver	£25,000.00	NO	Accept
2022/2023-1206	30/03/2023	IHC East (Area Team - East)	Healios Ltd	ND ASD/ADHD/Combined assessments	STW to support an Addendum to contract for the ND Healios contract (for up to 50 cases to be completed by 12th May 23)	£80,000.00	NO	Accept

Single Quote Waivers **(for items of expenditure between £5,000 and £25,000)**

It is normal practice to obtain three quotes. Where this is not possible then a single quote waiver should be obtained and approved ahead of expenditure being committed.

The table below provides a summary of waiver activity for period 1st January – 31st March 2023

Single Quote Waiver	**2021/22 Q4**	**2022/2023 Q4**	**2021/22 YTD**	**2022/23 YTD**
Waivers Issued	76	40	200	144
Waivers Approved	45	31	98	83
Value of Approved Waivers	£0.67m	£0.4m	£1.46m	£1.06m
Cancelled Waivers	2	0	2	1

All waivers relate to either a maintenance contract, sole supplier, interim arrangements, compatibility issue or continuation with current provider. A breakdown is provided within the table below.

Approved Single Quote Waivers: 1st January – 31st March 2023

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value £000s	Supported By Procurement
2022/2023-1055	06/01/2023	Corporate	Inner-Vision Technology Group	Tough-PAC Anti-microbial case systems for iPad (WNCR)	Genuinely one provider	£13,338.00	Accept
2022/2023-1072	09/02/2023	Capital	Henry Schein	Annual Software support for bespoke Dental Management System	Genuinely one provider	£8,702.89	Accept
2022/2023-1090	10/01/2023	Corporate	Joanna M Green (Sole trader)	Ear irrigation Training for primary care staff across north Wales	Genuinely one provider	£8,950.00	Accept
2022/2023-1096	25/01/2023	IHC East (Area East)	Becton Dickinson Dispensing UK Limited	Maintenance contract for pharmacy dispensing robot	Maintenance	£19,188.00	Accept
2022/2023-1109	10/01/2023	Sec Care - Managed Clinical Support	Sysmex UK Ltd	Maintenance of the RD-210 OSNA analyser	Genuinely one provider	£7,628.72	Accept
2022/2023-1111	14/02/2023	SecCare - Managed Clinical Support	Leica Bio systems	Software upgrade	Genuinely one provider	£20,034.52	Accept
2022/2023-1112	17/01/2023	Secondary Care - Managed Clinical Support	Siemens	Monitor for new MRI Scanner	Compatibility Issue (eg. warranty cover clause or specific equipment)	£5,800.00	Accept
2022/2023-1117	28/02/2023	Corporate	Alison Beal Limited	Provides expertise in consultancy work relating to GiRFT	Genuinely one provider	£16,200.00	Accept

2022/2023-1118	18/01/2023	IHC East (Area East)	Wrexham Borough Council	Secondment as above	Agreement (for a further 12 months from 28.2.23) with Wrexham Council for secondment of 0.2 Youth Worker, supporting Paediatric Dietetic team, with the delivery of SEREN structured education.	£10,823.20	Accept
2022/2023-1120	23/01/2023	Corporate	Anglesey County Council	Anglesey County Council will provide structured gym and leisure based physical activity sessions and will undertake monitoring of patient outcomes for the physical activity element of the BCUHB Level 2 Adults Weight Management Service. The service will be provided until the 31st of March 2023	Genuinely one provider	£21,249.68	Accept
2022/2023-1121	18/01/2023	Corporate	ASH Wales	Delivery of an Illegal Tobacco campaign entitled NO IFS. NO BUTTS in North Wales by the organisation aligned to Welsh Government for its delivery nationally.	Genuinely one provider	£18,333.33	Accept
2022/2023-1122	24/01/2023	IHC East (Secondary Care - YWM)	In Health	Mobile MRI scanner to visit HMP Berwyn to scan prisoners	Genuinely one provider	£24,000.00	Accept
2022/2023-1123	23/01/2023	SecCare - Managed Clinical Support	Probo Medical Ltd	supply and fit of X-ray tube for Philips Easy diagnost eleva at Llandudno	Maintenance	£8,890.00	Accept
2022/2023-1127	26/01/2023	SecCare - Managed Clinical Support	LEICA MICROSYSTEMS (UK) LTD	Service contract for maintenance of microtomes and Cryostats	Genuinely one provider	£5,933.64	Accept

2022/2023-1128	01/02/2023	IHC West (Secondary Care - YG)	Stanley Security Solutions	Rental, Support and maintenance of on-site paging system at Ysbyty Gwynedd Bangor to cover the period 1st July 2023 to 31st January 2024 after the existing 12-month contract expires. The company have quoted a new 12-month contract attached, which supersedes the existing contract ending 30th June 2023.	Genuinely one provider	£17,958.80	Accept
2022/2023-1134	31/01/2023	Corporate	Vivid Resourcing	IPC Specialist covering senior backfill for an 8B supporting other work for 1 day per week	Follow on previous waiver	£10,710.00	Accept
2022/2023-1140	09/02/2023	IHC Centre (Area Team - Central)	Flintshire County Council	Continuation with the current investment and collaboration of NW CAMH School in Reach Service (School in Reach) and Flintshire Young Person is Counselling Service. Collaboration and partnership working between BCUHB & Flintshire CC, the £17,000 provides additional support to promote health and wellbeing via an Occupational Health and Employee Assistance programme. This was previously invested in October Req 5435831 eg in Castell Alyn High school. The continuation of funding will facilitate an extension proposed by Helen Rock-Humphreys, Lead Counsellor for Young People's Counselling Service, FlintshireCC to support Primary Schools in order to evaluate how this initiative works in comparison to High Schools. Funding supports training on MH, wellbeing and coaching support. Training Head teachers on menopause issues, offer support to staff are under immense pressure. Evaluation to date indicates positive feedback from education staff. Issues arising are medical concerns, relationship issues and work stress. The BCUHB School in Reach Service will benefit from partnership working to further promote and support mental health wellbeing offered to educational staff, which is part of the Business Plan for the School in Reach Service.	Genuinely one provider	£17,000.00	Accept

2022/2023-1141	06/03/2023	Corporate	Sex Education Company	Resources such as promotional materials (leaflets, posters, signposting cards) training materials, activities and a large selection of books (which professionals can borrow) to enable effective delivery of the sexual health c-card scheme to the North Wales Population	Genuinely one provider	£7,925.61	Accept
2022/2023-1142	09/02/2023	IHC Centre (Area Team - Central)	Conwy County Council	Provision of Exercise Professional to work with patients in Conwy who are attending the Specialist Weight Management Service	Genuinely one provider	£9,356.00	Accept
2022/2023-1146	10/03/2023	Corporate	Aura Wales (Flintshire)	Aura Wales (Flintshire) will provide structured gym and leisure based physical activity sessions and will undertake monitoring of patient outcomes for the physical activity element of the BCUHB Level 2 Adults Weight Management Service.	Genuinely one provider	£14,082.00	Accept
2022/2023-1150	20/03/2023	Corporate	Gwynedd Council	Support to cover Maternity leave within Gwynedd Healthy Schools Team	Interim arrangement pending tender	£6,820.00	Accept
2022/2023-1164	27/02/2023	SecCare - Managed Clinical Support	GHG Software Development Ltd	Maintenance contract for voice recognition and dictation system	Genuinely one provider	£8,275.00	Accept
2022/2023-1175	29/03/2023	IHC Centre (Area Team - Central)	Gwynedd Council	Provision of an Exercise Professional to work alongside the Specialist Weight Management Service to support patients with activity from the Gwynedd and Anglesey area	Genuinely one provider	£17,932.76	Accept
2022/2023-1178	09/03/2023	Sec Care - Managed Clinical Support	Cell Path Ltd	PiSmart Slide Writers	Genuinely one provider	£13,300.00	Accept
2022/2023-1182	20/03/2023	SecCare - Managed Clinical Support	Bayer	Maintenance of contrast injectors	Maintenance	£24,000.00	Accept
2022/2023-1183	29/03/2023	IHC Centre (Area Team - Central)	Clevermed	Clevermed provide Badgernet Neonatal Patient Administration system, which was implemented and has been used across Wales since 2014.	Genuinely one provider	£23,205.44	Accept

2022/2023-1186	20/03/2023	Corporate	Gwynedd Council - Ysgol Gynradd Bethel	Support to cover Maternity leave within Gwynedd Healthy Schools Team	Interim arrangement pending tender	£7,440.00	Accept
2022/2023-1187	20/03/2023	Corporate	Gwynedd Council - Schools across Gwynedd	Funding to School Settings to enable the school to release staff to attend the training and mentoring opportunities. Please see attachment for further detail	Funding to School Settings to enable the school to release staff to attend the training and mentoring opportunities	£21,060.00	Accept
2022/2023-1188	29/03/2023	Corporate	Access Group (Formerly Elemental)	An extension of the existing service contract period for 3 months, which currently expires 28/5/23 to allow full tender process and minimises disruption to collaborate usage. We are currently evaluating service requirements along with our partners prior to releasing tendering details.	Interim arrangement pending tender	£9,947.00	Accept

2022/2023-1200	29/03/2023	Corporate	Community Wellness CIC	This service compliments existing community hub work and social prescribing activity in the Shotton and Deeside areas of Flintshire. It is focused on developing community wellness amongst the most vulnerable groups - in particular the homeless. The Community Wellness Company CIC was created as a social enterprise that aims to enable partnership working between communities and public, voluntary and private sectors to develop an innovative, integrated person centred model of care for those with most need. BCUHB carried out pilot activity during 21/22.BCUHB provided funding in 22/23 to continue to develop the activity, with Flintshire LA match funding the amount. The service focuses on engaging vulnerable and marginalised groups and those with complex needs. This includes people who experience social isolation challenges, those seeking employment, Mental Health challenges (both low level and complex conditions), Learning Disabilities, Dementia, Carers, those experiencing homelessness, addictions and substance misuse issues and people with Trauma responses. To recreate the existing infrastructure with another partner at this stage would be difficult without creating a risk of disruption to service delivery. The impact of this may create avoidable harm during a period when the services are essential to support our communities, health, wellbeing, and reducing demand for health services.	Follow on from previous waiver	£20,000.00	Accept

2022/2023-1202	29/03/2023	Corporate	Bwyd Da Mon	Bwyd Da Mon has been operating from Llangefni as a community food alliance for over two years. This additional funding will continuation of the programme of activity with particular focus on areas of deprivation. The scheme centralises surplus stock from supermarkets and other outlets for redistribution within the community. Recreating the existing infrastructure through other providers and partners at this stage would be difficult without creating a risk of disruption to service delivery. The impact of this may create avoidable harm during a period when the services are essential to support our communities, health, wellbeing, and reducing demand for health services.	Follow on from previous waiver	£24,500.00	Accept

Appendix 2 - Conformance with Losses and Special Payments Procedures

Losses and special payments should be exceptional in nature and, where they do arise, are subject to additional scrutiny and reporting to the Audit Committee. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

The losses and special payments table below provides an overview of the losses paid for the four quarters up to March 2023. Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 291 active claims at the end of March 23. Of these 158 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £123m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

46% of the caseload (133 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and financial challenges and require ongoing monitoring to ensure that any lessons are identified and actioned.

Year claim registered	No of claims
2022/23	39
2021/22	52
2020/21	60
2019/20	64
2018/19	31
2017/18	10
2016/17	11
2015/16	7
2014/15	5
2013/14	3
2011/12	4
2010/11	2
2009/10	2
2008/09	1
Total claims	**291**

Losses and Special Payments

	Q1 22/23 £	Q2 22/23 £	Q3 22/23 £	Q4 22/23 £	Latest quarter analysis and further action
Medical Negligence					
Gross cost	6,551,926	5,716,878	7,576,269	2,378,506	
WRPS Reclaim	(6,163,529)	(5,251,887)	(7,077,023)	(1,983,851)	Payments were made on 194 cases, of which 50 came under the Redress Scheme.
Net Cost	388,397	464,991	499,246	394,655	
Personal Injury					
Gross cost	65,010	85,027	189,117	69,411	
WRPS Reclaim	(0)	(32,933)	(95,872)	(21,122)	Payments were made on 27 cases.
Net cost	65,010	52,094	93,245	48,289	
Loss of cash	280	30	450	200	A loss of £200 occurred relating to patient's property, a new staff member had not followed the correct procedure and the cash went missing. Staff member informed of the correct procedure.
Debtors written off	0	0	14,927	11,275	Debtors are only written off as a last resort, after all means of collection have been exhausted.
Loss or damage to equipment, property and stock	51,907	68,574	77,245	233,213	Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off as part of the year end stock counts. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board.
Ex-gratia payments	15,173	23,293	8,055	179,027	Relates to 16 payments for loss/damage of patient's property, 9 ombudsman payments for delayed and unsatisfactory treatment and one payment relating to an employment tribunal.
VERS Payments	204,749	0	181,083	72,809	All payments are approved by the RATS Committee.
Total	**725,516**	**608,982**	**874,251**	**939,468**	

* The Welsh Risk Pool Service administers the risk pooling arrangement for negligence claims and reimburses amounts over £25,000

Teitl adroddiad: ***Report title:***	General Dental Services Assurance Report			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 November 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide an update on the position regarding assurance relating to the delivery of and payment for Primary Care Dental Services.			
Argymhellion: ***Recommendations:***	The Board is asked to note the contents of this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Adele Gittoes, Interim Executive Director of Operations			
Awdur yr Adroddiad: ***Report Author:***	Angie Tyrer, Senior Dental Contracts Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	

Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No The report does not relate to a 'strategic decision', no Equality Impact (EqIA) and a socio-economic (SED) impact assessment required.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No The report does not relate to a 'strategic decision', no Equality Impact (EqIA) and a socio-economic (SED) impact assessment required.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Dental Operational Team Meeting, by email and ratified 8th November
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim	

List of Appendices:
None

BOARD OF DIRECTORS MEETING IN PUBLIC
16th November 2023
REPORT TITLE General Dental Services Assurance Report

1. Introduction/Background

The purpose of this report is to provide an update on the position regarding assurance relating to the delivery of Primary Care Dental Services and describes the monitoring arrangements in place undertaken by the contracting team.

A paper outlining the position regarding assurance and verification of delivery and payment of GDS dental services was presented to the Audit Committee in November 2022.

On 21st December 2022, the Welsh Government confirmed the metrics for contractors for the 2023/24 period. This year is the second contract reform action learning year under which General Dental Service (GDS) providers have a choice to deliver services under Contract Reform or return to delivery wholly based on Units of Dental Activity (UDA). PDS Orthodontic contracts reverted to 100% of their normal Unit of Orthodontic Activity (UOA) targets from April 2022 and this will continue from April 2023.

Contract Reform

An example of Contract Reform metrics is illustrated below which is agreed through a contract variation to reduce the amount of UDAs to be delivered. Whilst the Annual Contract Value will be reduced (in this example from £177,650 to £44,412), the contractor will be able to receive the balance of the contract value of £133,238 if they achieve all of the following metrics in full.
There is an additional 5% tolerance to these metrics. At the start of the financial year 55 practices chose to deliver dental services under Contract Reform representing 75% of practices and 89% of the GDS budget.

Maximum contract value remains the same **£177,650**			
UDA element	**25% / £44,412** allocated to existing metrics (UDAs) (this value would be the ACV for the purposes of the SFEs) 1,700 UDAs	**75% / £133,238** allocated to new metrics (details below): Fluoride varnish **(10%)** New/Urgent patient target **(25%)** Supply of mandatory General Dental Services to (and completion of ACORNs for) existing patients **(40%)**	**New metrics**

UDAs

Practices had the option to return to contractual arrangements based wholly on delivery of Units of Dental Activity (UDA). The expected UDA target for these practices will be 95% of pre-Covid/pre-reform level. At the start of the financial year 18 practices chose to deliver under UDA only model, representing 25% of practices and 11% of the GDS budget

Orthodontics

Health Boards will again have discretion to apply a tolerance of 5% reduction in the UOA target if there are justified reasons for reduced patient throughput. This 5% is additional to the normal 5% tolerance. At the start of the financial year 6 practices were delivering orthodontic services.

2. Assurance

Management of Contracts (Weekly)

The Contracting team meet on a weekly basis to discuss any contractual concerns or raise any issues. An Operational log has been developed to record and reference any issues, including the status and, where necessary, escalation to the Dental Contract Management Group.

Performance Monitoring (Monthly)

All GDS contractors have access to Compass and eDen, which are online applications which allows practices to visualise their contract performance figures. Support for contractors on the use and interpretation of eDen and Compass data is provided by the Contract Managers on an individual contractor basis on request during the year.

All GDS contracts continue to be monitored on a monthly basis by the Dental Contracting Team using data provided by NHSBSA on the eDen information management system.

Monthly monitoring consists of a review of:

- Contracted activity (UDA)
- Historic Patient Activity
- New & New Urgent Patient Activity
- Fluoride Varnish Applications
- ACORN (Assessment of Clinical Oral Risks and Need) completion and RAG rating
- Distribution of claims by treatment band (Band 1, Band 2, Band 3 and Urgent)

Contracts identified with outlying performance figures will trigger supportive engagement by the Contracting team

Dental Contract Management Group (Quarterly)

The purpose of the group is to provide a forum for co-ordinating and reporting the development, delivery and monitoring of the systems and processes relating to the management of GDS and PDS contracts. The remit of the group encompasses all contracting issues, including access, activity, governance and finance. This group reports to: Primary Care Panel, Oral Health Strategy Group for contractual issues and the Dental Q&S Group for matters relating to clinical governance concerns or issues.

Risk Assessment Meetings (Quarterly)

The Risk Assessment Process is under review due to the outdated data on the Dental Assurance Framework (DAF). It is anticipated that the DAF will be updated in the future. In the interim NHS BSA Clinical Advisors are undertaking a quarterly review of contracts to assist Health Board's assurances which identify inconsistencies that may indicate reporting and/or clinical concerns (for example,

where the treatment provided does not appear to reflect the risks recorded in the ACORN).
NHS BSA Clinical Advisors provide an independent analysis of the scheduled claims data and provide recommendations for the Risk Assessment group to consider, which may include; Record Card Reviews, Dental Practice Advisor/Contracting team and/or Clinical Governance support

Mid-Year Review
All contracts are subject to a mid-year performance review.
For contracts performing in line with expectations this will consist of a desk-top exercise only, with performance figures confirmed with individual contractors via email along with an offer to meet to discuss if the contractor wishes.

For underperforming contracts (less than 30% of the targets achieved by mid-year) this will consist of a meeting between the contractor and the Contracting Team. The Contractor may be required to submit an acceptable action plan for the remainder of the year or enter into discussions to agree a variation to the annual contract value (ACV).

End of Year Review
Financial Contract sanctions for under performance are outlined in the CDO letter of 21st December 2023 are as follows:
UDA option – under performance by more than 5% will trigger a pro rata recovery of contract payments
Contract reform option – under performance of:

- Patient Metrics by more than 5% will trigger a pro rate recovery of payments made for that specific element
- Fluoride varnish application rates to qualifying patients of below 75% will trigger the recovery of 5% of the annual contract value (ACV)

It is the aim of the Contracting Team to identify early those contracts likely to finish the year in a position that will trigger financial sanctions and provide support and guidance to assist the contractor to address any issues and consequently avoid the associated financial sanctions. This may include withholding some of the monthly payments under the contract which is reconciled at the End of Year

If, however, any of the above areas of under performance are triggered by individual contracts and in the absence of any mitigation circumstances justifying the use of discretion by the Health Board financial sanctions will be applied and may include a Breach Notice.

Counter Fraud (Quarterly)
The Dental Contracting Team have an established working relationship with Counter Fraud. Any suspected fraudulent activity by contractors or patients identified by the Contracting Team will be reported to the Fraud Team.

North Wales Dental Services Operational Management Meeting (Monthly)
This forum provides the opportunity for the senior leaders in the service to discuss and raise any issues and updates relating to Primary Care Services, Transformation, Finance and Community Dental Services.

North Wales Oral Health Strategy Group (Quarterly)
The North Wales Oral Health Strategy Group replaced the North Wales Dental Advisory Forum which satisfied the requirements of WHC(2004)007. The NWOHSG takes on the forum's functions and incorporates all Oral Health issues and strategy. This NWOHSG will advise BCUHB and North Wales Dental Service via the Primary Care Senior Leadership Team.
The objectives of the NWOHSG are to:

- Define, lead and support the strategic direction and activities of the Health Board and its partners in relation to Oral Health.
- Provide a source of professional advice to the Health Board on issues such as service and delivery, specialist services and workforce planning.
- Advise the Health Board of North Wales issues and progress and draw to its attention those areas of particular concern and opportunity.

Primary Care Panel (Quarterly)
This panel receives escalations from the Dental Contract Management Group
Some of the purposes of the Primary Care Panel, on behalf of the Board is to:

- consider and make decisions on applications from GDS & PDS Contractors to amend service provision in accordance with the relevant Contractual regulations
- approve the Appeals process for Contractual disputes, including approval of Terms of Reference for the Independent Members' Panel
- consider and make recommendations to the Board regarding the issue of new GDS contracts
- provide a third stage appeals function in relation to disputes between Contractors and the Health Board in accordance with the relevant Contractual Regulations
- ensure appropriate contract monitoring and management arrangements are in place within the Health Board in relation to Primary Care Contractors

Performance, Finance and Information Governance Committee (Bi-Monthly)
This panel recieves esclations from the Primary Care Panel. 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, performance and delivery, and information governance.

Orthodontic Managed Clincal Networks (Tri-Annual)
The North Wales Managed Clinical Network in Orthodontics was established to ensure that patients have need based access to high quality orthodontic services. The network also enhances communication between stakeholders and provides a forum for key stakeholders to identify, discuss and advise on key issues arising from the provision of the NHS orthodontic dental services from the patient, Local Health Board and provider/contractor perspective.

General Dental Services Quality and Safety Meetings (Quarterly)
This meeting feeds into and take direction from the Performance Concerns Group (PCG). The PCG meeting is the forum by which individual concerns about dentists who have a performer number are discussed. This goes in hand with wider Q&S issues, however this meeting is held in tandem with GP performers concerns being discussed and is a closed group so is held separate to Q&S, however each group informs the other.

The Quality and Safety group meets with the purpose of:

- Ensuring consistent appropriate systems are in place for the quality assurance (clinical governance) of primary care GDS contractors and services across BCUHB.
- Ensuring best practice and learning is shared across BCUHB primary care dental services.
- Assurance that there are effective management processes in place for overseeing and dealing with individual clinician and practice performance concerns.
- Providing evidence based and timely advice to the Assistant Director of Dental Services in relation to risks associated with the provision of primary care GDS, to assist them in discharging their functions and meeting their responsibilities with regard to the quality and safety of healthcare;

Performance Concerns Group (Quarterly)

Concerns relating to clinical issues are shared with Clinical Governance. Any concerns are escalated to the Medical Director and discussed at the Performanace Concerns Group.

The group also informs the Quality and Safety meeting. The membership consists of; Medical Directors, Dental Practice Advisors, Clinical Governance, Practitioner Performance Advisor/ NHS Resolution

3. *Budgetary / Financial Implications*

3.1 There are no budgetary implications associated with this paper.

4. Rheoli Risg / Risk Management

There is a risk on Datix which is overarching of all of dental provsion across the West IHC area which is ID4321. We are working up this risk and then will work with the other two IHC areas to develop related risks for their area.

5. Equality and Diversity Implications

5.1 If this report does relate to a ‘strategic decision’ and therefore a Socio-economic Duty (SED) Impact Assessment (SEIA) and an Equality Impact (EqIA) is not included as an appendix.

Teitl adroddiad: ***Report title:***	Update on Internal and External Audit Recommendations (Tracker Tool)			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	16th November 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Audit Committee with an update regarding the Health Board's position in the implementation of Internal Audit and External Audit recommendations.			
Argymhellion: ***Recommendations:***	The Committee is asked; • to **note** the current position (October 2023) of outstanding audit recommendations. • take **assurance** that the Health Board has an appropriate tracking and reporting system in response to audit recommendations. • to **consider** proposed recommendations for closure.			
Arweinydd Gweithredol: ***Executive Lead:***	Acting Board Secretary, Phil Meakin			
Awdur yr Adroddiad: ***Report Author:***	Regional Risk Manager, Brenda Greenslade			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Whilst there remain a number of recommendations that are significant and overdue, the Office of the Board Secretary (OBS) has more recently developed a **resourced system** to ensure detailed responses are collated, recorded and that agreements have been made that an update on actions. Guidance and				

support is provided to all recommendation 'Owners' and the final approval / signing off of recommendations is executed via the relevant Executive Director.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	N/A other than those relating to individual audit reviews / recommendations
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Compliance with Internal and External Audit requirements.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (the report does not relate to a decision, strategic or otherwise).
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A other than those relating to individual audit reviews / recommendations
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A other than those relating to individual audit reviews / recommendations
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A other than those relating to individual audit reviews / recommendations
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	All 'Status Updates' are reviewed by the OBS well in advance (approx one month prior to the committee meeting) and an interim report is produced for each Executive detailing all of their outstanding recommendations. Status Updates that provide insufficient detail or that do not fully address the recommendation are flagged to the Board Secretary and the relevant Executive. The OBS then works with relevant leads to review and update. However, there may be some instances whereby the OBS is unable to contact relevant leads (absence / staffing / capacity etc.) and an up to date Status Update cannot be obtained. Final Report reviewed by the Interim Board Secretary

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A other than those relating to individual audit reviews / recommendations
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The Tracker is presented to each quarterly meeting of the Audit Committee. The OBS continues to provide support and advice for recommendation owners / leads.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1A: Recommendations Proposed for Closure by Executives • Appendix 1B: Open Internal Audit recommendations • Appendix 1C: Open External Audit recommendations	

Introduction/Background

This report details the status of internal and external audit recommendations over the past six years, which are overdue high priority yet, still noted as incomplete.

Body of Report

External Audit recommendations

Reference	Recommendation Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
209	CHC Training Programme	Not Rated	0	1	0	0	1	0				✓
210	CHC Service Delivery	Not Rated	1	0	0	0	0	0	1	0	0	×
211	Governance, Accountability and Performance	Not Rated	1	0	0	0	0	0	1	0	0	×
221	Recommendation 2 - Resources and Skills	Not Rated	0	0	1	0	0	1				✓
222	Recommendation 2 - Fraud Risks	Not Rated	0	1	0	0	0	0	0	1	0	×
225	R3 - Audit Wales Structured Assessment 2020	Not Rated	1	0	0	1	0	0				✓
230	R1b - Structured Assessment (Phase 2) 2021	Not Rated	1	0	0	0	0	0	1	0	0	×
244	R1 - Structured Assessment 2019	Not Rated	1	0	0	0	0	0	1	0	0	×
245	R5 - Structured Assessment 2019	Not Rated	1	0	0	0	0	0	1	0	0	×
			6	**2**	**1**	**1**	**1**	**1**	**5**	**1**	**0**	

There are 9 external audit recommendations. Three recommendations are fully implemented. There are 6 outstanding recommendations, 5 of which are high priority and 1 medium priority. Please see appendix 1C for further information.

Internal Audit Recommendations

The following internal audit recommendations are broken down as follows:
(Please note that the sub-categories of the overarching recommendations have been aggregated in data below and further details available in appendix 1B).

Between 2017 and 2020 there are 2 internal audit recommendations, both of which are high priority and outstanding.

Reference	Audit Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
243	R1	Not Rated	1	0	0	0	0	0	1	0	0	×
57	Reporting progress of Quality Improvement Strat	Limited	1	0	0	0	0	0	1	0	0	×
			2	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	

In 2021, there were 7 internal audit recommendations, 4 high priority, one of which is implemented. 3 medium priority, 1 implemented. 5 are outstanding.

Reference	Audit Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
226-228	Continuing Healthcare Arrangements	Not Rated	3	0	0	1	0	0	2	0	0	×
72-73	Performance measure reporting to the Board – A	Reasonable	0	2	0	0	1	0	0	1	0	×
146-147	Women's Services Division – Sustainability of se	Reasonable	1	1	0	0	0	0	1	1	0	×
			4	**3**	**0**	**1**	**1**	**0**	**3**	**2**	**0**	

In 2022, there were 34 internal audit recommendations, 21 high priority, 5 of which have been implemented. 12 medium priority, 7 of which have been implemented and 1 low priority also implemented. Of the 22 outstanding recommendations, 17 are high priority and 5 medium priority.

Reference	Audit Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
59	Risk Management	Reasonable	0	1	0	0	0	0	0	1	0	×
111	Impact Assessments	Reasonable	0	1	0	0	1	0				✓
114 - 118	Standards of Business Conduct: Declarations	Limited	4	1	0	0	0	0	4	1	0	×
119	Integrated Service Boards (ISB)	Limited	1	0	0	1	0	0				✓
120,121	Budgetary Control & Financial Reporting, includin	Reasonable	0	1	1	0	1	1				✓
123	Procurement & Tendering	Reasonable	0	1	0	0	0	0	0	1	0	×
127	Clinical Audit	Limited	0	1	0	0	1	0				✓
148,149	Employment of Medical Locum Doctors	Reasonable	1	1	0	1	0	0	0	1	0	×
150-152	Roster management	Limited	2	1	0	2	1	0				✓
154,155	Establishment control – Leaver management	Limited	1	1	0	0	1	0	1	0	0	×
158 - 161	On-Call arrangements	Limited	4	0	0	0	0	0	4	0	0	×
165	Waste Management	Reasonable	0	1	0	0	1	0				✓
167	Speak out Safely	Reasonable	0	1	0	0	1	0				✓
170	Comisiynydd y Gymraeg/Welsh Language Comn	Limited	1	0	0	0	0	0	1	0	0	×
173	Effective Governance: YWM	Limited	1	0	0	0	0	0	1	0	0	×
178	Effective Governance: YG	Limited	1	0	0	1	0	0				✓
183,185	Board and committee reporting	Limited	2	0	0	0	0	0	2	0	0	×
188	Chairs Action	Reasonable	0	1	0	0	0	0	0	1	0	×
235,240,241	Review of Eye Care Services	Not Rated	3	0	0	0	0	0	3	0	0	×
			21	**12**	**1**	**5**	**7**	**1**	**17**	**5**	**0**	

In 2023, there are 64 internal audit recommendations, 43 are high priority, 17 of which have been implemented. There are 21 medium priority, 11 of which are implemented. Of the 36 outstanding recommendations, 26 are high priority and 10 are medium priority.

Reference	Audit Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			0	Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L		H	M	L	
169	Comisiynydd y Gymraeg/Welsh Language Comm	Limited	1	0	0	1	0	0					✓
172,175	Effective Governance: YWM	Limited	2	0	0	1	0	0		1	0	0	×
184,186	Board and committee reporting	Limited	2	0	0	0	0	0		2	0	0	×
187,189,190	Chairs Action	Reasonable	1	2	0	0	0	0		1	2	0	×
193-6,198,19	Charitable Funds	Limited	4	2	0	2	1	0		2	1	0	×
202,203	Delivery of HB Savings	Limited	2	0	0	1	0	0		1	0	0	×
204	Management of Utilities	Substantial	0	1	0	0	1	0					✓
205-207	MH&LD	Reasonable	3	1	0	2	0	0		1	1	0	×
212	Digital strategy	Reasonable	1	0	0	1	0	0					✓
215,216	USC: Urgent Primary Care Centres - Business c	Limited	0	2	0	0	1	0		0	1	0	×
219	Public Health - Smoke free sites	Reasonable	1	0	0	0	0	0		1	0	0	×
238	Review of Eye Care Services	Not Rated	1	0	0	0	0	0		1	0	0	×
246	Financial Control – Receipting of goods and year-	Reasonable	1	0	0	1	0	0					✓
247-249	Recruitment of Substantive and Interim Executive	Limited	3	0	0	1	0	0		2	0	0	×
250-254	Risk Management & Board Assurance Framewo	Limited	4	1	0	2	1	0		2	0	0	×
256,257	Planned Care Recovery & Transformation Group	Limited	2	0	0	1	0	0		1	0	0	×
258-260	Data analysis – Triangulation of data	Limited	3	0	0	0	0	0		3	0	0	×
261,262,264 265	Contracted Patient Services: Quality and Safety A	Limited	4	0	0	0	0	0		4	0	0	×
269,270	Performance Management – Quality and Perform	Limited	2	0	0	1	0	0		1	0	0	×
271,272	Recruitment Improvement Review	Substantial	0	2	0	0	1	0		0	1	0	×
273	Hergest Unit Notice of Contravention (NoC) Actio	Limited	1	0	0	0	0	0		1	0	0	×
274	Cyber Security	Substantial	0	1	0	0	0	0		0	1	0	×
275,276	Accounts Receivable	Reasonable	1	1	0	1	0	0		0	1	0	×
277-279, 281	Clinical Audit – Tier 1 National Audits	Limited	2	4	0	2	3	0		0	1	0	×
284-289	GP Out of Hours	Limited	2	4	0	0	3	0		2	1	0	×
			43	**21**	**0**	**17**	**11**	**0**		**26**	**10**	**0**	

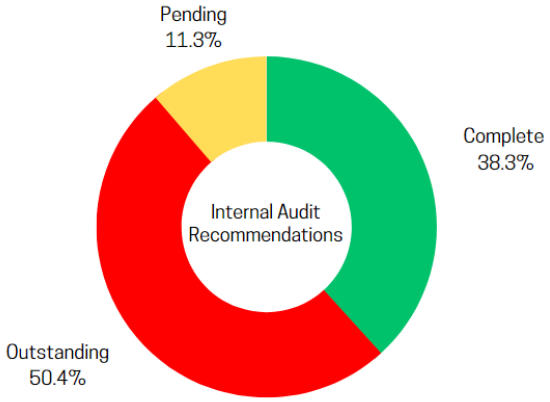
There are 8 (pending – not yet due) recommendations for 2024, 6 are high priority and 2 are medium, priority.

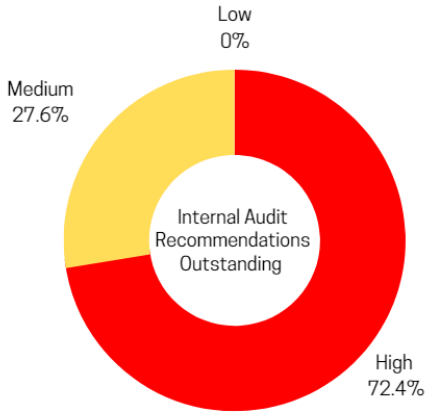
Reference	Audit Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
217,218	USC: Urgent Primary Care Centres - Business c	Limited	2	0	0	0	0	0				Pending 2024
220	Public Health - Smoke free sites	Reasonable	0	1	0	0	0	0				Pending 2024
263	Contracted Patient Services: Quality and Safety A	Limited	1	0	0	0	0	0				Pending 2024
266-268	Performance Management – Quality and Perform	Limited	2	1	0	0	0	0				Pending 2024
280	Clinical Audit – Tier 1 National Audits	Limited	1	0	0	0	0	0				Pending 2024
			6	**2**	**0**	**0**	**0**	**0**				

Outstanding Internal Audit Recommendations by Executive Lead

Executive		Number of open recommendations
Adele Gittoes	Interim Executive Director of Operations	18
Phil Meakin	Acting Board Secretary	16
Angela Wood	Executive Director of Nursing and Midwifery	8
Russel Caldicott	Interim Executive Director of Finance	8
Chris Stockport	Executive Director Transformation and Strategic Planning	6
Jason Brenan	Deputy Director of People	5
Ian Wilkie	Interim Director of MHLD	2
Nick Lyons	Executive Medical Director	2
Teresa Owen	Executive Director of Public Health	2
Dylan Roberts	Chief Digital and Information Officer	1

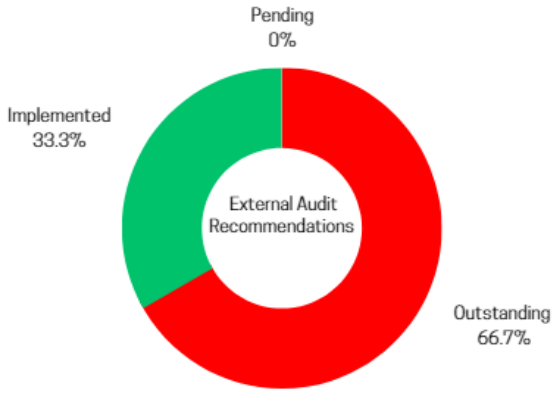
Analysis





Overall number of Internal Audit recommendations from 2017-2024 is 115
Total number completed is 44 (38.3%)
Total number outstanding is 58 (50.4%)
Total number pending is 13 (11.3%)

Of the 58 outstanding internal audit recommendations;
42 (72.4%) are high priority
16 (27.6%) are Medium priority



Overall number of External Audit recommendations from 2020 to 2023 is 9
Total number completed is 3 (33.3%)
Total number outstanding is 6 (66.7%)

Of the outstanding external audit recommendations;
5 (83.3%) are high priority
1 (16.7%) is medium priority.

The full details of the recommendations and status updated are detailed in an abridged version of the tracker below.
Audit Committee are asked to review Appendix 1A Recommendations Proposed by Executives for Closure.

Appendix 1A: Recommendations Proposed for Closure by Executives
Appendix 1B: Open Internal Audit recommendations
Appendix 1C: Open External Audit recommendations

Conclusion

There remains to be a number of high priority recommendations from internal and external audit which require progression. Finance, Medical and Workforce in particular have progressed several of their recommendations for closure. The majority of recommendations which remain open reside with operations and Office of the Board Secretary.

ID	Report Title	Internal Audit (IA) / Wales Audit Office (WAO)	Recommendation State	Recommendation Title	Recommendation	Priority	Est. Imp. Date	Revised Imp. Date	Last Status Update	Owner	Final Approver	Date Final approved	OBS Comments
72	Performance measure reporting to the Board – Accuracy of information	Internal Audit	Final Client approved	Reporting Accuracy	Whilst we recognise that first issue above was likely the result of a typing error, management must ensure that all data reported is accurate. To ensure consistency and transparency, changes to reporting methodology should be noted in the report and communicated to the reader.	Medium	31/07/2021	31/12/2022	In line with the development of the IQPR, a further Board workshop has been held to explore the requirements of Committee Chairs in terms of assurance levels with reporting. As a result of these discussons, a proposed alternative dashboard has been developed which will be supported by a decision tree and supported via MS 365. This dashboard will be used to monitor performance via accountability meetings and narrative will be captured to support reporting into committees.	Barbara Cummings, Interim Director of Performance	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
111	Impact Assessments	Internal Audit	Final Client approved	Policies and Procedures	1.1a Health Board to clarify and document requirements regarding other Impact Assessments, and ensure information is embedded or signposted in key Health Board policy documentation (e.g. OBS1 Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, and F017 Policy for Revenue Business Case Development), and is accessible and visible to staff developing proposals / policies. Consideration should be given to an intranet page with the relevant resources and expertise signposted for staff. 1.1b Health Board to consider progressing and developing the Impact Assessment Gateway document for strategic and policy decisions including written control documents and development proposals to ensure statutory requirements are met.	Medium	31/10/2022	31/12/2022	The Integrated Assessment Screening Tool has been drafted in conjunction with relevant stakeholders/corporate leads i.e. Equality Team, Welsh Language Team, Children's Services, Older Persons/Lead Nurse for Dementia, Safeguarding, Carers, Patient Experience, Finance and Transformation and Improvement Colleagues. The document is pending final review and comments with the Safeguarding Team and will then be sent on to Executives for final sign-off as per the Health Board's Policy on Policies. Following consideration the assessment is that a stand-alone intranet page is not necessary and would risk further confusion. Instead the IAST will be included on existing Equality/Policy/Business Planning intranet pages.	Sally Baxter, Assistant Director - Health Strategy	Jason Brannan, Deputy Director of People	30/08/23	Approved by Jason 30/08/2023

119	Integrated Service Boards (ISB)	Internal Audit	Final Client approved	ISB Governance Arrangements	The Health Board ensures Integrated Service Board governance arrangements are aligned with its own governance and planning frameworks, and is subject to regular review and scrutiny.	High	30/06/2022	30/11/2022	The revised Scheme of Delegation, together with the Risk Management Policy have been completed and were presented for sign off to the June Audit Committee. The revised Governance and Accountability Framework will be presented to the November Audit Committee. October 2023 updated received from Nesta Collingridge - The revised Scheme of Delegation, together with the Risk Management Framework have been completed and were signed off Sept 23. The revised Committee Framework will be presented to the November Audit Committee. Performance and Planning Frameworks were also approved.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	25/10/23	Phil to review status update and revised implementation date **Approved for closure by Interim Board Secretary 25/10/23 Recommended for closure.**
120	Budgetary Control & Financial Reporting, including COVID-19 financial governance	Internal Audit	Final Client approved	Authorised Virements	Finance to ensure that effective manual processes are in place to ensure segregation of duties are being adhered to, including regular sampling of virements.	Medium	25/06/2022		Sampling of 10% of virements has been built into the regular monthly workflow processes, which incorporates calling CFOs to account for any breaches within their team.	Michelle Jones, Head Of Financial Reporting	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
121	Budgetary Control & Financial Reporting, including COVID-19 financial governance	Internal Audit	Final Client approved	Questionnaire responses	Finance to review the findings of the audit questionnaire, and complete the planned rollout of divisional questionnaires commencing March 2022.	Low	24/06/2022		Questionnaire responses from the Audit questionnaires and the Finance questionnaires, where these have been received, have been reviewed.. As further responses are received these reviews will continue, and if necessary action plans to address any recurring themes will be drawn up.	Michelle Jones, Head Of Financial Reporting	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023

127	Clinical Audit	Internal Audit	Final Client approved	policy and process in place for clinical audit.	Review and update the policy and procedure document MD22, and include the governance structure within Appendix 1.	Medium	30/09/2022	30/04/2023	The policy was approved at EDG (Quality) meeting. The remainder of the process to upload onto the Policies page on the intranet, and link to our Clinical Effectiveness webpage, and for the team to disseminate to local CEGs will now be implemented. **October 2023 update received** - As referenced in Internal Audit report from October 2023 : 2.1 The Clinical Audit Policy and Procedure is available on the Health Board intranet site (BetsiNet). The QSE committee approved the latest version on 20 June 2023, and this was uploaded to BetsiNet on 6th July 2023. The document outlines the procedure for conducting clinical audits, including those required by the Welsh Government (Tier 1). Section 6 depicts the roles and responsibilities of persons within the clinical audit process whilst Section 7 of the policy/procedure outlines the organisational structure.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	08/08/2023	Approved via email by Nick 08/08/23 **October 2023 - Update received Executive sign off. Recommended for closure.**
149	Employment of Medical Locum Doctors	Internal Audit	Final Client approved	New Recommendation	The Health Board ensures there is a robust process to monitor the performance of the contract and this should be reflected in the Health Board Standard Operating Procedure / policy.	High	30/06/2022	31/01/2023	The meetings are now in place and a dashboard is reviewed as part of these meetings which will be revised as required, any issues arising from the performance are discussed and actions agreed to rectify them as part of the contract management oversight.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	30/08/2023	Approved by Jason 30/08/2023

150	Roster management	Internal Audit	Final Client approved	Policies and Procedures	Policy WP28a requires a review, needs to include a reference to the E-timesheets also include the SOP within the documents to be read alongside the policy section on the first page. Draft SOP needs to be approved and activated.	Medium	31/07/2022	31/08/2022	Revised policy is now live with all relevant amendments enacted, the issue around breaks is now being managed by senior corporate nursing leads.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	30/08/2023	Approved by Jason 30/08/2023
151	Roster management	Internal Audit	Final Client approved	Submission of timesheets by agencies	Agencies are formally reminded of the requirement to submit timesheets within 48 hours to ensure roster managers have sufficient time to check these. Compliance with the submission of timesheets to be monitored and where there are continued delays this should be escalated via contract arrangements.	High	30/06/2022	30/09/2022	Communication to all agencies has been issued. Communication to all Nursing Managers has been issued Training sessions have been put on for nursing teams on 2 separate occasions but have been poorly attended to date, this poor attendance has been flagged with AD for Nursing Workforce and further sessions are being arranged for September 22 with attendance now being made mandatory. All original actions and further actions have now been completed	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	30/08/2023	Approved by Jason 30/08/2023

152	Roster management	Internal Audit	Final Client approved	Implementation of 1 hour breaks	The Temporary Staffing Team to regularly review 12 hour shifts on the system (prior to submission to payroll) and amend the break times as per the procedures. 3.2 Agencies are formally reminded of the requirement to input breaks according to the timesheets submitted, and reminded of the declaration included on the system where they are confirming the details entered are correct. 3.3 Roster managers to be formally reminded of the requirement to check shifts match timesheets / exception sheets before they are locked for payment. 3.4 The 12 hour shifts where the break has not been adjusted should be identified and steps taken to recover the overpayments. 3.5 The Temporary Staffing team should regularly check a sample of shifts on the system against paper timesheets retained by agencies.	High	31/08/2022	30/09/2022	All actions have been implemented as per the action plan.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	30/08/2023	Approved by Jason 30/08/2023
155	Establishment control – Leaver management	Internal Audit	Final Client approved	Leaver data provided to areas / departments	Information on non-compliance with the leaver process should be included in monthly exception reports that are provided to areas / departments. Where non-compliance remains high action should be taken to improve compliance i.e. additional training and monitoring by Workforce & OD	Medium	31/01/2022		This action has been implemented. It was not signed off earlier as it had dropped off the owners log due to a technical error with the system	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	30/08/2023	Approved by Jason 30/08/2023

165	Waste Management	Internal Audit	Final Client approved	Non-compliance with Covid-19 operating procedure	Recommendations agreed to increase compliance with the Covid-19 SOP should be progressed and reviewed regularly to ensure implementation.	Medium	31/08/2022		Return to business as usual for the management of waste is now in place following a number of discussions and sessions with clinical and nursing team across the Health Boards Acute and Community Hospitals. On target for implementation by the end of August Compliance with the COVID19 SOP has now been achieve with oversight and reporting through the Infection Prevention Sub-Group which reports to QSE	Rod Taylor, Director Of Estates And Facilities	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
167	Speak out Safely	Internal Audit	Final Client approved	MDT Process log	1.1a Dates to be added into progress log i.e. 'date recorded' 'date of review' to enable tracking of concerns to outcomes. 1.1b Attendance at MDT meetings to be recorded to demonstrate meetings are quorate.	Medium	30/11/2022		MDT process log has been updated as per recommendations and reviewed by Ossama Lotfy from the Audit Team and signed off as meeting the required standard. Action completed.	Gareth Evans, Senior Organisational Development Manager	Jason Brannan, Deputy Director of People	30/08/2023	Approved by by Jason 30/08/2023

169	Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website	Internal Audit	Final Client approved	Policy and Management of Website Information	1.1 Health Board to establish formal policy to support the management of the Health Board website (and other digital) content. 1.2 Management review website user administrator access privileges and establish controls to ensure amendments or additions to the Health Board website are subject to review and scrutiny prior to publishing. 1.3 Management to establish controls or monitoring arrangements to ensure that changes published on the English web pages are also actioned on the Welsh pages.	High	31/03/2023	30/09/2023	1. The protocol has been developed and signed off, approved by HBLT (1st March 2023) 2. Website user administration access privileges have been reviewed and controls implemented (list of editors reviewed, redundant users removed and all remaining users issued with protocol and user agreement. Refresher training also provided). 3. New content translation managed by the Communications team, regular audits of new and/or amended pages conducted (noting that some of the pages are devolved responsibility, i.e. the OBS page). 4. Whilst the original Management response indicated the recruitment of a dedicated translator for the Comms team, the team have been unable to recruit on two separate occasions. Financial circumstances now mean that funding is no longer available.	Andrew Rogers, Head Of Corporate Communications	Teresa Owen, Executive Director Of Public Health	30/08/2023	Final approved 30/08/23
175	Effective Governance: YWM	Internal Audit	Final Client approved	Risk Management	5.1a The Risk Register requires review to ensure that risks are accurate and appropriate actions / dates are included. 5.1b Management to review consistency of reporting in accordance with the revised Operating Model / governance structure.	High	31/03/2023		We have fully integrated within the IHC governance framework	Ian Donnelly, Acute Care Director	Adele Gittoes, Interim Executive Director of Operations	05/09/2023	Approved by Adele via email 05/09/2023

178	Effective Governance: YG	Internal Audit	Final Client approved	Clinical audit	The list of Tier 3 audits should be shared with the QSCE to ensure there is no duplication of audits / efforts across the Ysbyty Gwynedd. This would also provide opportunities for work across more than one division / locality. Results and lessons from Tier 3 audits should be shared across the Health Board. Noting that divisions / localities are responsible for Tier 3 audits, we would suggest the learning / feedback is provided to the QSCE and the Clinical Effectiveness Team and a process put in place to ensure that relevant learning / feedback is shared across the site and potentially the Health Board. Management should ensure that staff contribute to Tier 2 audits where required, in order to progress the Health Board's Clinical Audit Plan.	High	31/12/2022	31/03/2023	The Quality Local Delivery Group across the West IHC has now been established and met for the first time in February 2023. A further meeting is scheduled for Wednesday 22nd March 2023. A cycle of business has been agreed and a programme of audit established. This will formally report through the Quality LDG in May 2023. The IHC Medical Director is also currently the chair of the Health Board Clinical effectiveness Committee, and will take any learning for wider dissemination to that forum. A new Organisational Learning Forum, chaired by the Executive Director of Nursing, has also been established, and the West IHC is represented by its Director of Nursing. Implemented as per update comments 21st March 2023.	Janw Hughes-Evans, Interim Area Nurse Director West	Adele Gittoes, Interim Executive Director of Operations	05/09/2023	Approved by Adele via email 05/09/2023
193	Charitable Funds	Internal Audit	Final Client approved	Information provided to the board	1.1 Induction information provided to Board Members - review and issue to all, to include responsibilities, key information and how they are provided with assurance on the operation of the Charity. 1.2 Review the content and frequency of information provided to Trustees, including: More frequent Board of Trustee meetings. More frequent performance reporting (financial and qualitative, such as achievement of goals and objectives, fundraising data, Charity team activity). Assurance provided on meeting requirements of the Charity Commission. Information on any changes to guidance and how these are being applied within the Charity.	High	31/01/2023		COMPLETED: Charity induction information prepared for new Board members. Request for in person (or Teams) 15 minute session with CFC Chair / Head of Fundraising be included in induction been approved. Information on charity activity is included in the IM & Exec updates and regular communications are included on the Betsinet page.	Kirsty Thomson, Head Of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023

198	Charitable Funds	Internal Audit	Final Client approved	Expenditure	A process should be put in place to review the benefits / outcome of funding to ensure these have been realised and captured by the Charity.	Medium	30/09/2023		COMPLETED. Dylan Evans, Grants and Data Manager, started in post from 27/03/23 and the development of a new grants management system, which includes new processes to capture more information, monitor and evaluate all charitable grants, is underway and due to be fully operational by the end of 2023.	Kirsty Thomson, Head Of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
199	Charitable Funds	Internal Audit	Final Client approved	charity objectives	The wording of the Charity's objectives should be reviewed to ensure it accurately reflects the spend of the charity i.e. staff and wellbeing support initiatives.	High	31/01/2023		Whilst the new strategy has not yet been finalised, the charity's objectives have been updated on all internal and external communications platforms, as required.	Kirsty Thomson, Head Of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
202	Delivery of HB Savings	Internal Audit	Final Client approved	Effective governance and oversight arrangements to deliver savings	The Health Board, through its Executive, review the governance and assurance structure in the delivery of savings schemes.	High	30/04/2023		**October 2023 update:** The Savings Plan process, including the associated requirement guidance and templates has been fully refreshed in 2023/24 and has been issued as part of the 2024/25 Annual Plan process. All savings schemes need to have approval sign off from: • The Programme Board, which includes the Programme Sponsor and Programme Finance Lead • Operational Lead (this may be a Clinical Lead) and budget holder(s), if different. • The IHC/ Service Directors in the scope of the scheme • CFO('s) in the scope of the scheme All Savings are reported to Welsh Government through the Monthly Financial Monitoring Return signed off by the Executive Director of Finance and CEO. Executive Committee, PFIGC and Board receive regular reports on the Savings Plans and delivery. Performance is also discussed at the Integrated Delivery Group.	Andrea Hughes (BCUHB - Finance) Interim Director Of Finance, Finance	Russell Caldicott, Interim Executive Director of Finance	25/10/23	Revised Status update and implementation date to be provided if not complete. **Owner now updated : Andrea Hughes - Interim Director Of Finance, Finance as from October 2023 Recommended for Closure by Owner. Executive Sign off received. Recommended for closure.**

204	Management of Utilities	Internal Audit	Final Client approved	Health Board EFPMS performance	Management to identify what actions are required to reduce consumption in the sites identified in order to meet the all Wales KPI for net energy consumption. Where actions are already planned i.e. as part of the Decarbonisation Energy plan, this should be clearly stated.	Medium	30/06/2023		Re:fit programme approved to proceed to Invitation to Tender in PFIG which will appoint an Energy Performance Contractor to support the Health Board	Arwel Hughes, Head Of Operational Estates - Interim	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
205	MH&LD	Internal Audit	Final Client approved	PADR Compliance & WARRN training	Further progression is needed in order to achieve the overall divisional completion target of 85%. Focus is necessary to increase the uptake of training within areas of the division	High	30/04/2023		MH&LD Divisional PADR compliance report recording 85% PADR compliance across the Division. Report presented and shared at Operational Leadership Meeting and will be shared at the forthcoming Service People and Culture meeting due to be held on 3/7/23. PADR Compliance report attached. Update on WARRN training - MH&LD Divisional WARRN training compliance at 81% up to 18/6/23. WARRN training compliance report attached. Twice monthly training course continue to be held. MH&LD Divisional PADR compliance rate at 85% for two consecutive months (April 23 and May 23). Report attached as evidence. Action completed.	Adrianne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director Mhld	31/08/2023	Approved by Iain 31/08/23

208	MH&LD	Internal Audit	Final Client approved	Ockenden Recommendations	Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management.	High	30/06/2023		The draft MH&LD Recruitment and Retention Strategy/Plan has been signed off and actions are progressing. Quarterly updates will be provided to MH&LD divisional SLT. Whilst some senior interim positions remain, these are longer term thus provide a greater level of stability than short term appointments, and a plan is in place for permeant recruitment. Therefore the proposal is to close this action.	Adrianne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director Mhld	31/08/2023	Approved by Iain 31/08/23
212	Digital strategy	Internal Audit	Final Client approved	Funding the implementation of the Digital Strategy	The Chief Digital and Information Officer, working with Finance colleagues: • identifies the costs associated in implementing the digital strategy. • ensures the budget report accurately reflects the funded establishment. • where funding is not available, the risks associated with cessation of the project is evaluated and formally reported to Committee.	High	30/06/2023		A full review of the DDaT Budget has been undertaken and many previous cost pressures for 2022/23 have been funded. The DDaT IMTP submission has not been funded due to constraints across the Health Board. Some of the national projects and programmes did come with funding and some have brought additional pressures to the Health Board. A list of unfunded projects and the risks associated with non-delivery has been developed and is in the process of being reported to the PPPH Committee when it starts again. The costs of delivering the entirety of current Digital Strategy have not been fully quantified or funded and the risks associated with that are in the BAF with an accepted level of tolerance. 2.5. There is a risk that we won't achieve our strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled change 2.6 There is a risk that we are unable to maintain the minimum level of service to our patients and population caused by having inadequate digital applications, infrastructure, security and resources that may result in major ICT failures or cyber-attack.	Andrea Williams, Head of Informatics Programmes Assurance and Improvement	Dylan Roberts, Chief Digital and Information Officer	15/08/2023	Revised Status Update received and Dylan confirmed to close

215	USC: Urgent Primary Care Centres - Business case outcomes achieved	Internal Audit	Final Client approved	Data reconciliation	3.1 Management to ensure reconciliation of reported performance information to source data is documented and retained. This could be incorporated within existing working documents. 3.2 Health Board to consider using UPCC engagement data to target promotion of the service to GP Practices that have low referral rates / have not used the service.	Medium	31/05/2023		3.1 - Data reconciliation of West data completed and master copies available. 3.2 - continuous review of GP practices not utilising the service is on-going and practices contacted directly for discussion 3.2 - Review of ED attendances - SBAR submitted to Area Directors for West for discussion, other options to be explored before final decision is made	Chris Couchman, Associate Director Of Primary Care	Adele Gittoes, Interim Executive Director of Operations	05/09/2023	Approved by Adele via email 05/09/2023
219	Public Health - Smoke free sites	Internal Audit	Final Client approved	Policy not up to date	Smoke free policy WP31 is progressed and agreed through the appropriate process as a matter of urgency to become compliant with legislation	High	31/10/2023		**October 2023** - Issue resolved around smoking shelters in relation to the policy and we will not be supporting smoking shelters across BCUHB premises. WP31 policy has been approved, signed off and has been disseminated and communicated across the health board. It is available via the workforce policy pages on Betsinet. A review of the policy will be made once all environmental officers have been employed and in place across the health board PHW colleagues are working with the IHCs to implement a management plan in support of the policy. **October 2023 -** Item to be marked as green/completed, as the Smoke-free Policy has now been updated and approved through the relevant process, also with dissemination and comms taking place. The remaining work regards ensuring compliance of the Policy and it's review will be ongoing and involve a number of actions in working with staff, line managers, IHC's, recruitment of environment officers.	Gavin Jones, Health Intervention Co-ordinator	Teresa Owen, Executive Director Of Public Health	27/10/23	Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Status update provided by Owner. Approved by Executive Lead.** **Status update also provided by Consultant in Public Health.** **Recommended for closure.**

221	Audit Wales Follow up - counter fraud	Wales Audit Office	Final Client approved	Recommendation 2 Resources and Skills	The Executive Director of Finance reviews succession planning and service continuity arrangements in line with the Audit Wales report, factoring in other NHS Wales comparators.	Low	07/12/2022		Agreement reached to submit a re-banding for a Deputy Head of Counter Fraud post (B7) - awaiting outcome of evaluation awaited. This would bring the structure of the team in-line with recent changes to the LCFS Teams across Wales.	Andrea Hughes, Interim Director Of Finance,	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
225	Audit Wales Structured Assessment 2020	Wales Audit Office	Final Client approved	R3	Reporting progress against delivery of plans: Ensure that outcomes achieved as a result of delivery of actions are appropriately articulated within quarterly plan and annual plan monitoring reports. This may require strengthening of underpinning business benefits analysis processes.	High	30/11/2020	31/12/2022	Update provided by Executive Director of Finance. An update has been provided to the board that includes NHS Wales Delivery Framework and narrative to articulate performance. The IQPF requires some further refinements in line with the development of the Integrated Performance Framework. However, assessment is that the rec can be closed.	Barbara Cummings, Interim Director of Performance	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023

246	Financial Control – Receipting of goods and year-end accruals	Internal Audit	Final Client approved	Procurement guidance and training	Ensure all staff involved in procurement receive mandatory training in line with the requirements stipulated by the Chief Executive of NHS Wales. Review the evidence provided for Purchase Order 9705645 for £293,787 and ensure it is accounted for in the correct financial year.	High	31/07/2023	01/11/2023	Item 7 in the Financial Control Environment Action Plan, which is monitored fortnightly by WG in conjunction with Special Measures, includes a learning lessons process. The inclusion of the audit for the 2022-23 financial year provides assurance these lessons have been learned with balances endorsed as true and fair by Audit Wales.	Andrea Hughes, Interim Director Of Finance,	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
248	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	Internal Audit	Final Client approved	Standing Orders Compliance	The engagement of all interim/agency appointments must comply with the Standing Orders, Standing Financial Instructions and associated Delegated Matters/Scheme of Delegation and Standard Operating Procedure. Issues of non-compliance must be included in all relevant Performance and Accountability meetings with clear actions Minuted and officers held accountable for continual non-compliance.	High	31/06/2023		July rem com received the first report identifying compliance against SOP etc, September meeting will identify further escalation for repeated non-compliance into the AC. Areas of non-compliance are reported to the CEO and the Exec team	Owner to be identified	Jason Brannan, Deputy Director of People	30/08/2023	Approved by by Jason 30/08/2023

269	Performance Management – Quality and Performance Reporting and Accountability Arrangements	Internal Audit	Final Client approved	Accountability meetings (b)	Review current action tracker to determine whether actions are still relevant.	High	31/07/2023		Recommended to close. Action Tracker reviewed/refreshed. Outstanding actions addressed and closed, refreshed arrangements to document the agreement of actions and outcome of each quarterly review will be done via accountability agreements (under the new Framework).	Barbara Cummings, Interim Director of Performance	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
272	Recruitment Improvement Review	Internal Audit	Final Client approved	Board and Committee reporting	Management to review governance and reporting arrangements to ensure implementation and performance is subject to Health Board review and scrutiny.	Medium	30/06/2023		Recs implemented - KPIs now included in WOD to PFIG. Local IHC dashboard have been developed to provide and rela time info.	Owner to be identified	Jason Brannan, Deputy Director of People	22/08/2023	Approved by by Jason 30/08/2023
275	Accounts Receivable	Internal Audit	Final Client approved	Cash Deficit	The Health Board should ensure that any discrepancies between money banked and payments receipts be fully investigated and formally reported to establish reasons and prevent further occurrences.	High	17/08/2023		Reviewed by Exec Director finance - close.	Ronnie Bright, General Office Manager	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
277	Clinical Audit – Tier 1 National Audits	Internal Audit	Final Client approved	Clinical Audit Plan	The Clinical Audit Plan for 2023/24 should be formally approved at the appropriate committee.	Medium	31/07/2023		The Clinical Audit Plan went to QSE Committee in August and is incorporated into future cycle of business.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	31/08/2023	Approved for closure by Nick 31/08/2023

278	Clinical Audit – Tier 1 National Audits	Internal Audit	Final Client approved	Clinical Audit participation	The Health Board to ensure resources are available to participate in audits in order to fully comply with the mandated audits.	High	30/09/2023		**October 2023 update** - Following on from Internal Audit Review one of the agenda items on Strategic Clinical Effectiveness Group 12th September was a request for each local CEG to discuss and identify resource gaps and how group come to that conclusion us to capture in Chairs Report to escalate to relevant Health Board meeting. Initially we have had updates on Tier 2 and are working through this, nothing has been raised on Tier 1 currently - we will escalate any concerns to QDG and QSE - **this can be CLOSED**	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	16/10/23	Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Status update provided - Approved for closure by the Executive Medical Director - Oct 23 Recommended for closure.**
279	Clinical Audit – Tier 1 National Audits	Internal Audit	Final Client approved	Validation of Data	Clinical Effectiveness Department liaise with the services to establish how the data is validated for each audit, this will enable the department to gain a better understanding of how the data is collected and validated.	Medium	30/09/2023		**October 2023 update -** The Clinical Audit Facilitators are working with all Tier 1 audits to clarify with each Clinical Audit Lead how the data has been validated and noting this to provide assurance within our our quarterly reports - **This can now be CLOSED**	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	16/10/23	Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Status update provided - Approved for closure by the Executive Medical Director - Oct 23**

282	Clinical Audit – Tier 1 National Audits	Internal Audit	Final Client approved	Learning from audits (a)	Ensure that the local service meeting minutes, which contain the lessons learned from the audits as specified within the service assessment of compliance form, are sent to the clinical effectiveness department as part of the assurance process.	Medium	23/07/2023		**October 2023 -** The Clinical Audit Facilitators have developed a service assessment for that is sent to each Clinical Lead after each publication. This allows the Clinical Lead to note where discussions are held, which meetings information is fed back, how learning is shared. The process will not be closed until all the relevant evidence has been sent to Clinical Audit Facilitator to include in our Quarterly Reports . This can now be CLOSED	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	16/10/23	Revised Status update and implementation date to be provided if not complete. **Status update provided - Approved for closure by the Executive Medical Director - Oct 23 Recommended for closure.**
283	Clinical Audit – Tier 1 National Audits	Internal Audit	Final Client approved	Learning from audits (b)	Clinical Audit updates / Annual Clinical Audit Report to be presented to the Quality and Safety Committee to allow Health Board members the opportunity to challenge and approve the documents. The quarterly reports clearly tables and monitors the performance and progress of Tier 1 mandatory audits - the reports also note where there are lack of engagement or if reporting is late and these are picked up within the local CEGs by the Clinical Audit facilitators and captured in the following quarterly report whether improvements have been made or not and if needed noted in CEG and QDG so has mechanism in place to escalate when necessary.	High	30/09/2023		**October 2023 -** Due to the QSE being stood down, at the time papers such as Clinical Audit Plan, Quarterly papers and Annual report were sent to Strategic Clinical Effectiveness Group and then to Quality Development Group. Now that QSE has been reinstated and meeting bi-monthly all those papers have been sent for information and approval . Also this will now be the process we follow to ensure that assurance and approval is received from all relevant groups. **This can now be CLOSED**	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	16/10/23	Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Status update provided - Approved for closure by the Executive Medical Director - Oct 23 Recommended for closure.**
272	Final Client approved	Board and Committee reporting	Management to review governance and reporting arrangements to ensure	Medium	30/06/2023		Recs implemented - KPIs now included in WOD to REIG Local	Owner to be identified	Jason Brannan, Deputy Director of People	22/08/2023	Approved by by Jason 30/08/2023		

275	Final Client approved	Cash Deficit	The Health Board should ensure that any discrepancies between money banked and payments receipts be fully	High	17/08/2023		Reviewed by Exec Director finance - close.	Ronnie Bright, General Office Manager	Russell Caldicott, Interim Executive Director of Finance	22/08/2023	Approved for closure by the Executive Director of Finance 22/08/2023
277	Final Client approved	Clinical Audit Plan	The Clinical Audit Plan for 2023/24 should be formally approved at the appropriate	Medium	31/07/2023		The Clinical Audit Plan went to QSE Committee in August and is incorporated	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	31/08/2023	Approved for closure by Nick 31/08/2023
278	Final Client approved	Clinical Audit participation	The Health Board to ensure resources are available to participate in audits in order to fully comply with the mandated audits.	High	30/09/2023		**October 2023 update -** Following on from Internal Audit Review one of the agenda items on Strategic Clinical Effectiveness Group 12th September was a request for each local CEG to discuss and identify resource gaps and	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	16/10/23	Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Status update provided - Approved for closure by the Executive Medical Director - Oct 23**
279	Final Client approved	Validation of Data	Clinical Effectiveness Department liaise with the services to establish how the data is validated for each audit, this will enable the department to gain a better understanding of how the data is collected and validated.	Medium	30/09/2023		**October 2023 update -** The Clinical Audit Facilitators are working with all Tier 1 audits to clarify with each Clinical Audit Lead how the data has been validated and noting this to provide assurance within our our quarterly	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	16/10/23	not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Status update provided - Approved for closure by the Executive Medical Director - Oct 23**
282	Final Client approved	Learning from audits (a)	Ensure that the local service meeting minutes, which contain the lessons learned from the audits as specified within the service assessment of compliance form, are sent to the clinical effectiveness department as part of the assurance process.	Medium	23/07/2023		**October 2023 - Update received from Joe Shillingford also email confirming closing the item from Nick Lyons - Executive Medical Director.** The Clinical Audit Facilitators have developed a service assessment	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	16/10/23	Revised Status update and implementation date to be provided if not complete. **Status update provided - Approved for closure by the Executive Medical Director - Oct 23 Recommended for closure.**

283	Final Client approved	Learning from audits (b)	Clinical Audit updates / Annual Clinical Audit Report to be presented to the Quality and Safety Committee to allow Health Board members the opportunity to challenge and approve the documents. The quarterly reports clearly tables and monitors the performance and progress of Tier 1 mandatory audits - the	High	30/09/2023		**October 2023 -** Due to the QSE being stood down, at the time papers such as Clinical Audit Plan, Quarterly papers and Annual report were sent to Strategic Clinical Effectiveness Group and then to Quality Development Group. Now that QSE has	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	16/10/23	Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Status update provided - Approved for closure by the Executive Medical Director - Oct 23 Recommended for closure.**
284	Marked as Implemented by Owner	Process Management (1.1)	Management to develop robust written control documents to support operational processes and strengthen governance arrangements	Medium	13/10/2023		**October 2023 update received - This action is completed**. A terms of reference has been finalised and regular	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations		**Executive Sign off to be confirmed?**
285	Marked as Implemented by Owner	Process Management (1.2)	Management to establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for	Medium	13/10/2023		**October 2023 update received - This action is completed.** This action is completed. A terms of reference has been	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations		**Executive Sign off to be confirmed?**
287	Marked as Implemented by Owner	Progress Update Log	Management to ensure that responsible officers and completion dates assigned to improvement actions are documented. We are aware that the	Medium	13/10/2023		**October 2023 update received - This action is completed.** Completion dates and improvement actions are now monitored via	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations		**Executive Sign off to be confirmed?**

ID	Report Title	Internal Audit (IA) / Wales Audit Office (WAO)	Recommendation State	Recommendation Title	Recommendation	Priority	Est. Imp. Date	Revised Imp. Date	Last Status Update	Owner	Final Approver	Date Final approved	OBS Comments
57	Quality Improvement Strategy	Internal Audit	Started	Reporting progress of Quality Improvement Strategy (QIS)	For the planned publication and launch of a new QIS for 2020 onwards, management should ensure the QIS: Is underpinned by a clear and concise implementation plan that records what actions/tasks are expected, by when and how success will be measured. Regular reports of progress should include clear performance and delivery per the implementation plan.	High	01/08/2020	31/03/2024	The new Quality Strategy is being developed in line with the vision of the new interim CEO and aligned to the Special Measures programme, including the expected clinical governance review by the independent advisors appointed by Welsh Government. Therefore a provisional revised implementation date has been input as the 31st March pending discussion/confirmation with the CEO and the Executive Director of Nursing to ensure alignment with the Special Measures programme.	Matthew Joyes, Assistant Director Of Patient Safety And Experience	Angela Wood, Executive Director of Nursing and Midwifery		Status update provided (responses reviewed by Angela 29/08/23)
59	Risk Management	Internal Audit	Pending	Strategic Objectives	The Health Board revisits its strategic priorities, setting objectives that are measurable by a set timeline. Further review of its completion to ensure aspects identified within the findings around risk appetite/target risk and controls etc.	Medium	31/03/2022	31/10/2023	Progress update required from Board Secretary and CEO - to be discussed at ET 08/11/2023.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.

73	Performance measure reporting to the Board – Accuracy of information	Internal Audit	Started	Standard Operating Procedure	Management to finalise and formally issue the RTT 26 Week Pathways Standard Operating Procedure. Ensure Risk Stratification controls and procedures are formally documented.	Medium	02/08/2021	14/01/2022	**October 2023 update -** The RTT 26 week SOP has been created and ratified, the education and training of this SOP has been conducted August 2021. However, since the creation of the document West have migrated onto WPAS from IPM and an Access Policy has been created that will supersede this document this is due to be sent for ratification November 2023.	Andrew Oxby, OPD Programme Support Manager	Adele Gittoes, Interim Executive Director of Operations		Revised Status update and implementation date to be provided if not complete. **OBS query - is this a revised Imp Date ? Sop provided as evidence to support update - Rather than embedding the item here - it is located here \\bcuestorage.cymru.nhs.uk\office of the board secretary\Board & Committees\Governance\Compliance\AC\Tracker Master\Additional evidence\Rec item 73**
114	Standards of Business Conduct: Declarations	Internal Audit	Started	Declarations of Interest Compliance	3.1 Governance leads to be reminded of their responsibility to review DOIs regularly and escalate non-compliance where required. 3.2 The Office of the Board Secretary to progress the options for reminding staff of declarations due via automatic emails.	High	30/06/2022	30/09/2023	The contract is now in place with Civica and implementation of the new system is underway following completion of the project set up documentation. Roll out due for week commencing 29/08/23.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.

115	Standards of Business Conduct: Declarations	Internal Audit	Started	Declarations of Interest Compliance	3.1 Governance leads to be reminded of their responsibility to review DOIs regularly and escalate non-compliance where required. 3.2 The Office of the Board Secretary to progress the options for reminding staff of declarations due via automatic emails.	High	30/06/2022	30/09/2023	**October 2023 - Update received-** The contract is now in place with Civica and implementation of the new system is underway following completion of the project set up documentation. Roll out took place on week commencing 29/08/23 and OBS Staff and Civica assisting any staff who are having any difficulties. Automated reminders will be sent out to staff who have not left a DOI and in a planned programme and communications around Gifts and Hospitality near Christmas. **Phil Meakin to review update and Final Approve, also review update against related recommendations.**	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete. **Phil Meakin to review.**
116	Standards of Business Conduct: Declarations	Internal Audit	Started	Declarations of Interest System	2.1 The Office of the Board Secretary should seek confirmation from Finance that this information has been updated on a regular basis, to ensure compliance can be accurately monitored. 2.2 Exception reporting should be produced and reviewed regularly to highlight any issues with the data and the impact on compliance rates.	High	30/06/2022	30/09/2023	The contract is now in place with Civica and implementation of the new system is underway following completion of the project set up documentation. Roll out due for week commencing 29/08/23. An update on compliance and progress will be provided to Audit Committee in January 2024.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.

117	Standards of Business Conduct: Declarations	Internal Audit	Started	Gifts and Hospitality requirements	4.1 The guidance regarding the process of accepting / declaring gifts as well as Hospitality should be circulated / highlighted to staff on a regular basis, ensuring all staff are made aware of the policy as well as what they should do when accepting either gifts or hospitality. Those who oversee governance for gifts and hospitality should be encouraged to remind Directors / Assistant Directors of their role in approving hospitality prior to acceptance.	Medium	30/06/2022	30/09/2023	This process will be automated on the MES Declare system (and will signpost to the staff intranet page with further info / Standards of Business Conduct Policy). Roll out of system due for week commencing 29/08/23. An update on compliance and progress will be provided to Audit Committee in January 2024.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.
118	Standards of Business Conduct: Declarations	Internal Audit	Started	Monitoring and Reporting arrangements	The Office of the Board Secretary to consider the monitoring arrangements in place for declarations, gifts and hospitality to ensure these are reviewed on a regular basis. 5.2 Reporting to the Audit Committee to be updated to include current compliance rates for DOIs. Consideration should be given to more regular reporting if compliance rates are generally low.	High	31/05/2022	30/09/2023	The OBS review will inform the Health Boards new Committee Structure and Audit Committee cycle of business will flow from this. A further review of the system is required post implementation to inform future reporting requirements (I.e. number of staff decs against KPIs etc.)	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.

123	Procurement & Tendering	Internal Audit	Started	E waiver system	Conditions or requests included as part of the approval of a waiver should be reviewed and actioned to ensure these are met.	Medium	31/03/2022	30/11/2023	Following a period of user testing the new system is now expected to go live at the end of August 2023. A communication plan for the launch is currently being developed to discourage use of STWs whilst promoting appropriate use of the new system. This is also subject to review fortnightly by WG as part of the Financial Control Environment Action Plan. Post implementation an assessment of impact will be conducted in September (revised date extended from March 2022 to end of September 2023) **October 2023 update received** - Go live has been put back until November to allow time to incorporate some key governance updates in the waiver process.	Laura Williams, Senior Accountant - Capital & Tax	Russell Caldicott, Interim Executive Director of Finance		Status update provided **Oct 2023 - Revised implementation date to 30/11/2023.**
146	Women's Services Division – Sustainability of services	Internal Audit	Started	Escalation of issues	Women's Division management to complete and submit the SBAR to the Health Board Chief Executive Officer. The outcome of the Executive level discussion with the Countess should be formally recorded at the appropriate Health Board forum. Concerns regarding quality of care must be escalated and the Health Board should undertake quality and safety audits to review issues raised.	Medium	31/12/2021	28/08/2023	A further Paper to support the de-commissioning of the Service , as part of the 23/4 Savings and Quality agenda, is being prepared by the Service to be submitted to the Exec Team Meeting.	Fiona Giraud, Director Of Midwifery & Womens Services	Adele Gittoes, Interim Executive Director of Operations		Revised Status update and implementation date to be provided if not complete.

147	Women's Services Division – Sustainability of services	Internal Audit	Started	Finance and Contracting Arrangements	The Health Board to ensure controls are in place to verify activity, treatment, and intervention charges, or obtain sufficient assurance that the data provided by the Countess of Chester Hospital is fair and reasonable. Furthermore: Contracting to share monthly data with Women's to enable periodic review and reconciliation. The Women's Division to engage with the Contracting Team during the negotiation stages to explore future reporting requirements and whether the concerns raised could be addressed via the terms of the contract. Representative from Women's Division to attend and escalate issues and concerns via the monthly contract meeting between the Health Board and the Countess of Chester Hospital as required.	High	31/12/2021	30/05/2023	Contract information is being received from COCH and distributed, any queries are captured and raised at contract meetings as and when they may arise. Contracts team members attend divisional f&P meetings. **October 2023 - Update provided -** This item, Audit reference ID147, relates to ID4019/ Risk Score 12 which sits on the Women's Service's Risk Register and refers to the ongoing risk that pregnant women known to BCUHB, who access commissioned care via the maternity services at the Countess of Chester Hospital Trust, may not be receiving high quality patient centred safe care and optimal clinical outcomes. This risk is a direct result of the Trust's inability to provide sufficient assurance on the quality of care which women known to BCUHB are receiving by them as a Provider. A high clinical intervention rate, the findings of a recent CQC Review (2022), recent Criminal Investigation relating to Neonatal Services and lack of timely KPI and Quality assurance reports to Commissioners is exacerbating the level of concern escalated numerous times to the Health Board. These concerns have been raised in a	Fiona Giraud, Director Of Midwifery & Womens Services	Adele Gittoes, Interim Executive Director of Operations		Meeting of September AC - not happy to close (had been marked as implemented by Owner' and need clarity on responsible Exec **Jody Evans has contacted Adele Gittoes to clarify if she is Final Approver or if it is to be updated to state that Angela Wood is the Exec Final approver.** **Adele Gittoes Clairified that; professional matter Angela Wood, Operational - Adele Gittoes or Medical - Nick Lyons.**
148	Employment of Medical Locum Doctors	Internal Audit	Started	Justification Notes	All requests for recruitment of locum medical staff should be completed to a good level and include all necessary information and justification notes, which will facilitate an effective audit trail.	Medium	30/06/2022	30/09/2023	This is now included in the monthly performance meeting and the initial report will start from 1st September 23. The delay in this is due to the implementation of a new booking system in August 23.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People		Status Update provided

154	Establishment control – Leaver management	Internal Audit	Started	Operational management compliance	Workforce and OD should progress the plans to improve leaver management as a priority, to ensure all employment controls are adhered to by operational areas e.g. submission of staff termination form to Payroll Services; return of all Health Board property/ID badge; and Network access is revoked.	High	31/01/2022	30/12/2023	No 4 was piloted but did not work for IT teams, this was escalated via IT to a national group who is looking at a solution for the IT element of this. Further work to align with National changes to leaver management.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People		Status update provided (Jason not happy to close - sent back to 'started')
158	On-Call arrangements	Internal Audit	Started	Review of on-call arrangements	1.1a The on-call review should be re-instated as a priority, to ensure arrangements match service requirements, and are reviewed considering changing needs as a result of changes due to VERS and the new Operating Model. 1.1b Management should consider the feedback from our questionnaire when reviewing on-call arrangements, and how these can be addressed. 1.1c Following completion of the review and update of guidance (see Matters Arising 2,3 and 4 below), this should be communicated to staff to ensure they understand their obligations and responsibilities for participating in the on-call rotas.	High	12/10/2022	31/10/2023	Full review underway with support from Workforce. Delays due to interim staff change over. Paper planned to Senior leadership Team by the end of September, then to Execs for the end of October. **October 2023 update -** T&F group implemented to review Bronze/Silver and Gold on call along with idenifying themes from the on call. WG EPRR lead has been requested to share any all wales on call documentation to support resilience planning. Financial costs of IHC on call one area is still outstanding. Next steps - End Of November SBAR to Operational Leadership team to agree on next steps for on call design.	Geraint Farr, Associate Director of Unscheduled & Emergency Care	Adele Gittoes, Interim Executive Director of Operations		Revised status update received

159	On-Call arrangements	Internal Audit	Started	Rota guidance / sustainability	The following should be documented for on-call rota's: Minimum staff numbers, Seniority / experience mix, Timelines for preparation and issuing of rotas, Frequency and type of each employees commitment is equitable, Process for staff being added to the rota when commencing an applicable senior role, Process for staff being removed from the rota, ensuring the impact this will have on other staff is considered, with reasons approved at an Executive level. Any staff removed from the rota should be reviewed regularly to determine if they can be put back on it	High	01/07/2022	31/10/2023	The definitive rota and implementation was delayed due to the delay in implementation of the operating model. This was flagged as a potential risk when the audit response was given. The revised timescale is October 2023 to Execs / HBLT for agreement. **October 2023 update -** On review in September it was identified a lack on governacne arrangments around on call provision and Process, noting variances across BCUHB of staff on call. This is being addressed by the creation of a BCUHB On Call policy that will need to go via OLT (End of November) for ratificaiton prior to executives for sign off.	Geraint Farr, Associate Director of Unscheduled & Emergency Care	Adele Gittoes, Interim Executive Director of Operations		Revised status update received
160	On-Call arrangements	Internal Audit	Started	Compensatory rest and payment	Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest. Guidance on compensatory rest and payment entitlement to be included on the staff intranet site and circulated to all staff included on on-call rotas. This should be done on a periodic basis to ensure new staff who are added to rotas are aware of their entitlements. Staff included in on-call rotas to be encouraged to take compensatory rest.	High	11/07/2022	31/10/2023	The compensatory rest policy is in the process of being confirmed, as there are many local differentiations in arrangements, and HR is reviewing the compensatory payments when we understand the intensity of the rotas, as per national/regulatory frameworks for payment. **October 2023 update - No further update as of October 2023.**	Geraint Farr, Associate Director of Unscheduled & Emergency Care	Adele Gittoes, Interim Executive Director of Operations		Revised status update received

161	On-Call arrangements	Internal Audit	Started	Training	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	High	12/12/2022	31//11/2023	Post implementation of policy, training programme to be implemented. Further considerations as to the recruitment to existing funded vacancies will be required for delivery. **October 2023 update -** Training process has commenced with 3 sessions completed in October 2023 regarding HFP and ambulance escalation. JESIP modeling has commenced for a training portfolio, along with development of a Training package on line for staff.	Geraint Farr, Associate Director of Unscheduled & Emergency Care	Adele Gittoes, Interim Executive Director of Operations		Revised status update received
170	Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website	Internal Audit	Started	Compliance with Welsh Language Standards (No.7) Regulations 2018 (Standards 39-43)	2.1a The Health Board must comply with the requirements of the Welsh Language Standards and ensure that information published on its website is consistent on both Welsh and English platforms. Controls to be implemented to ensure that the Welsh language is treated no less favourably than the English language. 2.1b Digital Communications Team to address the issues identified and review the Welsh website regularly to ensure consistency with the English website.	High	31/12/2022	30/09/2023	1. Controls implemented include: a. BCUHB Website & Social Media Content Management Protocol b. List of editors reviewed/refreshed and subject to periodic review c. New content translation managed by the Communications team, regular audits of new and/or amended pages conducted (noting that some of the pages are devolved responsibility, i.e. the OBS page). 2. Outstanding action relates to reviewing existing historical content. External support has been commissioned, review underway, expected completion date end of September **October 2023 - Update received** a. BCUHB Website & Social Media Content Management Protocol - Activated and implemented 10th August 2023 Policies and Written Control Documents - COM 01 - BCUHB Website and Social Media Content Protocol.pdf - All Documents (sharepoint.com) b. List of editors reviewed/refreshed and subject to periodic review - Editor listing reviewed and updated, work is ongoing to monitor periodically - August 2023	Andrew Rogers, Head Of Corporate Communications	Teresa Owen, Executive Director Of Public Health		Status update provided Update provided by Andrew Rogers - Activated and implemented 10th August 2023 Policies and Written Control Documents - COM 01 - BCUHB Website and Social Media Content Protocol.pdf - All Documents (sharepoint.com) **Status update provided by Owner.**

172	Effective Governance: YWM	Internal Audit	Started	Finance	Management to identify and progress savings schemes as a matter of urgency. Management ensure financial scrutiny is in line with the requirements laid out in the Operating Model.	High	31/03/2023	31/10/2023	East IHC Annual Plan has been signed off at IHC level (including oversight from the corporate plannng team). IHC F&P sub-group established as part of the new operating model. This will be subject to continuous review as well as part of the wider fianncial position (the saving guidance and templates are due for issue for the beginning of september).	Geraint Farr, Associate Director of Unscheduled & Emergency Care	Adele Gittoes, Interim Executive Director of Operations		Revised Status received
173	Effective Governance: YWM	Internal Audit	Pending	Clinical Audit	3.1a The list of Tier 3 audits should be shared with the East Clinical Effectiveness Group to ensure audits are focused on the risks within the site and that there is no duplication of audits / efforts across the site. This would also provide opportunities for work across more than one division / locality. 3.1b Results and lessons from Tier 3 audits should documented and shared across the Health Board. Noting that divisions / localities are responsible for Tier 3 audits, we would suggest the learning / feedback is provided to the East Clinical Effectiveness Group and a process put in place to ensure that relevant learning / feedback is shared across the site and potentially the Health Board	High	23/11/2022			Emma Jane Hosking, Hospital Site Medical Director / Consultant Anaesthetist	Adele Gittoes, Interim Executive Director of Operations		Revised Status update and implementation date to be provided if not complete.

183	Board and committee reporting	Internal Audit	Started	Request and submission of papers and reports.	1.1 We recognise that the Health Board have recently implemented a Board / Committee Paper Assurance and Publication SOP. Management to ensure established timescales are met, monitor compliance, and escalate issues of significance to relevant Executive Leads, Chairs, and/or Board Secretary. 1.2 Management to consider publishing meeting and committee calendar on the Health Board website to encourage public engagement.	High	31/12/2022	30/09/2023	SOP in place. Calendar in final stages and hoped to be issued as final by September	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.
184	Board and committee reporting	Internal Audit	Started	Submitted papers meet the Board / Committee requirements.	2.1 Management to ensure that papers and reports submitted to the BCU Board, Committees, or Advisory Groups are of the expected standard, meet the requirements of the Board / Committee and have been reviewed and quality checked prior to being submitted. Submissions to comply with Board / Committee Paper Assurance and Publication SOP. 2.2 Health Board to consider undertaking a root cause analysis of Board and Committee paper and report quality to determine whether there are underlying factors impacting the frequency of issues raised and determine appropriate solutions.	High	30/03/2023	31/12/2023	Update pending the outcome of the OBS review that will inform Committee type/ frequency of meetings and associated governance processes.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.

185	Board and committee reporting	Internal Audit	Started	Reporting Breaches.	Management to establish controls and monitoring arrangements to ensure that all reporting breaches are captured and reported to the Audit Committee.	High	31/12/2022	31/12/2023	Update pending the outcome of the OBS review that will inform Committee type/ frequency of meetings and associated governance processes.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.
186	Board and committee reporting	Internal Audit	Started	Cycles of Business and Terms of Reference.	4.1 Health Board/Committee Cycles of Business and/or Terms of Reference should be periodically reviewed and approved by relevant committees to ensure continued relevance. Approval should be recorded in relevant meeting minutes. 4.2 Management to consider publishing Board/Committee Terms of Reference and/or Cycles of Business on the Health Board website to promote public engagement and reintroduce the publishing of meeting minutes to improve accessibility.	High	30/03/2023	31/12/2023	Process reviewed and revised, with Chair's Action as a standard agenda item for all Board meetings. Outstanding action is to update ToRs (pending OBS review).	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.

187	Chairs action	Internal Audit	Started	Process Design	The Health Board should adopt a formal process for documenting requests and approval of Chairs actions. Details captured could include: Unique identifier; Timelines (Issue raised locally / request made to OBS / authorisation granted by IM's and Chair); Financial impact / cost; Category; and Usual approval route and reasons why this has not been used. The OBS should ensure all approved Chair's actions are reported to the relevant Board / Committee meeting and sufficient detail is captured in the report and the minutes of the meeting. Consideration should be given to reviewing Terms of Reference for Board Committees and whether responsibilities for undertaking Chair's actions relating to Committee business is permitted.	High	31/01/2023	29/02/2024	recommendation has been delayed due to OBS staffing issues and board member changes .	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.
188	Chairs action	Internal Audit	Started	Standard Operating Procedure	The SOP should be updated to reflect the detail of the process in place and consideration given to which IMs should be included in the approval of the request, where possible using their area of expertise.	Medium	30/11/2022	29/02/2024	recommendation has been delayed due to OBS staffing issues and board member changes .	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.
189	Chairs action	Internal Audit	Started	Information provided to members / committees	All Board/Committee members should have access to the information provided with the request to ensure transparency and further scrutiny.	Medium	31/01/2023	29/02/2024	recommendation has been delayed due to OBS staffing issues and board member changes .	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.

190	Chairs action	Internal Audit	Started	Lessons learned	4.1 There should be a periodic review of Chair's actions to determine the reason for the action and to establish if any changes need to be made to current processes / approval routes. 4.2 The Health Board should liaise with Board Secretaries /Office of Board Secretaries from HB3 and HB4, which may highlight areas where lessons can be learned to aid in reducing the number of actions	Medium	31/01/2023	29/02/2024	recommendation has been delayed due to OBS staffing issues and board member changes .	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary		Revised Status update and implementation date to be provided if not complete.
194	Charitable Funds	Internal Audit	Started	Charitable Funds Committee	2.1 Review Membership of the Charitable Funds Committee in light of Executive changes, including the quoracy required for meetings and update Terms of Reference to reflect any revisions. We suggest a minimum 2 Executives and 2 Independent Members, recognising the wider pool of IM and Executives who are Board of Trustee Members. 2.2 Review responsibilities and objectives of Committee and consider the regular information provided including more qualitative data on the operation of the Charity, updating the Terms of Reference to reflect any revisions. 2.3 Undertake a review of the effectiveness of the Charitable Funds Committee, in line with the requirements of the Terms of Reference (2.1) of the Committee, including requirements of the Charity Commission.	High	31/01/2023	31/03/2024	Following new Interim Board member appointments ToR review delayed. The intention is for the ToR to be signed off at CFC meeting Jan 2024 and ratified at the subsequent Audit Committee as necessary.	Kirsty Thomson, Head Of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance		Status update provided

195	Charitable Funds	Internal Audit	Started	Strategy	The Charity Strategy should be presented to Board of Trustees for review and approval.	High	31/01/2023	30/11/2023	The new Charity (and Charitable Partnerships) Strategy is due to be submitted to the Charitable Funds Committee for approval at the October with final ratification planned at November Board	Kirsty Thomson, Head Of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance		Status update provided
196	Charitable Funds	Internal Audit	Started	Policies & Procedures	4 .1 Policies and procedures are reviewed to ensure any changes are reflected. Feedback from the Fund Advisor questionnaire should be incorporated when reviewing the procedures. 4 .2 Training for Fund Advisors is reviewed and recommences as soon as possible.	Medium	30/04/2023	31/03/2024	Procedures update was delayed due to a decision to do a deeper dive into charity's finances. All procedures to be reviewed and submitted to the CFC for approval at the July 2023 CFC meeting and ratified as required by the Audit Committee in September. A new Fund Advisor training scheme is on track to be introduced by December 2023, but not as comprehensive as planned due to lack of capacity within the team.	Kirsty Thomson, Head Of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance		Status update provided

203	Delivery of HB Savings	Internal Audit	Pending	Transformational Savings and the establishment of the Transformational Team	The Health Board: • Completes an updated review of transformational opportunities, underpinned by impact assessments but recognising these will likely take a long period of time to embed and deliver cash releasing savings. • Reviews the role of the Transformational Team in driving service change and savings.	High	30/04/2023		Discussion ongoing between Finance and Transformation as to allocation. A proposal has been accepted in principle, to transfer ownership to the Transformation team. The purpose and role of the Transformation and Improvement team has always been to support and enable the organisation to transform and improve itself. It's the only way it works, as change that is centrally generated and driven never sticks as it is not created and owned locally by the front line teams. As part of special measures, there is a deliverable in the first 90 day cycle that is around ensuring that the Transformation and Improvement resource is allocated to support the priority areas. It has been agreed that the Portfolio Office continues supporting the central Special Measures coordination and the Improvement and Pathways teams are business partnered into the 5 health communities and priority clinical networks. Work is being finalised for those individuals to be re-allocated to those teams to support the organisational priorities, directed by the Interim Exec Director of Ops and Exec Director of Public Health.	Paula Dixon, Head of Financial Improvement	Russell Caldicott, Interim Executive Director of Finance		Suz confirmed (04/09/23) that Chris accepted in principle but needs to speak to russell. **October 2023 update: Finance have requested that the item needs to move out of Finance across to the T&I Team.**
206	MH&LD	Internal Audit	Started	Ligature remediation funding was allocated appropriately	MHLD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.	High	30/06/2023	31/12/2023	~~Progress has been made but further~~ work required to strengthen arrangements (i.e. reporting, auditing). An evidence log will be presented to MH&LD Senior Leadership team 05/09/2023 with further actions agreed. **October update:** An evidence log has been developed and is available to view here: \\bcuestorage.cymru.nhs.uk\office of the board secretary\Board & Committees\Governance\Compliance\AC\Tracker Master\Additional evidence\Rec item 206 The outstanding actions are two ToR's to be formally signed, both scheduled for November 2023. The Health Board is still waiting for some of the commissioned external reports and then further work will be developed identifying high, medium and low risk. Once all the external reports are completed, they will be shared with all local areas to address, mitigate and discharge the findings through actions plans. This will also entail tri-partate working with Estates, Health and Safety and Governance colleagues. An audit to check the governance arrangement for anti-ligature is currently underway with the final report ~~expected in November 2023. Expected~~	Adrianne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director Mhld		Discussion with, Adrianne Business lead 10/08/23 - discussion to be had at MH&LD divisional SLT on 15/08/23 and then update will be provided. **Feedback Received for October update, delayed Imp date. Additional evidence log available to view here: \\bcuestorage.cymru.nhs.uk\office of the board secretary\Board & Committees\Governance\Compliance\AC\Tracker Master\Additional evidence\Rec item 206**

207	MH&LD	Internal Audit	Started	Appropriate governance arrangements in place	ToRs require a review for signature and dates, OLM approval of draft ToR , development of a ToR for summit meetings. Formal reporting of information through the tiers is required, consideration needs to be given as using Divisional QSE as an exemplar. Cycle of business needs completion this will underpin any formal reporting requirements form the tiers.	Medium	30/04/2023	31/12/2023	Weekly Governance Framework meeting continues to be held to progress with the development of the MH&LD Governance Framework. All Divisional meetings aligned to the Framework have been established, and the cycle of business and reporting schedule is at the final stages of development and implementation to ensure a robust governance framework across the Division. Outstanding action to final approve / sign off remaining ToRs following the implementation of several new delivery groups. **October update:** Governance Framework and Reporting Cycle continue to be developed. Slight delay caused by additional MH&LD meetings being stood up, and also confirmation of corporate reporting cycle which is still being developed i.e. Performance reporting. Delayed completion date of 31/12/23 expected.	Adrianne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director Mhld		Status update provided **Feedback received for October update - delayed Imp Date.**
216	USC: Urgent Primary Care Centres - Business case outcomes achieved	Internal Audit	Started	Governance Frameworks and Communication Strategies	Governance frameworks, Communication Strategies, and supporting documents should be periodically reviewed and approved to ensure continued relevance and alignment with wider Health Board strategies. Evidence of scrutiny and approval should be retained.	Medium	31/05/2023	31/03/2024	Communications strategy paused pending outcome of Urgent Care Review and proposed new model. Central UPPC Governance Framework to be updated and signed-off at August/ September Quality & Safety meeting	Jo Flannery, Acting Associate Director, Primary Care	Adele Gittoes, Interim Executive Director of Operations		Revised Status received

217	USC: Urgent Primary Care Centres - Business case outcomes achieved	Internal Audit	Pending	UPCC Models	The Health Board should consider the future model of the UPCCs to ensure appropriate resources and accommodation are available to provide a consistent service that is accessible to all patients.	High	01/01/2024			Karen Higgins, Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.
218	USC: Urgent Primary Care Centres - Business case outcomes achieved	Internal Audit	Started	Benefits Realisation	2.1 Management to review UPCC capacity and establish measures that can be used to support the delivery of stated benefits. 2.2 The Health Board to ensure that where Business Cases and bids are received, clear measures are set out to assess benefits stated.	High	01/01/2024		Initial RBA training with primary care colleagues and wider teams to develop and confirm approach. USC Business Strategy being developed through USC & 6 Goals Programme Board, and will include development of population and performance scorecards and metrics as part of this work	Jo Flannery, Acting Associate Director, Primary Care	Adele Gittoes, Interim Executive Director of Operations		Revised Status received

220	Public Health - Smoke free sites	Internal Audit	Pending	MHLDS Training	MHLDS Division needs to establish how many staff require VBA training Clarification is necessary on what training is required with regards to talking about the various NRT options to patients Conformation by the MHLDS Division that if the contraindications/medical interaction training is not taking place, what is the requirement to meet objective 15. " Admitting practitioners and other relevant staff are aware of contraindications/interactions of using certain types of NRT ". All the above must be reflected in the action plan.	Medium	31/01/2024		October 2023 - The MHLD Division held a Smoking Cessation Training T&F group and the outcome was for the Division to align with the Health Board proposal for all MHLD staff to receive training on Level 1 smoking cessation training. This proposal outcome has been discussed in the MHLD Division Education & Training Group. The Division monitors the uptake of Level 1 training and the current position is 200 staff trained monitored via the Smoking Cessation Monitoring Group. The Help Me Quit Service has carried out a survey of smoking cessation awareness in the MHLD Division. More enhanced training needs will be considered once Level 1 training is more firmly embedded across the Division. The Help Me Quit Service report has been received by the MHLD Operational Leadership Meeting. The prescribing of NRT options is governed by an NRT approved procedure for the MHLD Division. The numbers of prescribers of NRT is largely carried out by medical prescribers and an audit of NRT prescribing options, indications, contraindications is taking place in November 2023 and will report December 2023 and the report considered in the Divisions Clinical	Adrian Jones, Assistant Director Of Nursing Mhld	Teresa Owen, Executive Director Of Public Health		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.
226	Continuing Healthcare Arrangements	Internal Audit	Started	R3	The Health Board's current work to drive consistency in the structure of its CHC teams should include work to ensure job descriptions reflect the roles required. These should be clearly articulated and understood by current and new CHC team members.	High	31/03/2021	31/03/2024	Work has commenced but not completed. We are currently linking with national work on reviewing / agreeing competencies for each roles within CHC. Awaiting timescales for the National work. **October 2023 update** - Implementation date extended to 31st March 2024 as action is pending national work.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director Transformation And Strategic Planning		Revised Status update and implementation date to be provided if not complete. **Status update provided by owner - October update received - Revised Imp Date: 31/03/24**

227	Continuing Healthcare Arrangements	Internal Audit	Started	R5	The Health Board's role as a contractor and commissioner of CHC is underdeveloped which causes inefficiencies and tensions amongst its staff and its providers. The Health Board should resume the work it began in 2019 to develop a CHC contracting and commissioning team with the capacity and capability to plan and deliver CHC more effectively and efficiently.	High	30/04/2021	30/11/2023	Business Case for Clinical and Business Support Hub is being drafted. BC will go through the required committees in preparation for Board. Target completion date extended to 30/11/23.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director Transformation And Strategic Planning		Check if status update / implementation date remains extant
228	Continuing Healthcare Arrangements	Internal Audit	Marked as Implemented by Owner	R8	While the Health Board strengthened leadership within its corporate CHC team during 2019, arrangements are currently ad hoc and temporary. The Health Board should seek to develop longer-term leadership to ensure improvement and robust central oversight of its CHC management.	High	31/01/2021	07/03/2023	Agreed as complete on local CHC Audit Action Plan 07/03/23.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director Transformation And Strategic Planning		Check if status update / implementation date remains extant

235	Review of Eye Care Services	Internal Audit	Started	R2	Sub-regional variation of patient waits: Undertake analysis on sub-regional variation in waits, either by the Health Board's three main locality areas or by county of residence.	High	31/03/2022	31/08/2023	Detail now available on waiting list by Risk factor on a health board and locality basis. This is enabling a prioritisation of treatment, follow up and pathway management on clinical risk factors in addition to local improvement plans Audit of R1 data completeness/application of Wait Time Rules/SOS utilisation commenced: with aim to inform R1 Clinical and non-clinical validation plan. Snap audit has identified data completeness and application of Welsh Waiting Time rules learning. A "Data, Planning and Performance Improvement group" will be taking forward a plan to redress learning. Interim refresh of SOP (Standard Operating Procedures), Welsh Waiting time rules and patient information (to maximise their commitment to care pathway) commenced. Oc**tober 2023 - Note from Owner - No further update available to be provided.**	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations		Check if status update / implementation date remains extant
238	Review of Eye Care Services	Internal Audit	Started	R5	Efficiencies: Service efficiencies - develop a clear plan to improve service eye care service efficiency and productivity. Where relevant, this should be linked to wider service change/modernisation plans.	High	31/03/2023	30/04/2024	To progress a clinically-led inception, Pan BCU Ophthalmology Plan: - A Continuous Improvement Network Steering Group to be formed within, Q2 2023 - This will deliver the inception, formulation and implementation of a plan that reflects National evidence-base, consensus good practice and the 5 clinical measure delivery for BCU HB.	Paolo Tardivel, Director Of Transformation & Improvement	Chris Stockport, Executive Director Transformation And Strategic Planning		Check if status update / implementation date remains extant

240	Review of Eye Care Services	Internal Audit	Started	R7	Accountability for eye care services: Undertake a review of the accountability arrangements for eye care services with the aim of: • ensuring effective integration of services across acute sites; • achieving better integration of services with community optometry; and • eliminating inappropriate sub-regional variation of service delivery and improving service efficiency	High	31/03/2022	30/11/2023	Work has commenced to review the current Eye Care Group and strengthen it's governance, remit and membership to oversee the development and delivery of an Integrated Eye Care service for the population of BCUHB..	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations		Revised status update received
241	Review of Eye Care Services	Internal Audit	Started	R8	Eye care clinical leadership: Strengthen the clinical leadership structure, with a specific focus on responsibilities, and accountabilities for eye care services. As part of this, ensure that the optometry clinical leadership integrates into the existing clinical leadership structure.	High	31/03/2022	30/04/2023	Requires explicit provision of dedicated clinical sessions to enable clinical leadership to be successfully discharged across the Health Board. So far, recruitment attempts have not been successful with just 1 session identified - such a role would need 2 minimum. **October 2023 update** - Discussions being had with potential internal candidates. If cannot appoint internally will seek to appoint externally reframing an existing clinical vacancy to include the role of clinical lead.	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations		Revised status update received

243	Managing Medicines in Primary and Secondary Care	Internal Audit	Started	R1	The Welsh Government, NHS Wales Informatics Service and all health bodies should agree a detailed, time bound plan for implementing electronic prescribing systems in secondary care, along with a clear process for monitoring the delivery plan.	High	30/09/2017	31/01/2024	EMPA Board established. SRO Executive Director of Nursing and Midwifery - programme board chaired by deputy director of nursing and midwifery. Pre-implementation plan ongoing within programme timescales. Further programme update planned for January 2024	Berwyn Owen, Chief Pharmacist	Nick Lyons, Executive Medical Director		Check if status update / implementation date remains extant
247	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	Internal Audit	Started	Appointment of substantive JESP/VSM Posts	Management must ensure all appointments to JESP/VSM roles are fully compliant with Welsh Government instructions and Health Board Standing Orders. Management ensure that mandatory procurement training is in place for all Executive Directors and all staff involved in procurement, as required by Welsh Government Chief Executive, NHS Wales.	High	31/07/2023	31/12/2023	Remuneration committee now receives monthly report to identify compliance with SOP, WG requirements and SFIs. WOD to identify process for procurement training for Executives and senior managers	Owner to be identified	Jason Brannan, Deputy Director of People		Revised Status received

249	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	Internal Audit	Pending	Remuneration & Terms of Service Committee - Reports for assurance	Management must ensure Committee Members are appropriately involved in determining the information they require for assurance and subsequent reporting/providing advice to the Full Board. As a minimum, any report to be submitted to the RATS Committee in relation to the appointment of an interim must incorporate assurance on compliance on key matters of control in Standing Orders, Standing Financial Instructions and Welsh Government instructions.	High	30/09/2023			Owner to be identified	Jason Brannan, Deputy Director of People		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.
250	Risk Management & Board Assurance Framework	Internal Audit	Marked as Implemented by Owner	Risk Management department duties	The Strategy is updated to include the duties of the Risk Management Department.	Medium	30/08/2023	28/09/2023	The revised RM01 draft makes provision for Corporate Risk Management team duties and will be submitted to Sept Board 23 for review/approval. **October 2023 updated received -** The revised RM01 details the Corporate Risk Management team duties was approved at Sept Board 23.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	25/10/23	Status Update provided **Approved by Phil Meakin 25/10/23 - Interim Board Secretary. Recommended for closure.**

251	Risk Management & Board Assurance Framework	Internal Audit	Marked as Implemented by Owner	Oversight, scrutiny and challenge of CRR and BAF	The Health Board must ensure meetings within the governance structure take place as required, to allow adequate review and scrutiny of the risks facing the Health Board. Clarification is required on how often the Health Board and Audit Committee receive the CRR and BAF for review and scrutiny.	High	30/08/2023	31/09/23	The OBS Independent review is now complete, which included a review of Committee ToRs. This will influence the outcome of this rec and therefore a revised date has been set end of September pending CEO/Board review. The board is also pending appointment of permeant Members to enable committee meeting to take place. The TOR on receiveing the CRR and BAF will subsequently be set out in all TOR. **October 2023 updated received -** The revised RM01 details COB for BAF and CRR and was approved at Sept Board 23. All COB for committees /Board also reflect this change.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	25/10/23	Status Update provided **Approved by Phil Meakin 25/10/23 - Interim Board Secretary. Recommended for closure.**
252	Risk Management & Board Assurance Framework	Internal Audit	Started	Board Assurance Framework	The process for reviewing and updating the BAF should be documented and implemented. The BAF should be updated when objectives of the Health Board are agreed, to ensure focused actions. The sections of the BAF should be fully completed. The level of detail in action plans should be reviewed to ensure there is sufficient information included to provide assurance to members that appropriate actions are in place to address risks identified.	High	30/08/2023	31/10/2023	The BAF SOP will be updated following the TOR for all committees however the BAF has been updated for the Sept Board and the format is being revised to allow for more detailed action plans. **October 2023 updated received -** The BAF is on track and has been updated. A full report is due to be approved at the November Board.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary		Status Update provided

253	Risk Management & Board Assurance Framework	Internal Audit	Marked as Implemented by Owner	Escalation and de-escalation of risks	Clarification is required on the Committee approval process for the escalation and de-escalation of risks.	High	30/08/2023	31/10/2023	The escalation and de-escalation of risks is being reviewed in light of RM01 and RM02 where this process will be outlined, including in TOR for RMG. **October 2023 updated received** - The escalation and de-escalation of risks is being reviewed in light of RM01 and RM02. RM01 has now been approved. The Exec team have now updated their agenda to ensure the BAF and CRR are a standing agenda item on bi-monthly basis as well as risks to be escalted/de-escalated.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	25/10/23	Status Update provided **Approved by Phil Meakin 25/10/23 - Interim Board Secretary. Recommended for closure.**
254	Risk Management & Board Assurance Framework	Internal Audit	Started	Oversight and scrutiny of Divisions / IHCs	Review of all meetings attended across the three areas by the Risk Management Department is required. This will give a better understanding of what meetings are taking place as well as providing a more consistent and robust approach towards the Divisions/IHCs risk management arrangements. Clarification required on how the West IHC will provide assurance on its risk management arrangements without a IHC meetings Risk Management Group meeting taking place.	High	30/08/2023	31/10/2023	The risk team compiled a list of meetings but IHC West processes are due to be discussed in Oct RMG as they employee a local approach. IHC west meetings are currently outstanding and due for review following Oct RMG. **October 2023 update received -** The risk team compiled a list of meetings for oversight but IHC West meetings are still due to be mapped. A meeting is in with IHC West to do this. IHC West did however presented their process for oversight at RMG in Oct and was approved as well as a view from internal audit.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary		Status Update provided

256	Planned Care Recovery & Transformation Group	Internal Audit	Started	Planned Care Recovery & Transformation Group	It is evident that benefits of establishing the Group have not been realised - the Health Board needs to decide if reinstating the Group is the way forward to provide assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented. If Group meetings to resume, then its membership and terms of reference should be reviewed and updated to enable the Group meet its objectives with measurable deliverables being developed and reviewed regularly. Management should ensure there are sufficient resources allocated to the planned care agenda, to ensure the planned care programme is successfully implemented.	High	31/07/2023		Inaugural board meeting held. PID being finalised and GIRFT work to be aligned with this program. **October 2023 update** - PID being finalised reported on Agenda at Planned Care Programme Board. GIRFT work to be aligned with this programme.	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations		Revised Status received (revised imp date not provided)
257	Planned Care Recovery & Transformation Group	Internal Audit	Marked as Implemented by Owner	Reporting	Review the mechanisms for reporting, ensure requirements have been clearly established and expectations communicated with the relevant Groups / Committee.	High	31/07/2023		Planned Care Board established with ToR approved **October 2023 update -** TOR have been updated to be re-submitted for ratification at Planned Care Programme Board November 2023	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations		Revised Status received (revised imp date not provided)

258	Data analysis – Triangulation of data	Internal Audit	Started	Triangulation of Data sets using consistent naming conventions	The Deputy Director of Quality: Continues to support the Quality Lead Manager develop the use of all data quality sets to inform Health Board wide reporting - This should be a priority. Ensures the standardisation of 'Location' within Datix, reviews the data associated with 'Do Not Use' and removes duplication of 'Categories', ensuring an appropriate audit trail where these are amended. Considers and progresses the findings within Paragraphs 2.3 to 2.5 inclusive of the Detailed Findings.	High	31/08/2023	31/11/2023	Work is in progress to develop dashboards. However, this is impacted by the National project. In the interim, Dashboards will be populated manually with a draft dashboard planned for submission to the QSE Committee in September. **October 2023 update** - A mock quality dashboard has been developed and is being tested and refined during Cctober and November for launch. A new Quality Systems Group is now inplace to ensure coordination across systems.	Matthew Joyes, Assistant Director Of Patient Safety And Experience	Angela Wood, Executive Director of Nursing and Midwifery		Status update provided (responses reviewed by Angela 29/08/23) **Oct 2023 - Chris Lynes, Deputy Executive Director of Nursing has reviewed and approved on Angela Wood's behalf.**
259	Data analysis – Triangulation of data	Internal Audit	Pending	Template minimum data sets	The three Clinical Executive Directors stipulate the minimum quality and safety data sets for regular reporting across the Health Board, with respective Clinical Directors determining the remaining service specific data required. The Deputy Director of Quality should ensure the minimum quality and safety data sets are consistently used across all IHCs and Divisions	High	30/09/2023	31/03/2023	**October 2023 update -** The link from quality systems, such as Datix, into the BCUHB data warehouse is now in place - this was deleayed due to national technical difficulties. Alongside the main Quality Dashboard, a number of sub-dashboards will be set to provide consistent data reporting for governance metings. The quality governance framework will be reviewed alongside the Special Measures Clinical Governance Review which has been delayed and is due to start in November 2023.	Matthew Joyes, Assistant Director Of Patient Safety And Experience	Angela Wood, Executive Director of Nursing and Midwifery		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Oct 2023 - Chris Lynes, Deputy Executive Director of Nursing has reviewed and approved on Angela Wood's behalf. Revised implementation date provided.**

260	Data analysis – Triangulation of data	Internal Audit	Started	Quality, Safety and Experience Committee reporting	The Quality, Safety and Experience Committee Members stipulate all the data it requires for assurance purposes.	High	30/09/2023		**October 2023 update** - A revised cycle of business was submitted to the QSE Committee for its meeting in October 2023.	Matthew Joyes, Assistant Director Of Patient Safety And Experience	Angela Wood, Executive Director of Nursing and Midwifery		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Oct 2023 - Chris Lynes, Deputy Executive Director of Nursing has reviewed and approved on Angela Wood's behalf.**
261	Contracted Patient Services: Quality and Safety Arrangements	Internal Audit	Started	Process management	Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning / contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	High	31/08/2023	31/01/2024	Work is progressing, with input from the CEO, to develop the CAF. Issues and progress are being monitored by the Executive team as to resource implications. The items noted in the recommendation will be picked up as part of this	Adrian Tomkins, Associate Director Of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery		Status update provided (responses reviewed by Angela 29/08/23)

262	Contracted Patient Services: Quality and Safety Arrangements	Internal Audit	Started	Contractual obligations	Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	High	31/08/2023	31/01/2024	Work is progressing, with input from the CEO, to develop the CAF. Issues and progress are being monitored by the Executive team as to potential resource implications.	Adrian Tomkins, Associate Director Of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery		Status update provided (responses reviewed by Angela 29/08/23)
263	Contracted Patient Services: Quality and Safety Arrangements	Internal Audit	Pending	Quality measures (a)	Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	High	31/03/2024		**October 2023 update -** The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Exec Director of Finance regarding Healthcare Contracts and contract management is scheduled to be discussed at the Exec Team on 25/10/23. This paper outlines the contract management process and roles and responsibilities requesting Execs to approve the recommendation included in the report directing professional leads engagement.	Adrian Tomkins, Associate Director Of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.

264	Contracted Patient Services: Quality and Safety Arrangements	Internal Audit	Pending	Quality measures (b)	Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	High	31/10/2023	31/03/2024	**October update -** The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Exec Director of Finance regarding Healthcare Contracts and contract management is scheduled to be discussed at the Exec Team on 25/10/23. This paper outlines the contract management process and roles and responsibilities requesting Execs to approve the recommendation included in the report directing professional leads engagement. **Estimated Imp Date: Pending the outcome of the Execs paper they will be partially met, but the Assurance Framework that underpins all the actions is on hold and awaiting the special measure review report and input from CEO.**	Adrian Tomkins, Associate Director Of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Status update provided by Owner. Revised Imp date provided.**
265	Contracted Patient Services: Quality and Safety Arrangements	Internal Audit	Pending	Board assurance	Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	High	31/10/2023	31/03/2024	**October update -** The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Exec Director of Finance regarding Healthcare Contracts and contract management is scheduled to be discussed at the Exec Team on 25/10/23. This paper outlines the contract management process and roles and responsibilities requesting Execs to approve the recommendation included in the report directing professional leads engagement.**Estimated Imp Date: Pending the outcome of the Execs paper they will be partially met, but the Assurance Framework that underpins all the actions is on hold and awaiting the special measure review report and input from CEO.**	Adrian Tomkins, Associate Director Of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight. **Status update provided by Owner. Revised Imp date provided.**

266	Performance Management – Quality and Performance Reporting and Accountability Arrangements	Internal Audit	Started	Performance report and measures	The Health Board continue with the improvement plan to review and update the quality performance report to ensure Committees are receiving appropriate, accurate and relevant information. This should assurance mechanisms in place through Board Committees, to ensure the Health Board are sighted on key areas of concern and are provided with assurance that Committees are considering all areas of performance.	Medium	31/03/2024		**October 2023 update -** The first iteration of the Integrated Performance Report (IPR) has been developed and shared at Integrated Performance Executive Delivery Group on 25.10.2023. This iteration will be presented at Performance, Finance & Information Governance Committee on 02.11.2023 as proof of concept. All pending changes identified at PFIG will be incorporated into the IPR before it's inaugural presentation at Health Board on 30.11.2023.	Barbara Cummings, Interim Director of Performance	Russell Caldicott, Interim Executive Director of Finance		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.
267	Performance Management – Quality and Performance Reporting and Accountability Arrangements	Internal Audit	Started	Procedures	1. Standard Operating Procedures should be in place for the process of collating information for the performance reports, including: - Roles and responsibilities (Performance staff, informatics, other staff providing data) - Data quality standards/consistent metrics/timescales - Data collation - process for receiving / extracting and collating data (including systems used and any training required for these) - Data validation - details of checks to be undertaken 2. Further work is required to provide assurance to the Board that the actions stated in performance reports are improving performance/outcomes.	High	31/03/2024		**October 2023 update** - Once the IPR is ratified at Health Board on the 30.11.2023, the Performance Intelligence & Assurance Directorate will produce the Standard Operating Procedures (SOPs) required to ensure efficient and accurate replication of the reports for updates as required. The SOPS will be tested and the Directorate will encourage a review by internal audit to ensure that they are robust and appropriate for a business continuity plan.	Barbara Cummings, Interim Director of Performance	Russell Caldicott, Interim Executive Director of Finance		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.

268	Performance Management – Quality and Performance Reporting and Accountability Arrangements	Internal Audit	Started	Accountability meetings (a)	The Health Board continue with the improvement plan to review and update Performance and Accountability Framework, ensuring meetings are scheduled regularly and the information discussed in performance meetings is captured, with expected outcomes clearly communicated to senior managers.	High	31/03/2024		**October 2023 update - 268 - Accountability meetings (a)** The Integrated Performance Framework (IPR) was ratified at Health Board on 28.09.2023. The Framework will enable the Performance Intelligence and Assurance Directorate and its partners to support the organisation in the delivery, monitoring, improvement and assurance regarding performance. The Framework outlines roles, responsibilities and expectations together with a structure and timeframe for performance governance mechanisms such as Integrated Accountability Reviews. The Acting Director of Performance Intelligence & Assurance is composing the Integrated Performance Intelligence & Assurance Strategy for 2023-27 and this will be presented at IPEDG in November 2023. The strategy will outline the implementation of the IPF including the Accountability processes, timelines, content and expectations. A test Accountability Review could be held in February 2024 as a learning session and then the 'real' reviews to be set up throughout 2024-2027.	Barbara Cummings, Interim Director of Performance	Russell Caldicott, Interim Executive Director of Finance		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.
270	Performance Management – Quality and Performance Reporting and Accountability Arrangements	Internal Audit	Started	Accountability meetings (c)	The process for reviewing actions should be revisited, to ensure actions from meetings are SMART, and progress is regularly provided (with reference to further detail in meeting minutes as required	High	30/09/2023		**October 2023 update - 270 - Accountability meetings (c)** The Integrated Performance Intelligence & Assurance Strategy for 2023-27 will outline the communication routes with regards accountability reviews. This will include the structure and process around recording and communicating the actions and outcomes of the reviews. There will be a clear escalation process and pathway ensuring escalations reach the appropriate forum, e.g QSE, PFIG. They will also ensure timely communication and feedback to the services being held to account, with clear SMART actions. Progress of such actions will be monitored by the Performance Intelligence & Assurance Directorate outside of the reviews to ensure progress and updates are available at the next review.	Barbara Cummings, Interim Director of Performance	Russell Caldicott, Interim Executive Director of Finance		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.

271	Recruitment Improvement Review	Internal Audit	Started	Published documents	Management to ensure all published documents and guidance notes are relevant, up to date, and reflect current practice / requirements.	Medium	30/06/2023	30/03/2024	WOD in the process of reviewing library. This will be influenced by the new operating model / structure as the WOD team realigns to the IHCs	Owner to be identified	Jason Brannan, Deputy Director of People		Status update provided
273	Hergest Unit Notice of Contravention (NoC) Action Plan	Internal Audit	Pending	Action Plan evidence	The action plan evidence is reviewed immediately and updated to demonstrate all actions are embedded both at Hergest, with wider assurance to the Health Board on practice across the Division	High	31/10/2023			Iain Wilkie, Interim Director Mhld	Teresa Owen, Executive Director Of Public Health		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.
274	Cyber Security	Internal Audit	Started	Use of KPIs	KPIs should be developed that show the current security posture of the organisation	Medium	01/09/2023	30/11/2023	KPIs drafted, awaiting approval at the local DDaT ICT Governance and Security Group before onward submission to the CDIO. Whilst this is in train, work is also ongoing across Wales to develop standardised KPI and reporting nationally.	Sion Jones, Assistant Director / Chief Technology Officer	Dylan Roberts, Chief Digital and Information Officer		Revised Status update and implementation date to be provided if not complete.

276	Accounts Receivable	Internal Audit	Pending	Financial Procedures	Management review and update relevant financial procedures as necessary to ensure they are fit for purpose	Medium	30/09/2023	30/11/2023	**October 2023 update:** Accounts Receivable Financial Procedures has been started and is in progress at the moment. Estimated implementation date is now 30th November 2023. Reasons for delay: • The audit of the 2022-23 annual accounts took a month longer than originally planned in the Welsh Government timetable and wasn't completed until the end of August; • Rather than looking at a standard update of the existing financial procedures we are carrying out a larger review to consider whether any can be consolidated or simplified which will take longer but will result in more user-friendly documents.	Simon Weaver, Head of Financial Control	Russell Caldicott, Interim Executive Director of Finance		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec **Status update provided - Revised implementation date to 30/11/2023.**
280	Clinical Audit – Tier 1 National Audits	Internal Audit	Pending	Progress reporting of Tier 1 audits (a)	The Health Board must ensure appropriate meetings within the governance structure take place as required and include clinical audit as an agenda point to allow adequate review and scrutiny of the issues affecting the Tier 1 process.	High	31/03/2024			Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.

281	Clinical Audit – Tier 1 National Audits	Internal Audit	Pending	Progress reporting of Tier 1 audits (b)	To enhance accessibility of audit activity, improve timely reporting and keep track of the identified actions, the AMaT system needs to be developed further outside of the department and continue to be implemented throughout the Health Board.	Medium	31/12/2023			Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director		Item not yet due so not reportable under current reporting requirements (AC Members only receive overdue recs). However, included for Exec oversight.
284	GP Out of Hours	Internal Audit	Marked as Implemented by Owner	Process Management (1.1)	Management to develop robust written control documents to support operational processes and strengthen governance arrangements.	Medium	13/10/2023		**October 2023 update received - This action is completed**. A terms of reference has been finalised and regular meetings are in place. These meetings will be minuted and all actions added to the action plan for the group.	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations		**Executive Sign off to be confirmed**

285	GP Out of Hours	Internal Audit	Marked as Implemented by Owner	Process Management (1.2)	Management to establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes / action log to promote transparency and document decision-making.	Medium	13/10/2023		**October 2023 update received - This action is completed.** This action is completed. A terms of reference has been finalised and decision making is documented. Minutes from monthly meetings will be recorded and an action plan is in place.	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations		**Executive Sign off to be confirmed**
286	GP Out of Hours	Internal Audit	Started	Process Management (1.3)	Management to review implemented improvement actions to ensure they are operating as expected / having the desired impact.	Medium	20/10/2023		**October 2023 update received** - This action is ongoing and in process. As actions are completed they will be monitored by the Primary Care Team. The outstanding actions will be monitored closely and will be reviewed when completed to ensure they are operating as expected.	Sefton Brennan, Head of Service GPOOH	Adele Gittoes, Interim Executive Director of Operations		

287	GP Out of Hours	Internal Audit	Marked as Implemented by Owner	Progress Update Log	Management to ensure that responsible officers and completion dates assigned to improvement actions are documented. We are aware that the Progress Update Log is currently being reviewed - management should consider the appropriateness and current utilisation of the Evidence field within the Update Log.	Medium	13/10/2023		**October 2023 update received - This action is completed.** Completion dates and improvement actions are now monitored via the action plan for the group. Responsible officers have been identified for each action. The evidence field and update log are incorporated onto the action plan.	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations		**Executive Sign off to be confirmed**
288	GP Out of Hours	Internal Audit	Started	Data Discrepancy	Management to clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate.	High	27/10/2023		**October 2023 update received. This action is ongoing and in process.** A number of meetings have now been held between the BCU OOH team and the national team to review data and agree on reporting processes moving forward. Meetings will continue until all work has been completed which will be dependent on an agreed timeframe from the system provider Adastra - this will be monitored via the action plan.	Sefton Brennan, Head of Service GPOOH	Adele Gittoes, Interim Executive Director of Operations		

289	GP Out of Hours	Internal Audit	Started	Board Assurance	Management to review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny.	High	27/10/2023		**October 2023 update received - This action is ongoing and in process.** Regular meetings are now in place for the Urgent Care Peer Review Improvement Group, and action plan has been revised and updated. The governance structure for Primary Care is in the process of being reviewed, so full confirmation about where this sits in accountability/scrutiny framework will be confirmed asap as part of overall review.	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations		

ID	Report Title	Internal Audit (IA) / Wales Audit Office (WAO)	Recommendation State	Recommendation Title	Recommendation	Priority	Est. Imp. Date	Revised Imp. Date	Last Status Update	Owner	Final Approver	Date Final approved	OBS Comments
209	Audit Wales CHC follow-up	Wales Audit Office	Marked as Implemented by Owner	Continuing Health Care (CHC) Training Programme	The CHC Team, working with colleagues in Health Communities/Divisions/Pan-North Wales services agree a method to capture training needs analysis information upon which directed training can be planned and delivered.	Medium	31/03/2023	01/09/2023	Training has been prioritised during 2023. This includes shifting the perspective on CHC training to consider it as a core business activity rather than a 'nice-to-have'. TNA approach taken and resources developed in line with this; strategic goals defined; required skills and knowledge outlined; current skills evaluated; performance gaps identified; generic and bespoke sessions implemented. 2024 rolling programme being finalised & modules being updated in light of new D2RA pathways and feedback; All the above have supported establishing training needs. Incremental approach to competency framework adopted; first phase pre & post training self-assessment competency questionnaire implemented (it remains that learners need considerable coaxing to complete and this is an ongoing challenge with creative approaches being adopted); lessons learned module being finalised for roll out 2024; training attendance data is shared with IHC's & LA's; strategic joint education group with 6 NW LA	Jane Trowman, Head Of Strategy & Health Planning	Chris Stockport, Executive Director Transformation And Strategic Planning		Revised Status update and implementation date to be provided if not complete. **Status update provided by owner - October update received - Revised Imp Date: 01/09/23**
210	Audit Wales CHC follow-up	Wales Audit Office	Started	CHC Service Delivery	Executive Management review the delivery of CHC across the Health Board to ensure consistent approach to service delivery in line with the Framework. Services must remain local but opportunities for resilience and career development will be enhanced through a single CHC Team, accountable to one Executive Director and should be considered.	High	31/03/2023	31/03/2024	Group now changed to CHC Cross-cutting Schemes that reports up to SMT. Target completion date revised to 30/09/23. Exec Lead confirmed as Executive Director of Transformation and Strategic Planning. Temp Asst. Director of CHC to support the longer term arrangements has been extended & will work with confirmed Exec lead. **October update received -** Implementation date to be extended as linking with national group looking at CHC cost cutting themes. Request to change imp date to: 31/03/2024.	Jane Trowman, Head Of Strategy & Health Planning	Chris Stockport, Executive Director Transformation And Strategic Planning		Revised Status update and implementation date to be provided if not complete. **Status update provided by owner - October update received - Revised Imp Date: 31/03/24**

211	Audit Wales CHC follow-up	Wales Audit Office	Started	Governance, accountability and performance	The Health Board review the governance and accountability arrangements for CHC which brings together people, quality, performance and financial information.	High	31/03/2023	30/09/2023	Contracts & Finance reports to PFIG and QAF update to Regional Commissioning Board and Regional Partnership Board continues (complete) Corporate CHC will remain with Executive Director Transformation And Strategic Planning, and Commissioning with Finance & Contracts (complete) Revised ToR were approved at January 10th SMT meeting and circulated post meeting. Following this an updated meeting agenda, membership and reporting format has been introduced for Sept 5th SMT. (complete) IHC and corporate risk registers aligned. This will be part of monthly review in line with corporate risk register requirements. (complete) ToR updated and included in June CHC Ops Chair's report for SMT 04.07.23. The Agenda/reporting format will be reviewed in line with updated SMT Agenda introduced Sept	Jane Trowman, Head Of Strategy & Health Planning	Chris Stockport, Executive Director Transformation And Strategic Planning		Revised Status update and implementation date to be provided if not complete. **Status update provided by owner - October update received - Revised Imp Date: 30/09/2024**

Teitl adroddiad: ***Report title:***	Internal Audit Progress Report 1 September to 31 October 2023
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	16 November 2023
Crynodeb Gweithredol: ***Executive Summary:***	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. • the Board and required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The progress report has been refreshed following feedback from the Audit Committee Chair and summarises two assurance reviews finalised since the last Committee meeting in September 2023, with the recorded assurance as follows: • Substantial assurance (green) – none; • Reasonable assurance (yellow) – none; • Limited assurance (amber) – two; • No assurance (red) – none; and • Advisory (grey) – none. The report also details the reviews with reports issued as draft and work in progress.
Argymhellion: ***Recommendations:***	The Committee is asked: • To receive the progress report.
Arweinydd Gweithredol: ***Executive Lead:***	Interim Board Secretary
Awdur yr Adroddiad: ***Report Author:***	Dave Harries, Head of Internal Audit, CMIIA, QiCA Nicola Jones, Deputy Head of Internal Audit, CMIIA
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒ I Benderfynu arno *For Decision* ☐ Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
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. The Health Board assurance ratings differ from those agreed across NHS Wales for internal audit opinions and therefore the assurance level has intentionally been left blank.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	N/A other than those relating to individual audit reviews / recommendations.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	The Equality duty is not applicable. This progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (the report does not relate to a decision, strategic or otherwise).
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A other than those relating to individual audit reviews / recommendations.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A other than those relating to individual audit reviews / recommendations.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The progress report is produced independently of management. The progress report has been shared with the Interim Board Secretary.

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A other than those relating to individual audit reviews.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The progress report is presented in accordance with the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1: Appendix 2: Progress report • Appendix 2: GP Out of Hours • Appendix 3: Falls Management	

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

1st September to 31st October 2023

NWSSP Audit and Assurance Services

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

Contents

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Disclaimer notice - please note:

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

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal control and the prevention and detection of fraud and other irregularities rests with Betsi Cadwaladr University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system. his 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.

Introduction

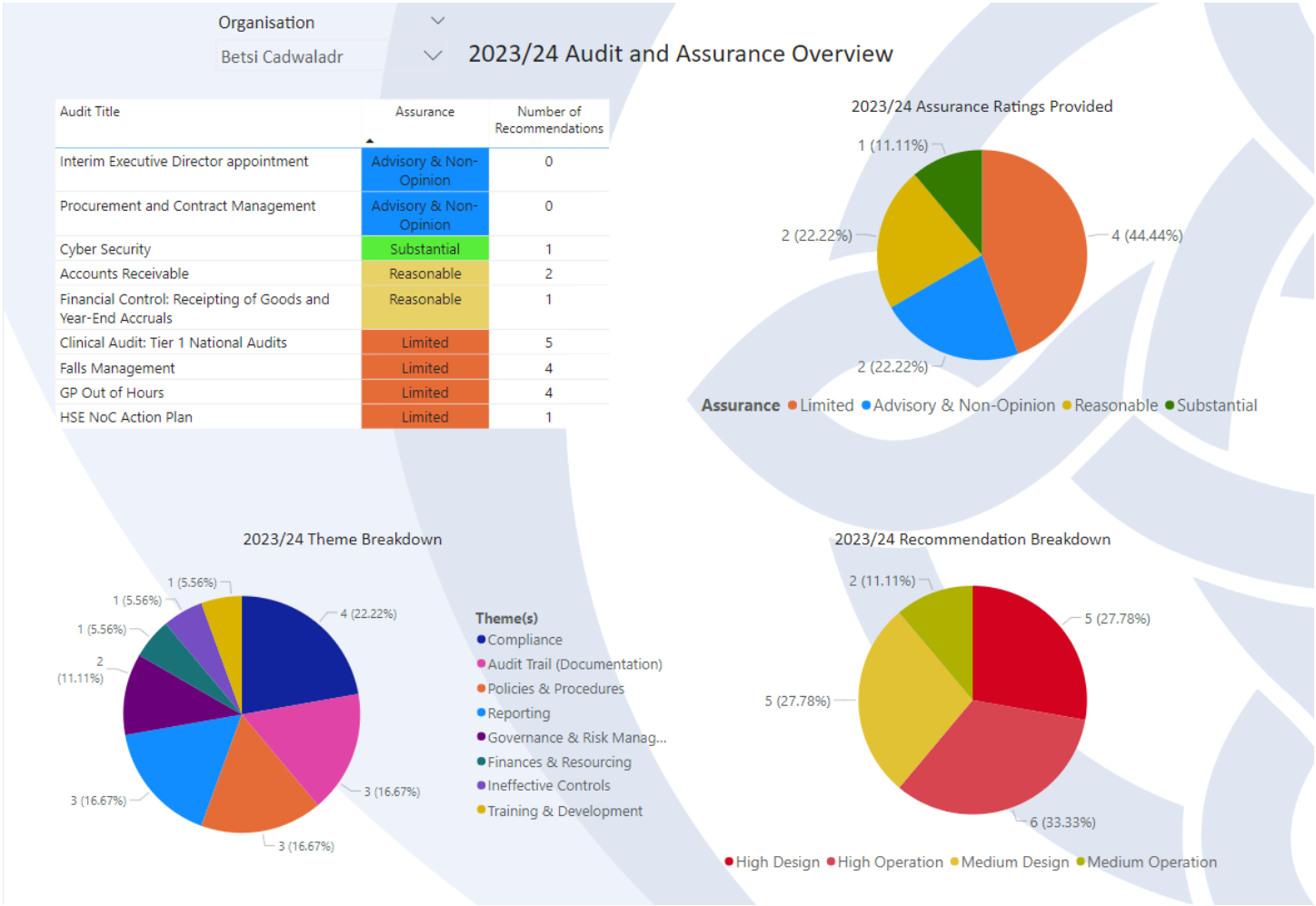
1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plan for 2023-24.

Reports Issued

2. Since the last progress report, three reviews have been finalised in conjunction with Health Board management and three issued as draft. A summary of the finalised reviews is provided in Table 1.

3. In reviewing the 2023/24 final reports issued to date (excluding Specialist Services unit reports), image 1 details the high level information from the reviews.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr ULHB at 31st October 2023



- Theme definition is included at Table 6.

Executive Summaries

GP Out of Hours	BCU-2324-09	28 September 2023
Report opinion:	Limited	

Purpose: The review has considered whether there are robust processes and controls in place within the Health Board to support the management and implementation of the GPOOH/UPCC Peer Review improvement actions.

Overview

The significant matters which require management attention include:

- There are no written control documents in place to support operational processes.
- Lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of Peer Review improvement actions are not documented.
- Delegated responsible officers and expected completion dates are not documented.
- Only twelve of the forty-three (27%) improvement actions are reported as complete, with a further 14 (31%) reported as in-progress.
- There is no assurance provided to the Board or its Committees regarding the implementation of Peer Review improvement actions.
- There is no evidence of Board oversight or scrutiny.

	Objectives	Assurance
1	There are robust processes in place to monitor, manage, and support the implementation of the Peer Review Improvement Plan, with issues or lack of progress escalated promptly.	Reasonable
2	Identified improvement actions have been implemented and are operating as expected (evidenced through sample testing).	Limited
3	There are robust governance arrangements in place to ensure Peer Review Improvement Plan implementation is subject to Health Board oversight and scrutiny and assurance of progress is provided to the Board and / or relevant Committees.	Unsatisfactory

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

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	There are no policies, SOPs, guidance notes or other written control documents in place to support operational processes. The Peer Review Group meeting does not have a formal Terms of Reference. Minutes / action logs are not maintained therefore there is no record of	1	Design	Medium

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
	operational decision-making or issues requiring escalation.			
2	There is no provision within the OOH UPCC Progress Update Log to record responsible officers and expected completion dates.	2	Design	Medium
3	We were advised that there are discrepancies between internally produced Out of Hours data and data presented by the national Peer Review Panel.	2	Design	High
4	The Health Board / Committees are not provided with assurance regarding the implementation of Peer Review improvement actions, and we found no evidence of wider oversight or scrutiny.	3	Design	High

Falls Management	BCU-2324-05	20 October 2023
Report opinion:	Limited	

Purpose: We reviewed compliance with Policy NU06 - The Prevention and Management of Adult In-Patient falls as well as reporting and management arrangements in place.

Overview

The significant matters which require management attention include:

- The Falls policy is overdue for review.
- Testing demonstrates a lack of detail included on completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and documentation pertaining to patient falls. Further detail is necessary to fully understand the patient's needs.
- To decrease the inconsistent information amongst documentation, standardising of patient fall documentation should be taken into consideration.
- There is high non-compliance of Patient Handling training. This requires urgent improvement to ensure staff are appropriately trained.
- There are a high number of agency staff on wards, with part of the responsibilities including completing falls documentation. There is no oversight of what training agency staff have received on falls to ensure effective completion of required documentation.
- There is no evidence to demonstrate appropriate reporting from the Health Board Patient Safety Group to the Executive Delivery Group – Quality (EDQG).
- We are unable to determine if there is a standardised process in place for identifying themes, patterns, and lessons learned from falls.

	Objectives	Assurance
1	Appropriate policies and procedures in place to support falls prevention processes.	Limited
2	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) have been completed for inpatients.	Limited
3	Staff are appropriately trained in patient handling and the completion of the Falls and Bone Health Multifactorial Assessment (FBHMA).	Limited
4	There is regular reporting and scrutiny of falls data at an appropriate forum.	Limited

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

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	The Falls Policy is out of date and requires review.	1	Design	Medium
2	Lack of detail in the FBHMA and inconsistent information between the FBHMA and patient details in the nursing record.	2	Operation	High
3	Compliance with falls training requires improvement, and there is no oversight of the training agency staff receive in terms of patient falls.	3	Operation / Design	High
4	Unable to view chairs assurance reports from the Health Board Patient Safety Group being submitted to the EDQG. There is no consistent method for identifying themes, patterns and lessons learned.	4	Design	High

Work in Progress Summary

4. The following draft reports have been issued:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued	Management response due
Lessons learnt	Draft report – awaiting management response	12 October 2023	10 November 2023

Review	Status	Date draft report issued	Management response due
Decarbonisation	Draft report – awaiting management review for factual accuracy and management response	31 October 2023	28 November 2023
Special Measures – Contract and Procurement Management	Draft report – awaiting management review for factual accuracy.	31 October 2023	N/A – Actions raised with no response required for Internal Audit.

5. The following 2023/24 reviews are currently in progress:

Review	Draft report due:
Digital Operating Model	November 2023
Adult and Older Persons Mental Health Unit (IAAP)	November 2023
Corporate Legislative Compliance: Water Safety	November 2023
Follow up: Welsh Language Commissioner – documents on the website	November 2023
Follow up of Internal Audit Recommendations	Ongoing - report as required

6. Audit briefs have been issued for the following reviews:

- Health and Safety.
- Effective Governance - IHC Central.
- Records Management – Fragmented Care records.
- Digital Health Record (Cito) – Patient Records Transition Programme.

Contingency/Organisational Support/Advice

7. Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.

8. We meet with Audit Wales, Healthcare Inspectorate Wales, Health & Safety Executive and Public Services Ombudsman for Wales regularly to discuss recent issues and areas of emerging risks to the Health Board.

Delivering the Plan

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

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

11. 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.

12. Table 4 is reporting a positive status across all indicators. Figures are based on nine reports issued as final to date.

Table 4 – Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]	Green	100%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 5 – Core Plan 2023-24 (April 2023 to March 2024)

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Special Measures - Contract and Procurement management review	October 2023	Draft report issued.	Not Applicable
Financial Control: Receipting of goods and year-end accruals	April 2023	Final report issued.	Reasonable
Accounts Receivable	June 2023	Final report issued.	Reasonable
Clinical Audit: Tier 1 National Audits	June 2023	Final report issued.	Limited
Falls management	June 2023	Final report issued.	Limited
Lessons learnt	July 2023	Draft report issued.	Limited
Cyber security	April 2023	Final report issued.	Substantial
Digital Operating Model	June 2023	Fieldwork complete.	
GP Out of Hours (Deferred from22/23)	June 2023	Final report issued.	Limited
Decarbonisation	September 2023	Draft report issued.	Limited

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Adult and Older Persons Mental Health Unit (IAAP)	April – September 2023	Fieldwork complete.	
Corporate Legislative Compliance: Water Safety	June 2023	Review in progress.	
Hergest Unit Notice of Contravention (NoC) Action Plan	June 2023	Final report issued.	Limited
Procurement and Contract management arrangements	June 2023	Briefing paper issued.	Not Applicable
Interim Executive Director appointment	September 2023	Briefing paper issued.	Not Applicable
Follow up - Delivery of HB Savings	October/ November 2023	Deferred to November to accommodate Contract and Procurement management review.	
Follow up - Welsh Language Commissioner - Documents on the Website	August 2023	Fieldwork complete.	
Follow up of Internal Audit Recommendations	October 2023 – March 2024	Review in progress.	
Health and Safety	October 2023	Draft brief issued.	
Effective Governance - Integrated Health Community – Central	October 2023	Draft brief issued.	
Discharge arrangements / patient flow management	October 2023	Planning meeting booked but now rescheduled to late November 2023	
Operating model	November 2023	Draft brief being prepared.	
Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality	December 2023		
Records Management – Fragmented Care records	November 2023	Draft brief issued.	
Womens Services	November 2023	Draft brief being prepared.	
Corporate Legislative	November		

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Compliance: NHS Appointment of Consultant Regulations 2005	2023		
Budgetary Control	December 2023		
Follow up - Recruitment of substantive and interim executive and senior posts	December 2023		
Charitable Funds	January 2024		
Follow up – Contracted Patient Services: Quality and Safety arrangements	January 2024		
Deprivation of Liberty Safeguards (DoLS)	January 2024		
Board Assurance Framework and Risk Management	February 2024		
Digital Health Record (Cito) – Patient Records Transition Programme	February 2024	Draft brief issued.	
Grievance procedure and case management	February 2024		
Wrexham Maelor Continuity	October 2023 – March 2024		
Workforce Strategy: Operational implementation (Deferred from 22/23)	June 2023	Deferred.	

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Table 6: Themes and definitions relating to Image 1

Ref.	Theme	Definition
1	Cyber & Data Management	Management of IT systems and data is inadequate, access rights are not monitored or maintained which may compromise cybersecurity.
2	Communication	Information is not communicated clearly internally within teams, or externally with partners, forums, or wider stakeholders.
3	Compliance	Non-compliance with relevant policies, procedures, standards, applicable laws and regulations, and government instructions. No formal compliance monitoring and issue escalation.
4	Policies & Procedures	Inadequate or lack of policies and procedures in place.
5	Audit Trail (Documentation)	There are missing or partially completed documents, or the quality of documents is not sufficient. A lack of document retention, unretrievable documents/data or inappropriate audit trail.
6	Engagement	Lack of engagement with staff, partners, and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored.
7	Governance & Risk Management	Formal governance routes are inadequate, ineffective, or there is a lack understanding of them. This may affect the ability to identify, assess and manage risk.

Ref.	Theme	Definition
8	Ineffective Controls	The necessary control(s) to mitigate risk(s) do/does not exist, is ineffective, or there are gaps which result in inefficiencies.
9	Reporting	The adequacy, quality, or accuracy of reporting is insufficient for assurance, or there is a lack of assurance mechanisms and central oversight in place. No formal reporting, escalation, and scrutiny processes are established, all of which may affect the ability to make decisions.
10	Finances & Resourcing	There are inadequate resources to deliver required tasks, a lack of resource management, monitoring, or funding. Financial viability and sustainability need to be properly considered and maintained.
11	Review	Whilst work is in progress and when it is completed, reviews are not undertaken regularly (or at all) to ensure quality, effectiveness and that the desired outcome is achieved or is on target to be achieved. Best practice is not reviewed or considered, lessons learned are not monitored or documented which may impact development and lead to repeated mistakes.
12	Physical Security	No consideration and actions to protect against current and future threats.
13	Planning, Delivery & Deadline Management	A lack of timescales or deadlines being set, or unmonitored scope creep resulting in missed deadlines, non-delivery of projects and/or tasks, overspends, or negative impacts on the quality of the final output.
14	Training & Development	A lack of training, opportunities to complete training, or training materials within teams; this may lead to gaps in knowledge and over reliance on certain staff members.
15	Contractual	Awaiting definition.
16	Strategy	Awaiting definition.
17	Other	If there is no correlation between a recommendation and one of themes outlined, this option can be selected to help monitor the accuracy of the list provided and to identify potential additional themes.

GP Out of Hours
Final Internal Audit Report
September 2023

Betsi Cadwaladr University Health Board

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

Contents

Review reference:	BCUHB-2324-09
Report status:	Final
Fieldwork commencement:	5 July 2023
Fieldwork completion:	30 August 2023
Debrief meeting:	18 August 2023
Draft report issued:	31 August 2023
Management response received:	27 September 2023
Final report issued:	28 September 2023
Auditors:	Rhys Jones, Principal Auditor Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit
Executive sign-off:	Adele Gittoes, Interim Executive Director of Operations
Distribution:	Karen Higgins, Director of Primary Care, Palliative Care & Childrens Services Rachael Page, Assistant Director of Primary Care Sefton Brennan, Head of Service GPOOH Phil Meakin, Interim Board Secretary
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Executive Summary

Purpose

The review has considered whether there are robust processes and controls in place within the Health Board to support the management and implementation of the GPOOH/UPCC Peer Review improvement actions.

Overview

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

- There are no written control documents in place to support operational processes.
- Lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of Peer Review improvement actions are not documented.
- Delegated responsible officers and expected completion dates are not documented.
- Only twelve of the forty-three (27%) improvement actions are reported as complete, with a further 14 (31%) reported as in-progress.
- There is no assurance provided to the Board or its Committees regarding the implementation of Peer Review improvement actions.
- There is no evidence of Board oversight or scrutiny.

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

Report Opinion

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	n/a

Assurance summary[1]

Objectives		Assurance
1	There are robust processes in place to monitor, manage, and support the implementation of the Peer Review Improvement Plan, with issues or lack of progress escalated promptly.	Reasonable
2	Identified improvement actions have been implemented and are operating as expected (evidenced through sample testing).	Limited
3	There are robust governance arrangements in place to ensure Peer Review Improvement Plan implementation is subject to Health Board oversight and scrutiny and assurance of progress is provided to the Board and / or relevant Committees.	Unsatisfactory

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	There are no policies, SOPs, guidance notes or other written control documents in place to support operational processes. The Peer Review Group meeting does not have a formal Terms of Reference. Minutes / action logs are not maintained therefore there is no record of operational decision-making or issues requiring escalation.	1	Design	Medium
2	There is no provision within the OOH UPCC Progress Update Log to record responsible officers and expected completion dates.	2	Design	Medium
3	We were advised that there are discrepancies between internally produced Out of Hours data and data presented by the national Peer Review Panel.	2	Design	High
4	The Health Board / Committees are not provided with assurance regarding the implementation of Peer Review improvement actions, and we found no evidence of wider oversight or scrutiny.	3	Design	High

1. Introduction

1.1 GP Out of Hours Services (OOH) provide health care for urgent, but not emergency, medical problems outside normal surgery hours (Monday to Friday 8am to 6:30pm, excluding bank and public holidays). The Health Board are responsible for ensuring that the North Wales population have access to high quality Out of Hours services that complies with Welsh Government published national standards.

In September 2022 the Health Board was subject to a national peer review of Urgent Primary Care (Out of Hours and Urgent Primary Care Centre) services. The purpose of the review was, *"to act as a 'critical friend' and to provide some direct support and advice for staff and the executive team as the LHB continues its re-organisation and stabilisation post COVID"*. In concluding their review, the Peer Review Panel identified a range of areas for improvement and provided the Health Board with an improvement plan for the Urgent Primary Care (OOH) team to *"to develop further and/or incorporate into your wider service delivery plans"*.

1.2 The following risks were identified at the outset of the review:

- Improvement actions are not implemented or progressed, adversely impacting quality of Out of Hours service provision.
- Lack of effective governance arrangements in place to support appropriate escalation.
- The Board are not provided with assurance that the service is operating as intended.

1.3 This review focuses solely on the management and implementation of the Peer Review improvement plan, and associated governance arrangements.

1.4 This report is based upon the information provided by the Acting Associated Director, Primary Care, Assistant Director of Primary Care, Head of Service GPOOH. and information available in the public domain. We would like to express our gratitude to colleagues in for their input during the undertaking of the review.

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

2. Detailed Audit Findings

Objective 1: There are robust processes in place to monitor, manage, and support the implementation of the Peer Review Improvement Plan, with issues or lack of progress escalated promptly.

2.1 On September 8th, 2022, the national Out of Hours Peer Review Panel issued the Health Board a Peer Review Follow-up letter outlining the findings of their review and a detailed draft Action Plan to support improvement. The Acton Plan noted the key issues to address and outlined forty-three (43) separate improvement actions against the following eighteen domains:

Table 1: Peer Review Improvement Actions by Domain

Clinical Governance & Risk (3)	Performance (2)	Urgent Primary Care Centres (5)
Workforce (3)	MDT Working (2)	Home Visiting (3)
Transport (1)	Relationship with OOH (1)	Clinical Cover (4)
Communication (2)	Risk Management (2)	Executive Support (3)
Future workforce (1)	Community Nursing Services (2)	Palliative care services (1)
Community Pharmacy (1)	Environment/Estates (4)	Culture (3)

Source: Peer Review Action Plan / BCUHB UPCC/OOH Peer Review Follow-up

2.2 To manage and monitor implementation of the Peer Review improvement actions the Health Board developed the GPOOH UPCC Progress Update Log (MS Word document) comprising information collated from the Peer Review Action Plan. The Progress Update Log includes provision for the following:

Table 2: Summary of Working Document Content

Working Document Heading	Source
Issues identified by peer review	Taken directly from Peer Review Action Plan.
Recommended improvement actions	Taken directly from Peer Review Action Plan.
Progress update	Update provided by responsible officers.
Evidence	Submitted by responsible officer to support and demonstrate implementation.
Status - RAG rating	Updated by Acting Associated Director, Primary Care following review of evidence and confirmation of implementation.
Outstanding actions / next steps	Overview of actions / next steps per Domain.

2.3 The Health Board Acting Associated Director, Primary Care has overall managerial responsibility for the delivery and implementation of the Peer Review improvement actions. The following operational processes, arrangements, and procedures have been established to support delivery:

- A Peer Review Group comprising the Acting Associated Director, Primary Care, Deputy Executive Medical Director, Assistant Director of Primary Care, Head of Service GPOOH, Senior UPCC Managers, and clinical input from senior nurses, has been established to oversee delivery. The Group meet every fortnight to review implementation progress and the meeting serves as a forum to discuss, raise, and escalate any concerns or issues of significance.
- All members of the Group have access to the GPOOH UPCC Progress Update Log, from which the Acting Associated Director, Primary Care allocates required improvement actions to responsible officers. No deadlines or timescales for completion are recorded, however progress updates are expected at the following meeting.
- Responsible officers are required to submit supporting evidence demonstrating progress / completion. The Acting Associate Director, Primary Care reviews all progress updates and supporting evidence and amends the improvement action status on the Progress Update Log accordingly.
- The Out of Hours Team also hold twice weekly operational meetings to review performance and plan service provision. Whilst the focus of these meetings is to review service performance and resource issues, we were advised that updates regarding implementation of relevant Peer Review actions were also given at these meetings, though we were unable to verify this as no minutes are recorded.
- We are advised that the primary route of escalation is via the Peer Review Group meeting, though issues of significance can be escalated directly with management (Clinical Lead and Assistant Director of Primary Care). We were also advised that operational risks are reported and managed via Datix in line with Health Board requirements and are escalated via the East Integrated Health Community (IHC) Risk Management Group. Whilst not specific to the management of Peer Review improvement actions, we confirmed that the GPOOH service lines of accountability and escalation, and operational escalation plan, were documented and up to date.

2.4 Whilst the forming of a specific Group to oversee delivery, supported by the Progress Update Log to track implementation, ensures active management of the Peer Review improvement actions, we noted the following limitations - we are advised that work is underway on developing and strengthening the robustness of current arrangements:

- There are no formal policies, SOPs, guidance notes, or other written control documents in place to support the management and implementation of Peer Review improvement actions.
- The Peer Review Group meeting does not have a Terms of Reference therefore the role, remit, reporting, and escalation requirements are not clearly defined and documented.

- Peer Review Group meeting minutes are not recorded and there is no supporting action log, therefore there is no evidence of progress review, scrutiny, or decision-making.
- The GPOOH UPCC Progress Update Log working paper, whilst comprehensive, does not have provision to record responsible officers / owners or deadlines for completion for individual improvement actions. We did note that owners and timescales had been added to Outstanding Actions / Next Steps section of the Log and were advised that the working document was currently being reviewed and revised.
- There is no formal benefit realisation strategy in place to review the effectiveness of implemented improvement actions. We were advised that any adverse impact would be picked up immediately and escalated as the GPOOH performance data is subject to continuous review. Evidence of comprehensive performance data analysis was provided for review, including analysis of length of queue, performance, staffing, and fill-rates.

Conclusion:

2.5 The establishing of a senior management Group and Progress Update Log to oversee and support delivery of the Peer Review improvement actions is good practice and ensures that progress, implementation, and issues of significance are subject to regular review and scrutiny. However, whilst the arrangements in place provide a robust foundation to progress delivery there are no formal written control documents in place to support operational processes.

We have concluded **reasonable** assurance for this objective.

Objective 2: Identified improvement actions have been implemented and are operating as expected (evidenced through sample testing).

2.6 The Health Board Primary Care team utilise the GPOOH UPCC Progress Update Log to track and monitor implementation. The following table provides a summary of implementation progress status as of July 2023:

Table 3: Summary of implementation progress as of June 2023

Improvement Action Status	Total Number*	As Percentage of Total
Complete	12	27%
In progress	14	31%
Pending review	14	31%
Outstanding	5	11%
Not started	0	0%

Source: GPOOH UPCC Progress Update Log (July 2023).

** Note that the status data (45 total) differs from the total number of improvement actions (43) as the progress of improvement action 2.1 (Performance) has been split into three steps, each with a different reported progress status.*

2.7 The Peer Review identified several improvement actions relating to the Health Board Urgent Primary Care Centre (UPCC) service. We were advised that at the time of audit the UPCC service was being reviewed as part of the organisation-wide Urgent Primary Care review. The outcome of the review would likely impact the recommended improvement actions therefore Primary Care management agreed to delay implementation pending the outcome of the Urgent Primary Care review - expected end of July 2023. Given this, fourteen (14) UPCC related improvement actions were noted as Pending Review in the GPOOH UPCC Progress Update Log.

We sought an update from management prior to draft report issue (end of August) regarding the outcome of the Health Board Urgent Primary Care review and implications of the review on Peer Review improvement actions. However, no response was received.

2.8 We reviewed the GPOOH UPCC Progress Update Log and noted the following:

- All issues identified and recommended improvement actions from the Peer Review were included in the Progress Update Log.
- The Update Log was well maintained with progress updates recorded for all improvement actions. The exception to this was the Evidence field / column, which was largely unused – we found that supporting evidence had been attached / noted for only two of the improvement actions.
- The Update Log does not have provision to record responsible officer and implementation deadlines against individual improvement actions. However, the provision has been included under the domain summary Outstanding Actions / Next Steps section of the Log. Of the eighteen domains, Outstanding Actions / Next Steps were recorded for nine domains, with action owners noted for seven of these – though timescales for completion were only specified in three instances.

2.9 As outlined in Par.2.3, we are advised that responsible officers are required to submit supporting evidence to the Acting Associated Director, Primary Care demonstrating implementation progress. To determine the robustness of reported progress updates / status, we sought to verify a sample of improvement actions noted as either Complete or In Progress in the Update Log. Our sample comprised of six (50% of total) Completed actions, and seven (50% of total) In Progress actions. For each action in our sample, we sought evidence demonstrating completion or progress made. We found no issues of significance – the Acting Associated Director, Primary Care provided supporting evidence of completion / progress for all improvement actions in our sample.

2.10 The evidence and supporting documentation we received demonstrates progress has been made against actions in the plan. The Peer Review group have recently completed a follow-up of their initial review - the outcome of this review and feedback will confirm the adequacy of actions implemented to date and will inform the Health Board's improvement plan going forwards.

2.11 There is no formal benefit realisation strategy in place to review the effectiveness of implemented Peer Review improvement actions. We were advised that all

proposed improvements were reviewed and considered prior to implementation and any adverse impact would be picked up immediately as the service performance data is subject to robust oversight and scrutiny. However, the Primary Care management team stated that there were inconsistencies between internally produced Out of Hours performance data and data produced by the National Peer Review team. We noted that this issue was documented in the Progress Update Log:

"The data presented by the national team at the second peer review session did not correlate with the data held internally – BCUHB data shows improvements at weekends. BCU team to work with National team to better understand national data sets and reasons for differences." (Progress update 1.2)

Conclusion:

2.12 Delivery of the Peer Review recommended improvement actions were ongoing at the time of review - approximately 27% were reported as complete, 31% were in-progress, 31% were on hold pending the outcome of the Health Board Urgent Primary Care review, and 11% were reported as outstanding. We reviewed the primary management tool used to track and monitor implementation (GPOOH UPCC Progress Update Log document) and verified the reported progress updates for a sample of improvement actions. We confirmed that the Progress Update Log was comprehensively maintained however noted the absence or recorded responsible officers and implementation / completion dates.

2.13 Whilst outside the scope of this review, the issue regarding discrepancies between internally produced Out of Hours performance data and data presented by the Peer Review Panel is significant and should be reviewed and resolved as a matter of urgency. Not only could this limit the Health Boards ability to accurately monitor and measure the effects of implemented improvement actions but may also lead to inappropriate service changes / developments where decisions are informed by inaccurate data.

We have concluded **limited** assurance for this objective.

Objective 3: There are robust governance arrangements in place to ensure Peer Review Improvement Plan implementation is subject to Health Board oversight and scrutiny and assurance of progress is provided to the Board and / or relevant Committees.

2.14 The Primary Care management team advised that the outcome of the Peer Review and progress of improvement action implementation were not subject to wider Board oversight or scrutiny, though senior Health Board staff, including the previous Chief Executive Officer and Vice Chair, had engaged in the initial OOH/UPCC Peer Review process.

2.15 To verify this, we reviewed the last three agenda bundles and minutes for the Board, Quality Safety and Experience Committee (QSE), and Performance Finance and Information Governance Committee (PFIG) and confirmed the following: *(note we did not review Partnership People Population Health Community (PPPH) papers as the Committee had not been held since January 2023)*.

- No assurance regarding the implementation or impact of Peer Review improvement actions was provided to the Board or its Committees during the period reviewed.
- No specific GPOOH/UPCC Peer Review papers, reports, or updates had been submitted to the Board and we found no evidence of Board or Committee GPOOH/UPCC Peer Review improvement action oversight or scrutiny.
- We did note that the Peer Review improvement actions were referenced in the Health Board 2023/24 Annual Plan (presented at the July Board meeting):

  "A recent Peer Review exercise identified a number of crucial improvement actions needed in order to strengthen the provision of urgent primary care across the Health Board's footprint, including governance and leadership; estates; workforce; criteria and model. A series of actions are in place to deliver against these actions in the short-term."

2.16 Despite the limited Board and Committee oversight, the Primary Care team advised that implementation progress and service performance was subject to review at the following forums:

- Peer Review Group meeting – *as 2.3 above, no terms of reference or minutes for group*.
- Out of Hours operational meetings - *as 2.3 above, no terms of reference or minutes for operational meetings*.
- Primary Care Quality, Assurance, and Sustainability Group (East) – *TOR and minutes of last two meetings provided for review*.
- East IHC Finance and Performance Sub-committee – *TOR and minutes of last three meetings provided for review*.
- East IHC Risk Management Group – *TOR and minutes of last three meetings provided for review*.
- North Wales Out of Hours Service – Finance, Operational, Planning and Performance Meeting - *TOR and minutes of last three meetings provided for review*.
- North Wales Urgent Primary Care Service (NWGPOOH & UPCC East) Quality and Patient Safety Group – *TOR and minutes of last three meetings provided for review*.
- East IHC Quality Delivery Group – *TOR provided for review, no minutes*.
- Welsh Government via monthly monitoring return – *not provided for review.*
- National Joint Operations Group – *monthly meeting to compare and discuss performance data – no TOR or minutes provided for review.*
- Service manager formal monthly one-to-one meeting with manager – *minutes not recorded.*

2.17 A review of the meeting minutes and agendas referenced above found no evidence of wider Peer Review improvement action oversight, review, or scrutiny. References to the OOH/UPCC Peer Review were limited to the following:

Table 4: Peer Review references in minutes reviewed.

Meeting / Forum	Extract from Minutes / Notes
IHC Finance & Performance Meeting 21/6/23	GPOOH: Performance; did have a peer review in October last year on return there are still areas of significant concern which they want us to log on corporate risk register which we are working on. We are working closely with GPOOH teams. Update given in slides though not detailed – noted that there are a number of recommendations for improvement and an action plan has been produced.
IHC Finance & Performance Meeting 17/5/23	GP out of Hours: Following a Performance Peer review (national process) there were concerns around operational performance in the out of hours and also with estates. Working with national team and new director of primary care across Health Board is reviewing that service to see how it is going to look in the future. Notification of follow-up given in Primary care slides.
East IHC Risk Management Group 16/6/23	New risk emerging following some feedback from peer review into out of hours service. Length of que out of hours, which is causing a potential risk. Still validating information as out of hours don't recognise some of the numbers. *(sic)* Action: ST will catch up with ID to go through following the meeting. Once reviewed can come back through this meeting for sign off. Added to action log - ID/ST to discuss new risk relating to Out of Hours Peer Review feedback
North Wales Urgent Primary Care Service (NWGPOOH & UPCC East) Quality and Patient Safety Group 12/7/23	No reference to Peer Review in minutes however Peer Review preparation included in Action Log.

Source: extracts taken directly from relevant recorded minutes.

Conclusion:

2.18 The Health Board does not have robust reporting and governance arrangements in place to ensure effective oversight and scrutiny of GPOOH/UPCC Peer Review improvement actions. No assurance or implementation progress updates were provided to the Board, Committees, or local forums during the period reviewed.

We have concluded **unsatisfactory** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Process Management (Design)		**Impact**
The Primary Care team have established operational processes to manage, monitor, and support implementation of GPOOH/UPCC Peer Review improvement actions. We reviewed the controls in place and noted the following limitations: • There are no written control documents (policies, SOPs, guidance notes etc) in place to support operational processes. • The Peer Review Group meeting, which is the main forum established to support implementation, does not have a Terms of Reference therefore the role, remit, reporting, and escalation requirements are not clearly defined and documented. • Minutes are not recorded for the Peer Review Group meeting and there is no supporting action log, therefore there is no evidence of progress review, scrutiny, or decision-making. • There is no formal process in place to manage and review the effectiveness of implemented improvement actions.		Potential risk of: • Lack of clarity, consistency, and transparency. • Lack of robust governance arrangements. • Implemented actions ineffective / adverse impact.
Recommendations		**Priority**
1.1	Management to develop robust written control documents to support operational processes and strengthen governance arrangements.	**Medium**
1.2	Management to establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes / action log to promote transparency and document decision-making.	
1.3	Management to review implemented improvement actions to ensure they are operating as expected / having the desired impact.	

Agreed Management Action		Target Date	Responsible Officer
1.1	Agree with recommendation. Management will develop robust written control documents to support operational processes and strengthen governance arrangements. Much of this will be incorporated into 1.2 Terms of Reference.	13/10/2023	Associate Director of Primary Care - East
1.2	Agree with recommendation. Management will establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes / action log to promote transparency and document decision-making.	13/10/2023	Associate Director of Primary Care - East
1.3	Agree with recommendation. Management will review implemented improvement actions to ensure they are operating as expected / having the desired impact.	20/10/2023	Head Of Service GP OOH and IHC Associate Directors of Primary Care

Matter Arising 2: Progress Update Log (Design)			**Impact**
The Primary Care team have developed the GPOOH UPCC Progress Update Log document to track, manage, and monitor implementation of GPOOH/UPCC Peer Review improvement actions. We reviewed the document and noted the following limitations: • The GPOOH UPCC Progress Update Log has no provision to record responsible officers or expected completion dates for individual improvement actions. We were advised that responsible officers are assigned improvement actions at the Peer Review Group meeting, however this is not documented. • The evidence column within the GPOOH UPCC Progress Update Log is not utilised.			Potential risk of: • Lack of ownership and accountability. • Update Log not fully utilised.
Recommendations			**Priority**
2.1	Management to ensure that responsible officers and completion dates assigned to improvement actions are documented. We are aware that the Progress Update Log is currently being reviewed – management should consider the appropriateness and current utilisation of the Evidence field within the Update Log.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agree with recommendation. Management will ensure that responsible officers and completion dates assigned to improvement actions are documented. Management will consider the appropriateness and current utilisation of the Evidence field within the Progress Update Log.	13/10/2023	Associate Director of Primary Care - East

Matter Arising 3: Data Discrepancy (Design)	**Impact**
Management advised that there were discrepancies between internally produced Out of Hours performance data and the data presented by the national Peer Review Panel. The Progress Update Log noted the following: *"The data presented by the national team at the second peer review session did not correlate with the data held internally – BCUHB data shows improvements at weekends. BCU team to work with National team to better understand national data sets and reasons for differences".* We acknowledge that a responsible officer / action owner has been named to *"Work with Bertie Bassett to review our data and the data held nationally in order to understand disparities" (Outstanding Actions / Next Steps section of Log)*, however a timescale for completion has not been defined.	Potential risk of: • Inaccurate data informing decision making / service changes. • Implementing improvement actions that are based on inaccurate data. • Inaccurate reporting.

Recommendations		**Priority**
3.1	Management to clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Agree with recommendation. Management will clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate. The BCU team will work with the national team to agree on the content and presentation of the appropriate data sets.	27/10/2023	Head Of Service GP OOH

Matter Arising 4: Board Assurance (Design)			**Impact**
The Health Board does not have robust reporting and governance arrangements in place to ensure effective oversight and scrutiny of GPOOH/UPCC Peer Review improvement actions. No assurance or implementation progress updates were provided to the Board, Committees, or formal IHC forums during the period reviewed.			Potential risk of: • Limited oversight and scrutiny. • Board unsighted on issues of significance impacting service provision. • Lack of transparency.
Recommendations			**Priority**
4.1	Management to review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Agree with recommendation. Management will review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny. A paper will be produced that clarifies the arrangements for sign off by the IHC and executive team.	27/10/2023	Associate Director of Primary Care - East

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Falls Management
Final Internal Audit Report
October 2023

Betsi Cadwaladr University Health Board

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

Contents

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Auditors:	Patrick Williams, Principal Auditor Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit
Executive sign-off:	Angela Wood, Executive Director of Nursing and Midwifery
Distribution:	Diane Read, Ward Accreditation Team Lead, Mandy Jones, Deputy Executive Director of Nursing Tracey Radcliffe, Head of Patient Safety Russell Caldicott, Interim Executive Director Of Finance Phil Meakin, Associate Director of Governance Bathen Wassel, Statutory Compliance, Governance and Policy Manager Andrea Hughes, Interim Director of Finance Joanne Garrington, Finance Director - Commissioning & Strategy Karen Balmer, Independent Member
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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

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.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Betsi Cadwaladr University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

We reviewed compliance with Policy NU06 - The Prevention and Management of Adult In-Patient falls as well as reporting and management arrangements in place.

Overview

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

- The Falls policy is overdue for review.
- Testing demonstrates a lack of detail included on completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and documentation pertaining to patient falls. Further detail is necessary to fully understand the patient's needs.
- To decrease the inconsistent information amongst documentation, standardising of patient fall documentation should be taken into consideration.
- There is high non-compliance of Patient Handling training. This requires urgent improvement to ensure staff are appropriately trained.
- There are a high number of agency staff on wards, with part of the responsibilities including completing falls documentation. There is no oversight of what training agency staff have received on falls to ensure effective completion of required documentation.
- There is no evidence to demonstrate appropriate reporting from the Health Board Patient Safety Group to the Executive Delivery Group – Quality (EDQG).
- We are unable to determine if there is a standardised process in place for identifying themes, patterns, and lessons learned from falls.

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

Report Opinion

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

Assurance summary[1]

	Objectives	Assurance
1	Appropriate policies and procedures in place to support falls prevention processes.	Limited
2	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) have been completed for inpatients.	Limited
3	Staff are appropriately trained in patient handling and the completion of the Falls and Bone Health Multifactorial Assessment (FBHMA).	Limited
4	There is regular reporting and scrutiny of falls data at an appropriate forum.	Limited

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	The Falls Policy is out of date and requires review.	1	Design	Medium
2	Lack of detail in the FBHMA and inconsistent information between the FBHMA and patient details in the nursing record.	2	Operation	High
3	Compliance with falls training requires improvement, and there is no oversight of the training agency staff receive in terms of patient falls.	3	Operation / Design	High
4	Unable to view chairs assurance reports from the Health Board Patient Safety Group being submitted to the EDQG. There is no consistent method for identifying themes, patterns and lessons learned.	4	Design	High

1. Introduction

1.1 The National Institute of Health and Care Excellence (NICE) identifies that falls and fall-related injuries are a common and serious problem for older people and falls in hospital are the most common patient safety incidents reported. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality, not only affecting patients but also affecting the relatives, carers and hospital staff.

Falling has an impact on quality of life, health and healthcare costs and the Health Board recognises that the prevention of falls, and effective management of patients following a fall, is an important patient safety challenge, in common with all Health Boards.

1.2 The risks considered in the review were:

- Patient Safety is compromised through lack of formal risk assessment.
- Staff are not compliant with Health Board mandatory training requirements; and
- Reputational risk through increased publicity of patients falling and associated litigation.

2. Detailed Audit Findings

This report is based upon the information provided by officers supporting our review. We have relied solely on the documents, information and explanations provided and, except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

We would like to thank the Ward Accreditation Team Lead and Transforming Quality Care Nurse who accompanied and supported us with this review.

Objective 1: There are appropriate policies and procedures in place to support falls prevention processes, including escalation of avoidable falls.

2.1 There is a Health Board Policy in place, NU06 401 'The Prevention and Management of Adult In-Patient Falls' (Falls Policy), which was due for review in April 2023. We are advised that the Policy is in the process of being updated and circulated for comments prior to being submitted for approval. We are advised the Policy has been developed by reviewing the National Institute of Health & Care Excellence (NICE) clinical guidance Falls in Older People: Assessing Risk & Prevention (CG161) and 'State of the Nation – Wales report Royal College of Physicians' to reduce falls and their effects on patients and staff.

The advice and recommendations are intended for use by healthcare experts, other professionals, and personnel who provide care for elderly individuals who are at danger of falling.

2.2 The Falls Policy is consistent with the principles of the NICE guidance, Section 6 depicts the roles and responsibilities of persons within the falls management process whilst Section 7 of the policy outlines the falls assessment process.

Section 7 includes guidance on the actions to be taken on patient admission, stipulating timescales for completion, review, updating of the Falls and Bone Health Multifactorial Assessment (FBHMA), falls prevention, post falls management and monitoring and compliance.

Conclusion:

2.3 There is a Falls Policy in place that also outlines the process for falls management. This is available on the intranet, however at the time of undertaking this review the policy was out of date and is currently under review.

We have concluded **limited assurance** for this objective.

Objective 2: The All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) have been completed for inpatients, and where necessary appropriate action taken to reduce the risk of a fall.

2.4 The digitised Falls & Bone Health Multifactorial Risk Assessment tool has been implemented across the Health Board, and it focuses on manageable risk factors and identifies actions to reduce the risk of falling. It incorporates NICE clinical guidance CG161 current best practice.

2.5 We sought to establish that the FBHMA assessments are being fully completed for all inpatients prior to a fall, and where necessary appropriate action taken to reduce the risk of a fall.

We reviewed 42 completed FBHMA assessments across three acute hospitals and three community sites one in each area.

- Wrexham Maelor, Ysbyty Gwynedd, Ysbyty Glan Clwyd, and
- Penrhos Stanley Hospital, Llandudno Hospital, Deeside Hospital.

We were accompanied by either the Ward Accreditation Team Lead or the Transforming Quality Care Nurse to advise on clinical issues.

Our key findings are:

2.6 <u>FBHMA</u>

- All wards we reviewed were using the digital Welsh Nursing Care Records (WNCR) containing the FBHMA.
- There was a lack of detail included in the FBHMA in identifying the patients individual risk factors for falling e.g. parts of the forms had limited to no detail for visual and hearing issues.
- There is contradicting detail between the information contained in the communication, mobility, patient handling and patient notes sections of the Nursing Care record compared to the FBHMA i.e.

- There were no visual issues noted in the communication domain, however the patient was noted as 'requires glasses' in the FBHMA.
- The patient was noted as Mobility category A (mobile) in patient handling form, however, was noted as needing a zimmer frame in the FBHMA.
- There were no issues noted relating to a patients hearing in the FBHMA, however the patient was noted as requiring hearing aids in the communication domain.

- Nurse perception of risk in relation to patient falls varies. For example, patients identified as a high risk of falls, and upon review a week later identified as no risk of falls, with no change to the documentation.
- There is inconsistent review of FBHMA upon transfer from one ward to another.
- Communication and Mobility domains were not being reviewed following the patient being admitted. This can cause inconsistencies of the patients profile as the FBHMA is reviewed.
- In accordance with the policy, the FBHMA should be completed within a six-hour timeframe; from the sample reviewed, 27 (64%) were completed within this time frame, with 15 (36%) completed outside of it.
- The post fall management section of the FBHMA was completed with all patients who had fallen within our sample.
- Business Continuity – at times when the digital system drops out the wards revert to a paper version. This information is then added to the Nursing Care record once the system is available.
- FBHMA's tended to provide information on what's wrong with the patient rather than what is required to give staff a view of what is needed for the patient.
- Abbreviation of terminology within two of the FBHMA was not recognised by a qualified nurse who accompanied us for the testing.

<u>Other findings in relation to patient falls: -</u>

- Eleven of the thirteen wards we visited were using STREAM, a digital service situated at the nurse's station, containing the details of all patients on the ward.
- Within the West community, the RAMBLEGUARD system is being used which identifies which patients are at high risk of falls and are using pressure mats when seated. The system includes an alarm and identifies which patient has fallen/slipped from the chair.
- The West community hospital is trialling pagers which identify which patient has fallen/slipped.

- Not all wards are using the 'Hot de-brief' short document, which was intended to be utilised across the Health Board immediately following a patient fall. This includes a review of how the fall occurred.
- All wards we sampled had a nominated nurse situated within a bay where there are patients at a high risk of falls.
- Areas of good practice include a QR code being available on one ward which when used directs the staff to all the latest falls documentation; signage above beds to indicate a patient at risk of a fall; and in one ward a 'I must' board is being used by the beds of patients at risk of a fall, which highlights to staff what the patient must do to reduce the risk of a fall.

Conclusion:

2.7 Having reviewed the FBHMA's, it would be challenging for staff reviewing the material to acquire a clear picture of the patients' needs due to the FBHMA's lack of clarity.

Although digitised on tablets, the FBHMA forms, communication, mobility domains, and patient handling assessment forms are still distinct and not in a single common document, making it challenging to obtain consistent up to date data regarding patient falls.

The Health Board may benefit from good practice on some wards employing QR codes and 'I must' boards over the beds.

Having spoken to several staff members whilst undertaking the testing, the perception of the documentation seems to be one of, falls documentation often seen as something we need to complete rather than a recipe for care.

We have concluded **limited assurance** for this objective.

Objective 3: Staff are appropriately trained in patient handling and the completion of the Falls and Bone Health Multifactorial Assessment (FBHMA).

We note that the observations below are based on the training of Health Board staff and do not include agency staff. We have been unable to determine what training agency staff receive on patient falls, and whether this is of the same standard and consistency as the training provided to Health Board staff.

2.8 The Falls Policy requires that staff must undertake relevant training to ensure that they have the required competencies to comply with their responsibility in implementing the policy and associated procedures.

All Health Board staff must complete the Mandatory Level 1a Adult Falls Prevention Awareness training on ESR. This training is to be completed every 2 Years.

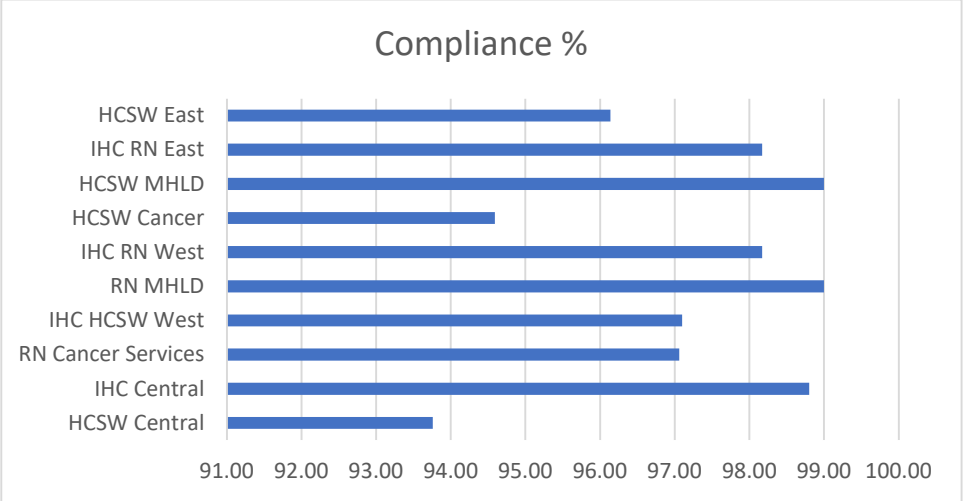
We reviewed the training required before an employee commences in a post where they may be moving / handling a patient or completing the FBHMA:

Level 1b Adult Falls Prevention Awareness training

Additional training for Clinical staff which includes instruction on how to complete the FBHMA and additionally the care and management of an adult patient following

an in-patient fall.

Table 1: Breakdown of compliance for 1b training up to August 31st, 2023.

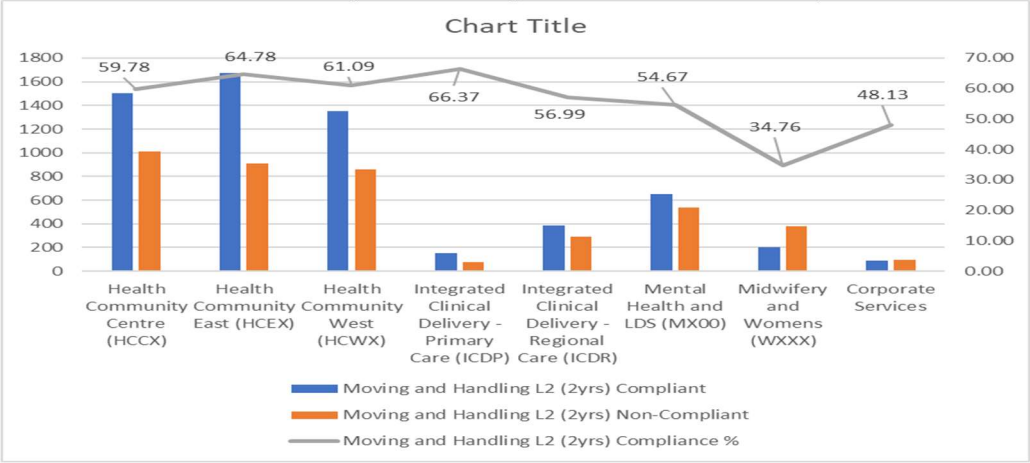


2.9 Patient Handling Training

Clinical staff must complete face to face training every two years which includes an overview of the FBHMA completion as well as care of the patient who may be falling / fallen / collapsed in line with the All Wales NHS Manual Handling Training Passport and Information Scheme.

Figures obtained from the Manual Handling Department show that as of the end of June 2023, from a total of 10,160 staff who require patient handling training 5,999 staff had been trained, with 4,161 non-compliant (59% trained).

Table 2 - Breakdown of compliance throughout the Health Board up to June 30th 2023



2.10 Level 2 Adult Safeguarding training

Clinical staff must complete the training, an element of the training includes post Falls management as per Falls Policy.

Following email correspondence with the Safeguarding Department it was determined that there was no reference to post falls management from a safeguarding perspective within the package.

2.11 Bedside Learning

Bedside learning has been introduced throughout the Health Board in Autumn 2022. A member of the Ward Accreditation Team will go through a live FBHMA while collaborating with a member of the ward's staff to identify good and bad practice. The learning is in real time with the real challenges the patients and environments pose.

At present the roll out of bedside learning is limited due to resources; it is currently delivered on an ad hoc basis by the Ward Accreditation Team or when it is requested by the wards.

2.12 Falls Champions on the Ward

A draft version of the Generic (Falls) Champion Framework was provided to us. The framework is generic and is used for other key Champion roles. It is envisaged that this framework will provide mentoring and coaching for the Champions as well as ensuring the right person for the role. The time allocated to perform the champions duties is seen as a challenge as training will be needed for the role to carry out bedside learning and monitoring of the FBHMA document.

Conclusion:

2.13 Training is in place for staff for both the FBHMA and patient handling. The Health Board currently has a 97% completion rate for the Adult Falls Prevention Awareness training. Compliance with the Patient Handling training requires improvement, as shown by the low completion in Table 2 of the report.

Clarification is required relating to safeguarding training and the inclusion of post falls management.

Due to resource constraints, bedside learning is currently undertaken on an ad hoc basis. The implementation of falls champions on the wards would facilitate this learning process.

We were unable to establish the quality and consistency of the patient falls training that agency staff had undertaken. It is noted that there is a high number of agency staff on wards at present, so this is a high-risk area for the Health Board which needs to be addressed, ensuring agency staff are able to effectively complete the FBHMA.

We have concluded **limited assurance** for this objective.

Objective 4: There is regular reporting and scrutiny of falls data at an appropriate forum. Falls incidents are investigated and monitored to identify themes, trends and lessons learned, with assurance provided to the Health Board.

2.14 We reviewed the following meetings (section 6 of the policy) to establish the reporting and assurance to the Health Board.

Quality Safety and Experience (QSE & Executive Delivery Group - Quality (EDGQ)

Health Board Patient Safety Group Terms of Reference

The PSG shall:

- *provide a Chair's Assurance Report that will be shared with the QDG (additionally, a Patient Safety Report is provided to the QSE Committee which will include details of the work of the PSG).*

Patient safety reports which included falls key actions were presented to the QSE meetings on the following dates 20th January 2023, 19th May 2023 and 25th July 2023. We note that the QSE did not take place from 20th January 2023 – 19th May 2023.

We were provided with the following minutes: 12 June, 14 August 2023; and agendas: 14 August & 11 September 2023 from the Executive Delivery Group for Quality (EDGQ). The EDGQ agendas for August and September each include the chairs' reports from the Patient Safety Group. It should be noted that the EDGQ meeting in July 2023 was a workshop and the meeting in September 2023 was stood down.

Health Board Patient Safety Group

Three sets of minutes were provided to us for meetings which took place on the following dates 21 April; 24 May and 22 June 2023.

We noted:

- Chairs report from the strategic Patient Safety Group can be seen being presented at all the of the minutes provided which includes: -
    - Issues for escalation requiring action and for information.
    - Summary of business conducted including training and establishment of weekly IHC harms meeting.
    - Data on inpatient falls (total number of falls).
    - Resources.

Strategic Inpatient Falls Steering Group

Three sets of minutes were provided to us for meetings which took place on the following dates 24 November 2022; 6 April and 25 May 2023.

We noted:

- Feedback from the Strategic Community Prevention of Falls Group, All Wales Falls Group and Strategic Occupational Health and Safety Group.
- Updates on training compliance for 1a, 1b, and Patient Handling.
- Performance data including level of harm per division, area, and how to accurately record falls on Datix to ensure assisted falls are recorded as falls.
- PowerPoint presentation on types of falls, and number of falls, broken down into areas, RIDDORs and severity of falls.
- Due to the high number of RIDDORs, a decision has been made to continue with the current position i.e. all staff regardless of work area need to complete 1a training in order to have an increased awareness of falls.

2.15 The table below highlights the number of inpatient falls between 1 June and 31 August 2023 and the number of RIDDORs reported to the Health and Safety Executive (HSE).

Incident Service - BCU Division	No of Incidents	RIDDORs
Cancer Services	7	
Dentistry	1	
IHC Central	350	
IHC East	308	
IHC West	230	2
Integrated Health Community (IHC) - (Old hierarchy)	3	
Mental Health and Learning Disabilities	136	
Midwifery and Women's Services	10	
(blank) no Division Highlighted	30	
Total	1075	2

2.16 Within the minutes of the Group on 24 November 2022 it states that the frequency of meetings is changing:

"The Strategic Falls Group has moved to bi-monthly meetings but attendance has not been as expected".

We did not receive any minutes for December 2022 to March 2023 with the January 2023 meeting being stood down. April and May meetings were convened on a monthly basis. The Terms of Reference (TOR) does state monthly however we are advised that the TR will be reviewed at the next meeting.

2.17 As evidence of regular investigating and monitoring of falls, details from harms meetings that take place in all three areas were provided to us.

Every week, harms meetings are held where all recent falls are discussed. The details of the falls are reviewed to determine if the falls were avoidable or unavoidable.

We note that we were provided with evidence to demonstrate discussions concerning falls, including the updating of DATIX as cases were addressed, the review of fall documentation, and what had been done to reduce the risk of the patient falling in the future.

2.18 Along with the harms meetings, evidence of learning lessons was provided, which included:

- Falls presentation at quarterly 'safety days' on sites.

- Alerts regrading falls.
- Emails highlighting incidental findings from a fall.
- Discussions on post falls i.e. issues around lying and standing blood pressure.

We note that while evidence of lessons learned has been provided, there does not appear to be a standard procedure in place for identifying themes, patterns, and lessons learned.

2.19 When completing a DATIX incident form, a lessons learned section needs completing when closing the incident. A total of 851 had been closed from our sample of 1,075. All 851 had completed the lessons learned section. Of the 851 incidents, 317 had input comments such as "N/A," "As above," "NIL," and "Non Identified." Seven events had a full stop or a dash recorded within the section of lessons learned.

2.20 Weekly and monthly matrons audits are conducted as part of ward accreditation, these look at the FBHMA as well as other areas that need to be reviewed.

We received evidence of the audits from the wards we sampled, whilst confirming that the necessary audits are being conducted on schedule. We note the majority of the audits are achieving 100% when answering the question below.

"Have all sections of the falls pathway been completed accurately?"

Concerning the lack of detail, this does not correspond to the results of the testing we undertook on the FBHMA.

Conclusion:

Lessons learned are being shared, but the Health Board's approach to patient falls can be improved with a robust process that regularly identifies themes, patterns, and lessons learned.

Consideration needs to be given to a drop-down box within the lessons learned section in Datix order to prevent staff inputting a full stop or a dash – This undermines the ability of the Health Board to demonstrate it is a learning organisation.

Our sample findings do not correspond to the high percentage scores that the weekly and monthly matrons audits are achieving in regard to the FBHMA completion accuracy. The FBHMA are complete, however the lack of detail has the ability to obscure the patient's actual needs.

A review of incident data from Datix relating to falls highlights over 1,000 falls in a three month period, with two classed as RIDDOR reportable falls. We are advised the two incidents were within the West IHC, with no RIDDORs reported for Central or East. Whilst we have not reviewed the details of these falls and made no recommendations, the RIDDOR figures appear low and require urgent review.

We have concluded **limited assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policy (Design)			**Impact**
The Prevention and Management of Adult In-Patient Falls NU06 situated on the intranet is currently outdated and requires review.			Potential risk of: • Staff are not provided with up to date policies and procedures, increasing the likelihood of non-compliance with requirements.
Recommendations			**Priority**
1.1a	The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1a	Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: • Review/consultation by Health Board Inpatient Falls Steering group; • Approval required by the Health Board Patient Safety Group; • Health Board Clinical and Written Documents policy process for uploading, communication and replacing of the current version on Betsinet	30th November 23 30th November 23 31st December 23	Ward Accreditation Team Lead / Deputy Executive Director of Nursing

Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	**Impact**
A number of issues were identified through our testing of completion of the FBHMA: • Lack of detail in the FBHMA when identifying each patient's unique risk factors for falling, such as sensory and communication components of the forms. • FBHMA forms, communication, mobility domains, and patient handling assessment forms although digitised are separate. • Contradicting detail within the relevant documentation. • Inconsistency in FBHMA not being reviewed when patients are transferred between wards. • FBHMAs tended to focus on the patients issues rather than what is necessary to help other staff members understand requirements to mitigate the risks of a potential fall. • Nurse perception of risk in relation to patient falls varied. • Abbreviation of terminology within two of the FBHMA. • Fifteen of the 42 forms were not completed within a six-hour timeframe in accordance with the Policy.	Potential risk of: • FBHMA assessments are not completed appropriately and do not identify requirements to mitigate the risk of patient falls.

Recommendations		**Priority**
2.1a	Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	**High**
2.1b	To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered.	
2.3c	Reminder to staff that all FBHMAs are to be completed upon patient transfer between wards. Compliance with this should be reviewed through existing audit mechanisms.	

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1a	• Health Board mandatory training Falls Prevention E learning module 1b relating to the FBHMA has been updated;	Completed	Deputy Executive Director of Nursing

2.1b	• How to guide/good practice guide to support Adult Inpatient with completion and quality of FBHMA to be developed and implemented across all Adult Inpatient wards; • In addition to the established Health Board monitoring mechanisms, an additional level of monitoring/coaching to improve the quality of the risk assessments will be implemented across the Adult Inpatient wards, this will be a peer review process completed by suitably trained registrant. This will be a pilot of 3 months, evaluate outcomes and present recommendation to the Strategic inpatient falls Group for sustainable model. • The Welsh Nursing Care Record currently does not auto populate with patient detail such as mobility status form the admission assessment section into the FBHMA. This will be future enhancement to the Welsh Nursing Care Record on an all-Wales basis. To mitigate this risk: o the Health Board Training resources stress the requirement for using this detail to promote accurate and consistent patient profile.	30th November 23 1st February 24 1st February 24 then ongoing	Deputy Executive Director of Nursing
2.1c	• Training resources outlined 2.1a will include the re enforcement of when the FBHMA requires review and updating in line with national standard. • The B6 Clinical MH Advisors now lead the patient risk assessment bedside learning programme (for falls and patient handling risk assessments) for the H&S team.	30th October 23	

Matter Arising 3: Training (Operation and Design)			**Impact**
At the time of writing this report only 59% of staff had completed the Health Boards patient handling training. Other issues relating to training include: • Safeguarding training does not reference post falls management. • Bedside learning is presently done on ad hoc basis due to resource constraints. • There is no overview of the training undertaken by agency staff relating to patient falls, to ensure they are aware of the requirements when completing falls documentation.			Potential risk of: • Staff are not trained appropriately in falls management, resulting in increased risk of patient falls.
Recommendations			**Priority**
3.1a	To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.		**High**
3.1b	Review Safeguarding training to include post falls management.		
3.1c	Consider a more formal training method for the bedside learning programme, and consider resources required to provide this to staff. Ensure records of training are kept.		
3.1d	Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation.		
Agreed Management Action		**Target Date**	**Responsible Officer**

3.1a	Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce Internal training facilities to be identified by each IHC by December 2023.	January 2024	Head of Health, Safety and Security
3.1b	MH corporate team to progress contract arrangements for external training facilities to support capacity by December 2023. Text messaging reminders for booked training session to be implemented to reallocate capacity from Did Not Attend (DNA) individuals.	30th December 23	Head of Health, Safety and Security
3.1c	Health Board Falls Lead to make a formal request to the Safeguarding all Wales programme regarding consideration of safeguarding following recurrent falls. Falls lead to include Safeguarding matrix within the revised Falls Policy NU06 to support staff as to when to refer/engage Safeguarding following recurrent falls.	1st April 24	Deputy Executive Director of Nursing
3.1d	Bedside learning programme to be recommended as a formal programme of training that will be implemented collaboratively with IHC Practice Development Nurses, Corporate Patient Safety team and Health & Safety team.	1st December 23	Head of Digital Workforce and Resourcing

	Scope of what training agency staff (58 external agencies part of the All Wales Framework) receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation. • Temporary Staffing team for the Health Board to ensure the agencies have access to the Health Board e learning packages and are encouraged to complete; • the Health Board are amending and implementing the agency worker ward induction documentation to include familiarisation with risk assessments.	Complete Completed	Head of Digital Workforce and Resourcing

Matter Arising 4: Governance (Operation)			**Impact**
Although there has been evidence of lessons learned, it is not clear if there is a standardised process in place for identifying themes, patterns, and lessons learned. Staff are completing the lessons learned section of DATIX however not all information inputted relates to lessons learned. Our sample findings do not correspond to the high percentage scores that the weekly and monthly matrons audits are achieving in regard to the FBHMA completion of accuracy.			Potential risk of: • Repeated falls incidents taking place due to lack of learning and sharing of information.
Recommendations			**Priority**
4.1a	The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.		**High**
4.1c	Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated / reported as appropriate, and to deter staff entering a full stop or a dash in the section.		
4.1d	Review the ward accreditation audits on the FBHMA to establish if the audits can include specific questions on detail that give a true reflection of the patient requirements.		
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1a	The revised Health Board policy NU06 outlines the following process for Inpatient falls to support identification of themes, trends and learning as follows: • Hot debrief on the ward following the fall for immediate learning and mitigation; • All falls are reviewed daily by local quality teams; • All falls are subject to focused review contained within Datix system;	1st December 23	Deputy Executive Director of Nursing

	• All falls identified as harm being Moderate or above will have a Make it safe review within 72 hrs; • All falls identified as serious harm will have an executive led Rapid Learning Panel (RLP) which may then lead to an external investigation to identify potential additional learning opportunities. • The Health Board will communicate the revised policy NU06 via Health Board communication channels in addition core Health Board meetings. • Ongoing Monitoring will be via Patient Safety team.		
4.1b	• Each Integrated Health Community (IHC) Health Board has established weekly harms review meeting that includes Inpatient Falls, to improve the sharing of lessons learned the Health Board will develop a SOP to ensure standardised practice across the IHC's.	30th December 23	Deputy Executive Director of Nursing
	• The Health Board Patient Safety team will provide a weekly report from Datix of the previous weeks closed incidents to monitor quality of completion to be sent to IHC Directors of Nursing and IHC Governance leads to action locally this will be an ongoing process;	Completed	Deputy Executive Director of Nursing
	• The Health Board Patient Safety team will provide training and support to clinical teams to include best practice, lessons learned etc due to commence November 23 and will be an ongoing programme of training and support across the Health Board.	20th November 23 then ongoing	Deputy Executive Director of Nursing
4.1c	The ward accreditation metrics are currently under review as part of the Health Board Ward Accreditation review. The revised metrics will be tested across the Health Board Inpatient wards to confirm the appropriateness and level of detail within the metric.	1st April 24	Deputy Executive Director of Nursing

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Follow Up Review of Follow Up Outpatient Services – Betsi Cadwaladr University Health Board

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Contents

Summary report

About this report

1 Patients who receive an appointment in a hospital or clinic but do not need to stay overnight, are categorised as outpatients. The appointment may be for treatment, diagnosis, or a procedure. If subsequent appointments are arranged with the healthcare professional, these are categorised as follow-up outpatient appointments.

2 We have reviewed follow-up outpatient services at Betsi Cadwaladr University Health Board (the Health Board) twice in recent years. In 2015 the Auditor General carried out a review of follow-up outpatients across all seven health boards in Wales. Our work at the Health Board concluded that: 'The Health Board faces growing numbers of delayed follow-up patients and does not fully know its clinical service risk but is beginning to plan to modernise its outpatient services.' We made five recommendations within the report.

3 In 2017 the Auditor General reported the findings from his assessment of progress against the 2015 recommendations at the Health Board. Our overall conclusion was that the Health Board had made progress, but it still needed to improve the way it identified clinical risks and incidents, quicken the pace of service improvement, and reduce the backlog of delays.

4 Since we last looked at this area, NHS services have seen dramatic changes to demand and service delivery. The outbreak of COVID-19 led to an initial cessation of new planned care activity in Wales. The gradual recovery of planned care activity was accompanied by a shift towards virtual appointments. Together these factors helped some health bodies reduce their follow up outpatient waiting list.

5 The planned care backlogs caused by the pandemic have resulted in increased Referral to Treatment (RTT) pathway waits and an associated deterioration in performance in respect of waiting times for follow up outpatient appointments.

6 In June 2022, the Health Board developed a Planned Care Transformation Programme which articulates how it intends to address the significant challenges it faces in relation to planned care services and the significantly increased waiting lists. There are four workstreams in place to deliver the specific elements of the Planned Care Transformation Programme. Workstream two is termed 'prudent outpatients' which is focussed on outpatient improvement.

7 This report sets out the findings from our most recent work on follow up outpatient services at the Health Board. Our work sought to answer the following overall question: 'Are there effective arrangements to address long follow up outpatient waits and develop sustainable outpatient services in future?' Our key messages are set out in the following section with more detailed information provided throughout the rest of this report.

Key messages

8 The overall conclusion from our latest review is that the Health Board has made limited progress in implementing our previous audit recommendations on follow up outpatients and continues to carry significant clinical risks associated with delayed follow up appointments across a number of specialties.

9 Our fieldwork found that the Health Board has made some improvements to its follow up outpatient services. In response to our previous audit recommendations, the Health Board has:

- ensured it is appropriately reporting its follow up outpatient wait figures to Welsh Government;
- improved the provision of management information on follow up outpatients to clinicians and managers;
- started a programme of work to develop new approaches for, and improvement of follow up outpatients.

10 However, overall progress has been slow. Of the five original recommendations from our 2015 report, only one is fully complete and further work in required fully implement the remaining recommendations.

11 Our fieldwork identified that arrangements for reporting and oversight of clinical risks associated with delayed follow up appointments still require strengthening. There are significant and growing waiting lists with alarmingly long follow up outpatient delays within specific specialties such as ophthalmology. The Health Board should have clear plans for monitoring and managing these clinical risks at specialty level. These need to be overseen corporately and should provide regular assurance to the Board on the effectiveness of actions taken.

12 The Health Board's outpatient improvement programme is successfully driving the ongoing implementation of the 'See on Symptom' and 'Patient Initiated Follow Up' pathways. These have the potential to increase efficiency and patient experience. However, while the Health Board is continuing to invest in its outpatient improvement programme, there remain several challenges and risks that are inhibiting the levels and pace of improvement needed. These include lack of clinical leadership for the improvement programme, and lack of clarity on the recurrent resources available for improvement activity.

13 Since our 2015 report, the overall numbers of patients waiting for a follow up outpatient appointment at the Health Board have increased substantially. Most of those patients who are delayed are waiting at least twice as long as they should be (100% delayed). Many of those are in specialties where their condition could increase the risk of harm because of a delay.

14 The Health Board must work at pace to address the increasing follow up outpatient waiting lists and delays patients face in receiving a follow up appointment. As part of this there is a need to better manage clinical risks associated with delayed follow up appointments. To do so, the Health Board will need to carefully consider how

services become more efficient as well as what further, longer-term resourcing it will require to achieve sustainable improvements to follow up waits.

Recommendations

15 In the main, the recommendations we made in 2015 are still valid and appropriately cover the areas where our audit work has identified a need for improvement. The Health Board needs to strengthen its clinical leadership of follow up outpatients and reinvigorate its efforts to ensure it fully implements the outstanding recommendations from our previous audit work. We have made additional recommendations to that effect (**Exhibit 1)**.

Exhibit 1: New recommendations in respect of follow up outpatients.

New recommendations	
R1 (2003)	Take immediate steps to strengthen the clinical leadership for the programme of work to improve follow up outpatient performance
R2 (2003)	Develop a refreshed management response to the outstanding 2015 audit recommendations that identifies clear actions to fully implement the recommendations, timescales for implementation and the officers responsible.

Detailed report

The Health Board has made limited progress in delivering significant improvement to follow up outpatients and implementing our previous audit recommendations

16 This section of the report focusses on the progress the Health Board has made in implementing new follow up outpatients care pathways alongside an assessment of progress on the recommendations that we made in 2015. We assessed:

- Follow up outpatient related aspects of the planned care transformation programme; and
- actions that the Health Board have taken in relation to our previous recommendations and what more may need to be done.

The Health Board is taking action to help improve outpatient services as part of wider planned care improvement. However, there is a need to broaden work on the outpatient programme to tackle long waits for follow up appointments

17 In June 2022, the Health Board developed a Planned Care Transformation Programme which articulates how it intends to address the significant challenges it faces in relation to planned care services and the significantly increased waiting lists. Of the differing Planned Care workstreams, workstream two focusses on outpatient improvement. The outpatient improvement work covers broad elements of improvement, including:

- See On Symptom pathway[1];
- Patient Initiated Follow Up pathway[2];
- Remote and e-Consultation - Virtual clinic appointments and video group clinics;
- Once for North Wales: Outpatient principles;
- Centralised booking; and
- Validation, including review of Did Not Attend policy.

18 Due to capacity and clinical leadership constraints, not all the areas have progressed equally. The Health Board prioritised its work on the See On Symptom and Patient Initiated Follow Up pathways but other areas are slower to progress.

[1] The See on Symptom pathway supports patients with short-term conditions. It allows the Health Board to discharge a patient into the community earlier and then enables them to book an appointment if needed, such as symptoms re-emerging.

[2] Patient Initiated Follow Up provides access for patients with chronic long-term conditions when they need it.

The aim of the new pathways is to enable patients to access care when they most need it to help manage their condition, rather than relying on routine appointments which sometimes are not needed. As a result, this can release outpatient clinic capacity. However, the new pathways are not suitable for all patients, and Welsh Government has set a target of 20% of patients managed through these new approaches.

19 The Health Board has prioritised the introduction of these new pathways. It met its internal target of implementing 10 See on Symptom and Patient Initiated Follow Up Pathways by March 2023. Overall though, it is not meeting the Welsh Government target of 20% of patients on new pathways. As of March 2023, 9.1% of patients moved to these new pathways, albeit this is an improvement on the 5.8% achieved in November 2022.

20 While there is progress with the introduction of new outpatients approaches, the introduction of See on Symptom and Patient Initiated Follow Up pathways will only go so far in addressing the large numbers of patients waiting for appointments. There is an urgent need for the Health Board to ensure effective delivery of its wider outpatient improvement programme achieves improvements in follow up outpatient performance.

The Health Board has made limited progress in implementing our previous audit recommendations

21 It is eight years since we issued our original recommendations, and there are key areas that continue to require attention. The status against each of the previous recommendations is set out in **Exhibit 2**. **Exhibit 3** provides our summary assessment of progress against these. We recognise that the Health Board has taken some action to address these recommendations. However, given the deteriorating follow up outpatient waiting list performance, it is clear that greater priority is needed.

Exhibit 2: status of 2015 recommendations

Total number of recommendations	Implemented	Ongoing action	No action	Superseded
5	1	4		

Source: Audit Wales

Exhibit 3: assessment of progress against 2015 recommendations

Original recommendation to be addressed[3]	Summary of progress
R1 **Implemented** - Comply with Welsh Government reporting requirements by reporting on the numbers of both booked and un-booked follow-up outpatients, in line with the revised all Wales template.	In 2017 we reported that this recommendation was implemented. Our latest fieldwork confirms that the Health Board continues to comply with Welsh Government reporting requirements for reporting numbers of booked and not booked follow-up outpatients.
R2 **In progress -** Develop the business information warehouse approach for follow-up outpatients by: • expanding the scope, depth, and detail of information available to ensure management and staff can access operational information relevant to their departmental business need.	Building on progress we found in 2017, the Health Board is improving the outpatient services business intelligence systems to help staff better manage services. The Health Board has introduced a follow-up waiting dashboard to capture data on the See on Symptom and Patient Initiated Follow Up pathways. The dashboard information is live and forms the basis of regular outpatient steering group meetings. The Health Board also compares its performance on this dashboard with other Health Boards to identify learning and good practice. However, the Health Board's dashboard is currently limited to the See on Symptom and Patient Initiated Follow Up pathways. The Health Board are currently pulling together information across the outpatient programme to include within the dashboard, which should progress during 2023.
• use the information to reduce clinical variation across sites, clinical conditions and amongst clinicians.	Whilst the Health Board is still developing the dashboard, it has improved staff access to outpatient services information. The dashboard helps to identify clinical variation in managing follow-up appointments by providing a picture of activity by group, specialty, and consultant. But we understand this this hasn't yet reduced the extent of variation of follow up outpatient waits across sites and by specialty. The Health Board is sighted of the highest users of the new See on Symptom and Patient Initiated Follow Up pathways.

[3] Green indicates that the recommendation has been implemented; Amber indicates ongoing action to address the recommendation; Red indicates that insufficient or no action has been taken; and Blue indicates that the recommendation has been superseded.

Original recommendation to be addressed[3]	Summary of progress
• using the information to learn from 2014-15 activities to both profile and reduce follow-up not booked (FUNB). Seek to understand why profiling was not as expected and build this into trajectories for 2015-16 (**Superseded**).	This part of recommendation 2 is now out of date and no longer requires action.
R3 **In progress** - Identify clinical conditions across all specialties where patients could come to irreversible harm if delays occur in follow-up appointments. Develop targeted interventions to minimise the risk to patients with these conditions who are delayed beyond their follow-up target date.	The Health Board's Integrated Health Communities are responsible for managing their follow-up outpatient waiting lists, including having oversight of patients facing clinical risks due to long waits. Given the very high levels of patients delayed on the follow up outpatient waiting list, many within specialties managing high-risk conditions, we remain concerned about the level of risk and potential harm coming to patients. At present, actions being taken to reduce harm resulting from delays are not sufficiently effective. We recognise that the Health Board has improved its focus on cancer patients with a cancer harms review process in place. However, this needs to be broadened out to cover all patients that have waited longer than their expected time. The Health Board has explored technological solutions to identify clinical risk. However, it is currently operating a paper-based system, which inhibits the ability to effectively identify, escalate and prioritise those at highest clinical risk of harm. In absence of this, the Health Board needs to strengthen its current manual processes of monitoring and managing clinical risks in relation to its follow-up outpatient lists.
R4 **In progress** - Improve the reporting of clinical risk information in relation to delayed follow-up outpatients to ensure that:	There has been limited progress in implementing this recommendation. Where there are incidents of harm resulting from delays, we are not assured that these are

Original recommendation to be addressed[3]	Summary of progress
• incidents of harm resulting from delays are analysed, escalated, and reported; and • scrutiny and assurance focus on the high-risk specialties and clinical conditions	effectively analysed and reported to help inform management where to focus and prioritise action. There is some evidence of tracking outpatient performance at Board and committees but again these do not sufficiently cover clinical risk implications nor targeted action to reduce the clinical risk to patients.
R5 **In progress** - Identify and put in place the change management arrangements and resources needed to accelerate the pace of delivery for long-term outpatient transformation, including: • clinical resources, including medical, nursing, and allied health practitioners; • change management capacity and capability; • internal and external engagement with stakeholders. • primary and community care leadership capacity to support outpatient modernisation;	Most posts within the Health Board's planned care team are funded by the Welsh Government non-recurrent funding, rather than directly from the Health Board's budget. There is a small team in place to deliver the Health Board's outpatient improvement programme. During 2022, the team primarily focussed on the roll-out of See on Symptom and Patient Initiated Follow Up. This is reflected in the progress made with implementing these pathways in 2022, while progress for other schemes has been slower because of limited team capacity. The Health Board received £146,500 in funding for outpatient transformation from Welsh Government for 2022-23. Those we spoke to during the fieldwork raised some concerns that the process to allocate funding to various projects was not effectively targeted. We were unable to review the funding decision-making process due to turnover of staff within the team. The Health Board should however ensure the process for allocating non-recurrent funding is formalised, robust, prioritised and focusses on sustainable improvement. At the time of our fieldwork, there was no dedicated clinical leadership in place for the outpatient programme to support clinical engagement (**Recommendation 1, 2023**). The absence of a specific clinical lead for outpatient service transformation has led to a reliance on a small number of consultants within specialties to volunteer as informal advocates. Consequently, there is a lack of consistent clinical leadership to drive the clinically led change for outpatient services. In addition, corporate support for the Health Board's outpatient transformation programme has

Original recommendation to be addressed[3]	Summary of progress
• the need to start health economy care pathway redesign early, and deliver this concurrently with other improvement initiatives (**Superseded**); and • applying lessons learnt from other recent related projects (**Superseded**).	been fragmented and unstable, with fluctuating staffing levels due to staff leaving or accepting secondments outside of the team. There are regular meetings in place between the operational manager for outpatient transformation with leaders from primary care across the Health Board. These have focussed predominantly on the roll-out of 'Consultant Connect' online consultations, in late of the outpatient improvement programme. The last two points in the recommendation have been superseded.

Continuing concerns around delayed follow up outpatient appointments highlight the importance of implementing our audit recommendations as part of wider outpatient improvement activities

22 This section of the report focusses on follow up outpatient waiting list performance. In doing so we assessed the following criteria, i.e., whether the Health Board is:

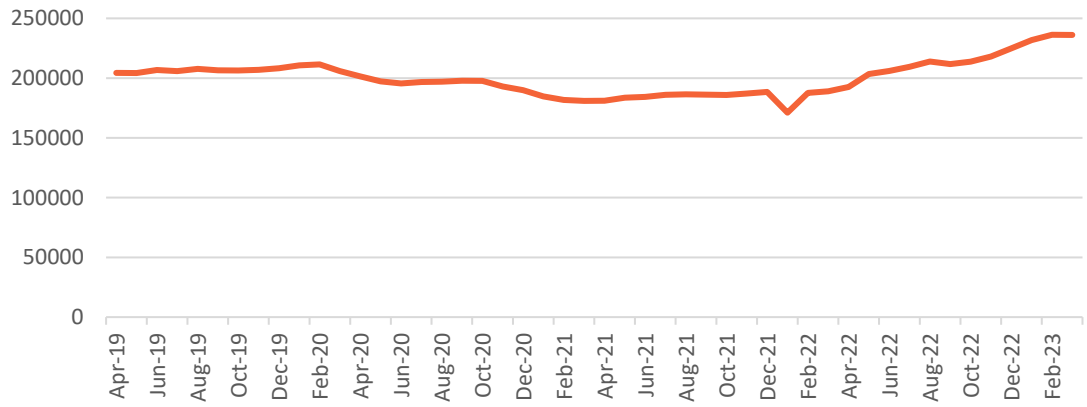
- successfully managing growth in the follow up waiting lists; and
- reducing the levels of patients that are experiencing a significant delay.

The number of patients waiting for a follow up appointment has grown substantially in recent years

23 Between April 2019 and March 2023, the follow up outpatient waiting list grew from 204,421 to 236,115 patients (**Exhibit 4**). This is an increase over this period of over 31,000 patients. Looking back further, there are now over twice as many patients waiting than when we first reported on follow up outpatients, in 2015.

24 It is likely that follow up demand could grow which would increase waits further. The Health Board received a record level of referrals for elective care (referral to treatment) during 2022-23 and this is resulting in high overall referral to treatment waits. But as the Health Board increases its capacity and activity levels to address high elective waits, many of those patients who are treated will subsequently increase demand for follow-up appointments.

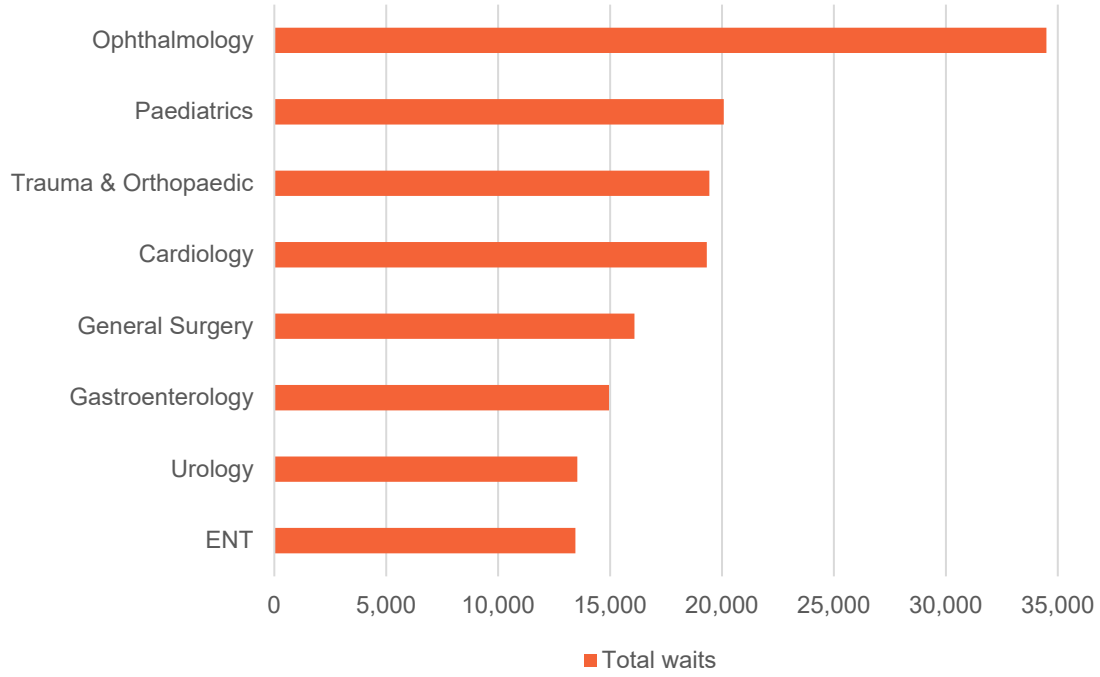
Exhibit 4: Trend in the numbers waiting for a follow up outpatient appointment, April 2019 to March 2023



Source: Audit Wales analysis of Betsi Cadwaladr University Health Board data submission

17 Within the shortlist of specialties highlighted in **Exhibit 5**, there are significant numbers of patients waiting for a follow up outpatient appointment. Some specialties have also seen much more extreme growth in demand than others. For example, gastroenterology and cardiology has seen its demand grow 91% and 65% respectively between April 2021 and February 2023. This suggests targeted action is needed to ensure capacity meets demand.

Exhibit 5: Specialties with the largest follow up waiting list, March 2023



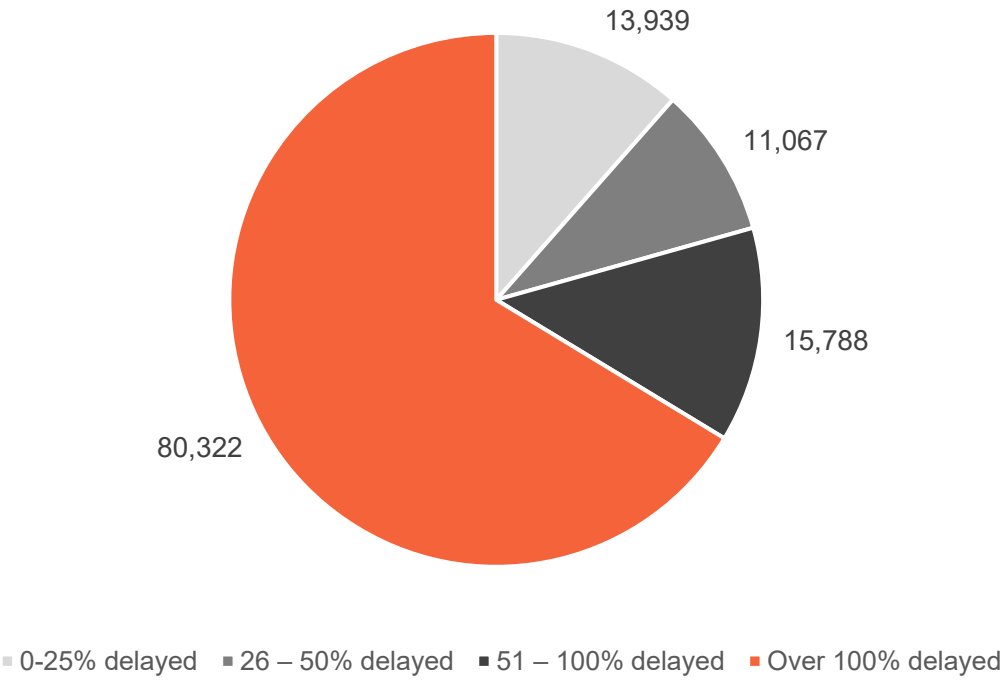
Source: Betsi Cadwaladr University Health Board data submission

A large number of patients are experiencing delays in receiving their follow up appointments, increasing the risk of harm for many individuals

18 The number of patients delayed past their target date is very concerning. Many patients waiting may not experience any harm while experiencing a delay. For others their condition may deteriorate, they could come to serious irreversible harm and experience discomfort potentially leading to inability to work or remain independent at work. In March 2023, 121,116 of the 236,115 patients (51%) waiting for an appointment were delayed (i.e. had breached their target date). Of greatest concern are those that are delayed the most.

19 As **Exhibit 6** shows below, of those 121,116 patients delayed, the majority (66%) of patients are waiting at least twice as long for their follow up appointment than they should be i.e., they are delayed over 100% past their target date.

Exhibit 6: Total number of patients waiting for follow-up who are delayed past their target date (shown as a percentage delayed past their target date), March 2023



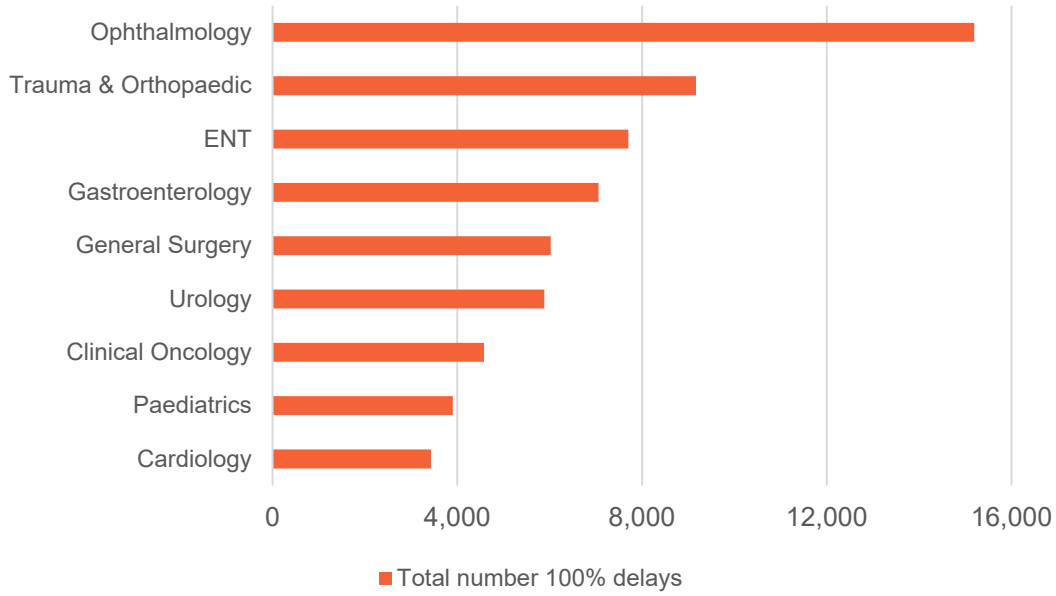
Source: Betsi Cadwaladr University Health Board data submission

Note: Different health conditions require different timeframes for a follow up appointment. As a result, NHS Wales reports the extent that a clinical target date is exceeded (i.e. the percentage that a patient has passed their target date. A 50% delay for someone with a target date for an appointment of 4 weeks would see them waiting 6 weeks. But it is also the case that someone with a clinical target date of 6 months who waited 9 months is also 50% delayed.

20 Some of the patients waiting over twice as long as they should be in specialties which have high levels of extreme delays and high risk of harm (**Exhibit 7**). For example, ophthalmology services have the largest follow-up waiting list. As of March 2023, there were 34,945 patients waiting of which 15,194 had waited over twice as long as they should have for a follow-up appointment. Ophthalmology is a high-risk specialty in respect of the harm that could result from delayed follow up appointments. The Royal College of Ophthalmologists has stated that 'Permanent harm from delays to care, in terms of avoidable visual loss, is 9 times more likely to happen in follow-up patients than in new patients.'

21 There are clinical conditions in other specialties that also result in significant patient risk because of delays. It is therefore imperative that the Health Board effectively reduces its waits, and crucially, that there is proactive management of patients at higher clinical risk of harm.

Exhibit 7: Specialties with the highest number of patients waiting twice as long as they should be for a follow up appointment (i.e., 100% delayed), March 2023



Source: Betsi Cadwaladr University Health Board data submission

Appendix 1

Management response to recommendations

Exhibit 8: Response to new recommendations made in 2023.

The table below shows the new recommendations made in 2023 as part of the follow up outpatients review.

Recommendation		Management response	Completion date	Responsible officer
R1 (2023)	Take immediate steps to strengthen the clinical leadership for the programme of work to improve follow up outpatient performance.	A refreshed Planned Care Programme has been initiated which covers outpatient transformation initiatives. All supporting work streams have a clinical and managerial lead appointed and the programme has an overall senior clinical lead from the Executive Medical Director's Office.	Completed	Interim Executive Director of Operations
R2 (2023)	Develop a refreshed management response to the outstanding 2015 audit recommendations that identifies clear actions to fully implement the recommendations, timescales for implementation and the officers responsible.	Set out below		

Response to 2015 recommendations not yet complete.

Note: To ensure that the Health Board only responds to the outstanding areas of previous recommendations, we have removed the aspects of previous recommendations in the following table that we consider are either complete or superseded.

Recommendation	Management response	Completion date	Responsible officer
R2 Develop the business information warehouse approach for follow-up outpatients by: • expanding the scope, depth, and detail of information available to ensure management and staff can access operational information relevant to their departmental business need. • use the information to reduce clinical variation across sites, clinical conditions and amongst clinicians.	We have established a set of planned care dashboards which now allow drill through to individual patient level detail ensuring we can manage our areas of challenge in a consistent way and with a single approach thereby reducing potential variation.	Dashboards launched in July 2023	Interim Executive Director of Operations

Recommendation		Management response	Completion date	Responsible officer
R3	Identify clinical conditions across all specialties where patients could come to irreversible harm if delays occur in follow-up appointments. Develop targeted interventions to minimise the risk to patients with these conditions who are delayed beyond their follow-up target date.	We continually review our areas of risk and our follow up reduction programme is working to ensure that we maximise the use of PIFU and SOS pathway options to ensure that only the patients requiring follow up are being done so on clinical need.	Follow up reduction programme will complete early 2024 but ongoing work to maximise follow up alternatives will be ongoing	Interim Executive Director of Operations
R4	Improve the reporting of clinical risk information in relation to delayed follow-up outpatients to ensure that: • incidents of harm resulting from delays are analysed, escalated, and reported; and • scrutiny and assurance focus on the high-risk specialties and clinical conditions	This risk is held on the risk register of each of the high-risk specialities, with any episodes of patient harm reported via Datix.	ongoing	Interim Executive Director of Operations

Recommendation	Management response	Completion date	Responsible officer
R5 Identify and put in place the change management arrangements and resources needed to accelerate the pace of delivery for long-term outpatient transformation, including: • clinical resources, including medical, nursing, and allied health practitioners; • change management capacity and capability; • internal and external engagement with stakeholders; • primary and community care leadership capacity to support outpatient modernisation.	The establishment of the BCU Planned Care Programme brings together clinicians and managers across specialties supported by our transformation and improvement team, digital and planning and communications and engagement. Project Board as representatives from Primary Care and the Associate Director for Planned Care sits on the Primary Care Programme Group to ensure improved join up.	In place as of August 2023	Interim Executive Director of Operations

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Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: November 2023

Document reference: 3733A2023

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.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting 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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Contents

Audit, Risk and Assurance Committee update

About this document

1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts – increased fee	Russel Caldicott, Interim Executive Director of Finance	The audit has been completed and the accounts laid at the Senedd. Our detailed audit plan for the audit of the 2022-23 accounts included an estimated audit fee of £282,163. However, we incurred additional costs due to issues identified within the 2022-23 accounts and the qualification matters reported. As a result, we intend to raise an additional fee of £123,000 to cover these costs.	Discussed with Interim Executive Director of Finance	December 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts – post project learning	Russel Caldicott, Interim Executive Director of Finance	We held a post project learning session with the finance team on 5 October 2023. This identified areas of good practice and ways in which we can work together to facilitate the delivery of the audit.	Complete	Not applicable
Charitable Funds: • Planning • Audit of Charitable Fund Financial Statements	Russel Caldicott, Interim Executive Director of Finance	This work involves undertaking risk assessment procedures to identify risks of material misstatement within the Charitable Fund's financial statements. The subsequent design and performance of our audit approach will be responsive to each assessed risk. We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable the Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Planning has commenced	Early 2024

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Progress review of follow up outpatients	Adele Gittoes, Interim Executive Director of Operations	This work assesses the progress made in addressing the recommendations made in our 2015 report in the context of the current organisational performance.	Report finalised	November 2023
All Wales thematic work on Unscheduled Care Arrangements: Phase 1 work on patient flow and discharge planning	Adele Gittoes, Interim Executive Director of Operations	This work has been carried forward from the 2020 Audit Plan, after having initially been postponed due to the pandemic. Our phase one work has examined discharge planning arrangements and patient flow. We will assess the Health Board's progress against the 2017 audit recommendations we made on discharge planning. We are also producing a report for the Health Board and its partners on the Regional Partnership Board that describes progress being made in developing whole system solutions to delayed discharges.	Draft reporting	January 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic on workforce planning arrangements	Jason Brannan, Deputy Director of Workforce & Organisational Development	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	We are expecting to issue the draft report in November 2023	January 2024
Follow-on work on board effectiveness	Carol Shillabeer – Chief Executive Officer	This work will consider the progress the Health Board has made in addressing the concerns on board effectiveness identified in the Auditor General's report in the public interest in February 2023.	Fieldwork in progress	January 2024
Structured Assessment 2023	Carol Shillabeer – Chief Executive Officer	Our core structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 core Structured Assessment work will review: • Corporate systems of assurance; • Corporate planning arrangements; and	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		• Corporate financial planning, management, and performance arrangements. Please note that board effectiveness, which is normally part of our core structured assessment work, will be considered separately in the follow-on work that has been referenced above. In addition to the core structured assessment work, we will also undertake “deeper dive” work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans. The focus of this work is currently being developed and further details will be shared in due course.		
Local thematic project: Use of additional Welsh Government	Interim Director of Finance	We had originally planned to include work in our 2023 Audit Plan that would examine how the Health Board had used the additional strategic Welsh Government	To be deferred for inclusion in the 2024 Audit Plan	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
strategic assistance funding		funding that was allocated to the Health Board following de-escalation from Special Measures in November 2020. However, the scope of our urgent follow up work on board effectiveness has consumed all of the time that was allocated for local thematic work within our Audit Plan. We therefore propose to defer the work on tracking the use strategic assistance funding to the 2024 Audit Plan.		

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
NHS Wales Workforce data briefing	**September 2023**
Approaches to achieving net Zero across the UK	**September 2023**
NHS Wales Finances Data Tool	**September 2023**

Additional information

7 Audit Wales recently consulted on its fee rates. The closure for response was 10 October 2023.

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Audit Wales

NHS Workforce data briefing

September 2023

Report of the Auditor General for Wales

This is an interactive pdf

To navigate through the document please use the buttons on the left side of the page and the links marked with underlined text

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg

The NHS workforce is facing a number of significant challenges

Foreword

The Welsh Government's National Workforce Implementation Plan was published in February 2023 in response to the growing workforce pressures being experienced by the NHS in Wales.

The Implementation Plan, which builds on the 10-year Strategy for Health and Social Care Workforce, is an acknowledgement of the need to accelerate action to address the workforce challenges that the NHS in Wales is currently facing.

Whilst the workforce in NHS Wales has seen notable growth in recent years, long standing issues around recruitment and retention have been magnified and added to by the COVID-19 pandemic. Staff who are tired and at risk of burnout are working in a system that is seeing increased demand as services look to recover and deal with backlogs as well as heightened unscheduled care pressures.

My Taking Care of the Carers report described the positive action that was taken to support staff through the pandemic. However, despite these efforts the NHS workforce continues to be stretched with large numbers of vacancies, higher levels of sickness absence, increasing levels of staff turnover and a continued and growing reliance on temporary and agency staff to fill gaps in the workforce.

The Welsh Government's national implementation plan is timely and needs to be complemented by sound workforce planning within individual NHS bodies. Audit Wales are currently examining the approach to workforce planning in each of the 12 NHS bodies in Wales.

This data briefing is designed to help contextualise that work by bringing together a range of metrics and trends that help illustrate the challenges that need to be gripped locally and nationally. Those challenges are significant and are not unique to Wales, however, they must be tackled if the NHS is to remain fit for purpose and a rewarding place to work.

Adrian Crompton
Auditor General for Wales

Key facts

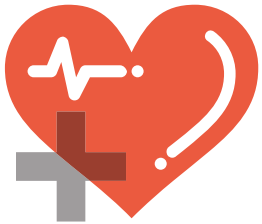
£5.64 billion - Cost of the workforce

£325 million agency spend

1.4 million** working days lost to sickness absence in 2022

Around **6,800** vacancies as at March 2022

9,153 doctors on the GMC register originally trained in Wales of which **3,975** remain in Wales as at February 2023



38,901 nurses educated in Wales of which around **26,500** remain in Wales (Sept 2022)**

27% NHS workforce growth between 2012-13 and 2022-23

91,404 full time equivalent (FTE)* staff - total NHS workforce

Data is for the period 2022-23 unless otherwise stated

*abbreviations and terminology are provided at the back of this briefing

**estimates

Key messages

NHS workforce levels have increased over time, but there is a risk that nursing numbers and the workforce on some medical specialties are not increasing with demand

Workforce costs have grown substantially, because of increasing workforce levels and a shift to a richer staff grade mix

Wales has the joint lowest level of registered doctors relative to population in the UK

Reliance on agency staffing is increasing, it represents around 5.5% (£325 million) of the total workforce costs in NHS Wales

Overall trends show that staff turnover is increasing

There is significant variation in sickness absence but in general, absence levels are high and have grown. The 6.9% sickness absence rate in 2022-23 equates to around 1.4 million working days

NHS Wales is becoming a more flexible and equal employer but there is still more to do

Wales is growing its own workforce, with increased nurses and doctors in training. Despite this, there is still a heavy reliance on medical staff from outside of Wales

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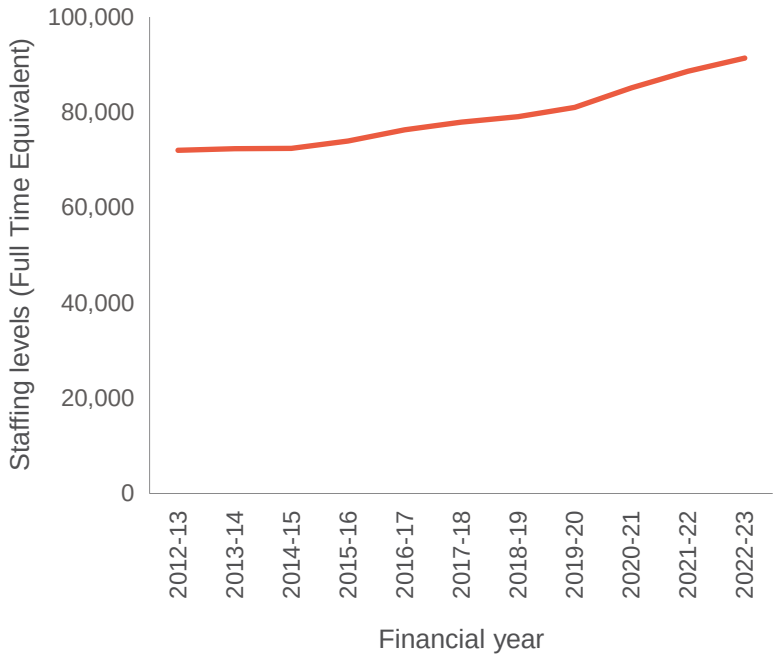
01 How is the NHS workforce changing?

All NHS Wales staffing

Exhibit 1: NHS Wales staff levels, 2012 to 2023



Source: Stats Wales

Between 2012-13 and 2022-23, the overall NHS Workforce in Wales increased by around 27%.

But that growth in staffing is not uniform across all staff groups. NHS Wales has seen ambulance staffing and administration and estates staffing grow substantially.

At the same time healthcare assistants and support staffing levels have reduced and nursing has seen some, but limited growth.

Note: There have been some changes to the definitions for staff groups over this timeframe. This will apply to all 'staff group' related data analysis in this briefing.

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Exhibit 2: NHS Wales percentage change in staff numbers from 2012-13 to 2022-23, by staff group

	2012-13	2022-23	Percentage change
Admin and estates	15039	22731	51.1%
Ambulance staff	1937	2749	41.9%
Scientific, therapeutic and technical	11549	15971	38.3%
Medical and dental	5917	7836	32.4%
Nursing, midwifery and health visiting	31176	36113	15.8%
Other non-medical	124	126	1.8%
Healthcare assistants and other support staff	6259	5878	-6.1%
All staff	**72002**	**91404**	**26.9%**

Source: Stats Wales

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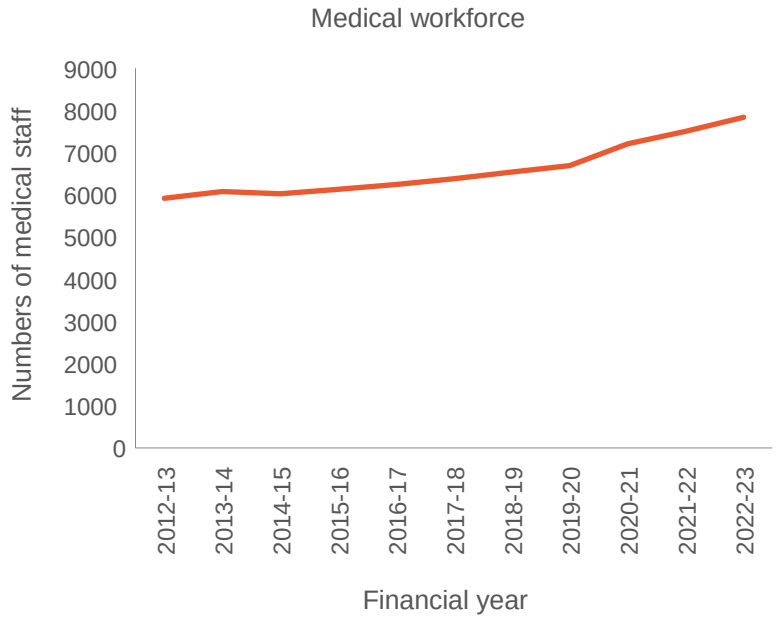
Medical workforce

Exhibit 3 shows an increase of around 32% in the medical and dental workforce over the last decade. As a basic comparison, this is broadly in line with the increase in referrals prior to the pandemic.

Exhibit 3: Change in medical and dental workforce between 2012-13 and 2022-23



Source: Stats Wales

Exhibit 4 shows changes in the numbers of referrals and the medical workforce for selected high-volume specialties. For some specialties, this raises questions around capacity and demand.

Exhibit 4: Change in referrals and staffing between 2012-13 and 2022-23

	% change in numbers of referrals	% Change in medical workforce
General surgery	+28%	+12%
Ophthalmology	+56%	-2%
Ear, Nose and Throat	-1%	+21%
Gynaecology	+29%	+9%
Trauma & orthopaedics*	-5%	+17%

Note: *We anticipate reducing orthopaedic referrals is as a result of community-based services which are helping to manage demand in different ways.

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GP workforce (General Medical Services)

The total numbers of GPs in Wales has remained constant over the last 10 years at around 2,000 (headcount). However, demands on GP services are expected to continue to increase.

This is because the proportion of the population that are elderly is forecast to grow. Linked to this will be an increasing need to manage chronic conditions in the community.

Over the last 10 years the number of the GPs per 10,000 population aged over 65 has reduced by around 14%.

Going forward, we are expecting around a 17% increase in people aged over 65 in the 10 years (Source: Stats Wales).

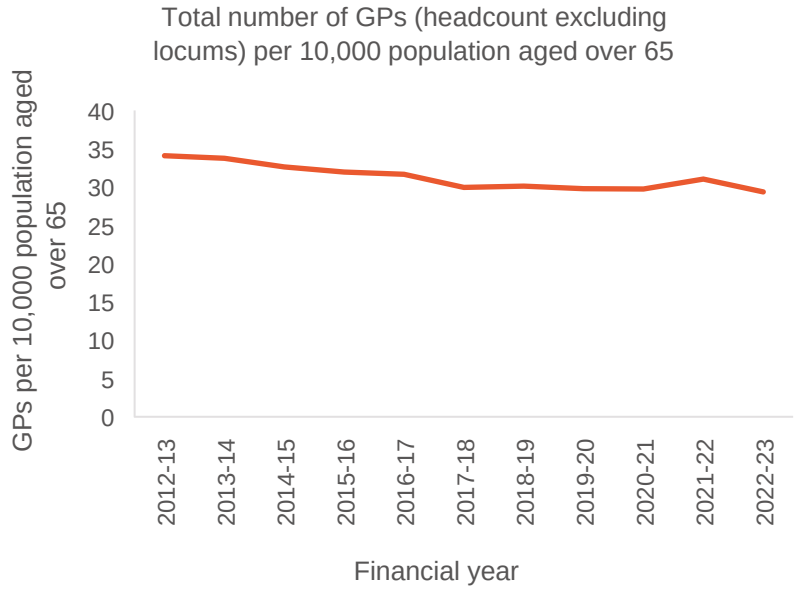
Notes:

A GP (General Practitioner) is doctor who is trained in general medicine and who works in the local community.

GPs are increasingly working part-time which may affect overall capacity in primary care if this continues. As a result, practices are starting to move to multi-disciplinary team models to help meet demand.

Changes to the collection and reporting of GP workforce data may affect comparisons over the 10-year time period.

Exhibit 5: Total number of GPs (headcount) per 10,000 population aged over 65, 2012-2023



Source: Stats Wales

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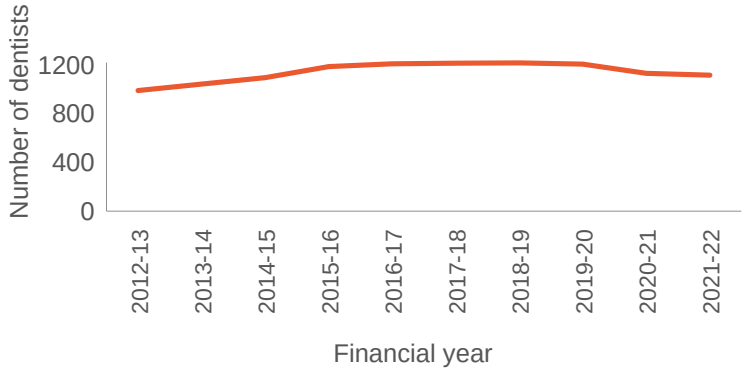
Dentist workforce

Exhibit 6 shows around 13% growth in the numbers of dentists between 2012-13 and 2021-22.

Exhibit 6: Dentist numbers in Wales (headcount)



Source: Stats Wales, General Dental Services

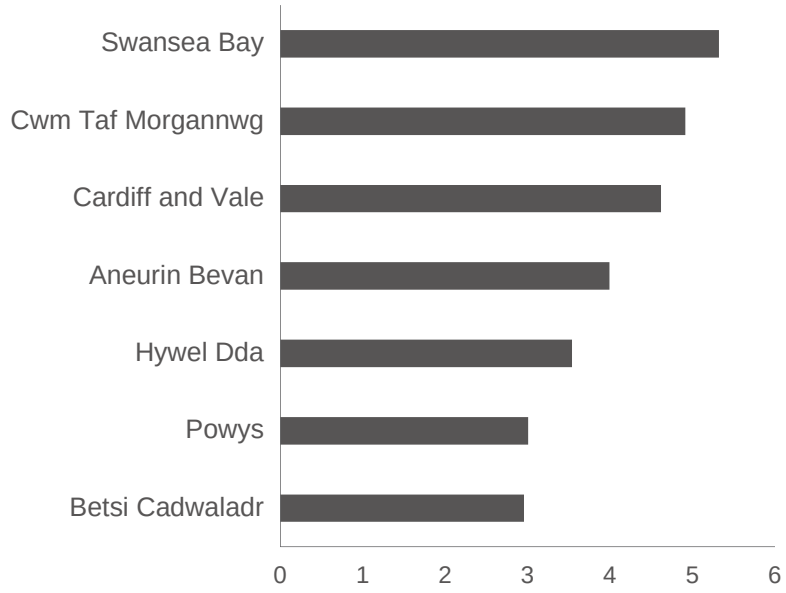
Notes:

Dentist numbers exclude hospital-based dentists. All data relates to 2021-22 with the exception of Scotland, which uses the latest available 2019 data.

The data is presented as 'headcount' and not 'full-time equivalent'. Some dentists will also undertake private work, which limits their capacity for NHS-based community dentistry.

Exhibit 7 shows the variation in registered dentists relative to population in different Health Board areas.

Exhibit 7: Numbers of dentists per 10,000 population (headcount), by health board, 2021-22



Source: Stats Wales, General Dental Services

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Change in grade mix

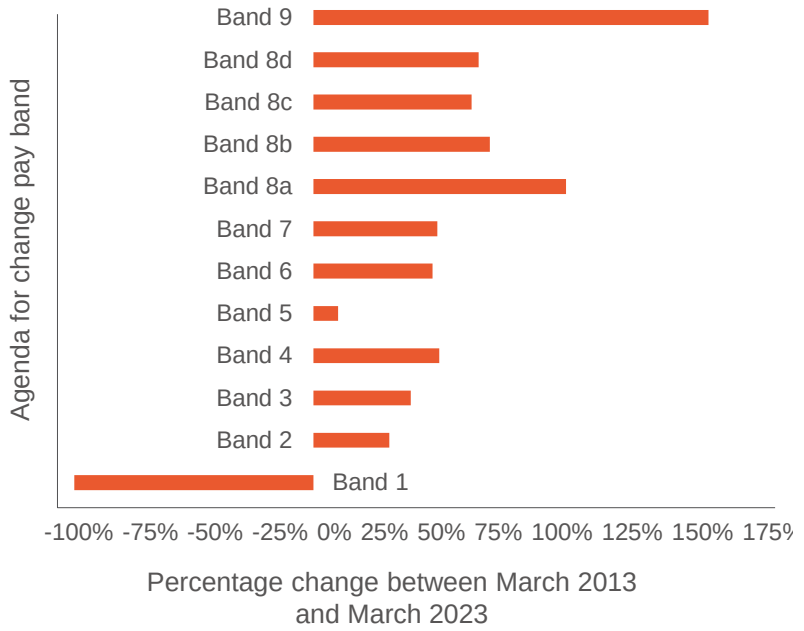
Agenda for Change is the national pay system for the majority of NHS staff.

Agenda for Change pay rates start at around £20,000 for lowest Band 1 and rise to £109,000 once at the top of band 9

Exhibit 8a shows higher pay bands are proportionately increasing at a higher rate. Band 8 and 9 roles are typically senior clinical and management positions. This growth reflects increasing use of advanced practitioners, for example advanced nurse practitioners, who undertake some of the clinical roles previously undertaken by medical staff.

In terms of actual numbers of staff, the greatest increase between 2013 and 2023 is seen at Band 7 and below.

Exhibit 8a: Change in NHS Wales staffing levels between March 2013 and 2023 by 'Agenda for Change' bands 1 to 9



Source: Health Education and Improvement Wales

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Change in grade mix

Exhibit 8b: Change in NHS Wales staffing levels between March 2013 and 2023 by 'Agenda for Change' bands 1 to 9

AFC band	Staff numbers in 2023	Change in staff numbers between 2013 and 2023
Band 9	219	+132
Band 8d	407	+159
Band 8c	879	+334
Band 8b	1430	+580
Band 8a	3554	+1756
Band 7	10260	+3326
Band 6	15875	+5009
Band 5	16886	+1468
Band 4	9034	+2961
Band 3	12247	+3355
Band 2	16367	+3722
Band 1*	129	-1579

*Note: The substantial decrease in Band 1 staff is a result of the scale being closed to new entry staff

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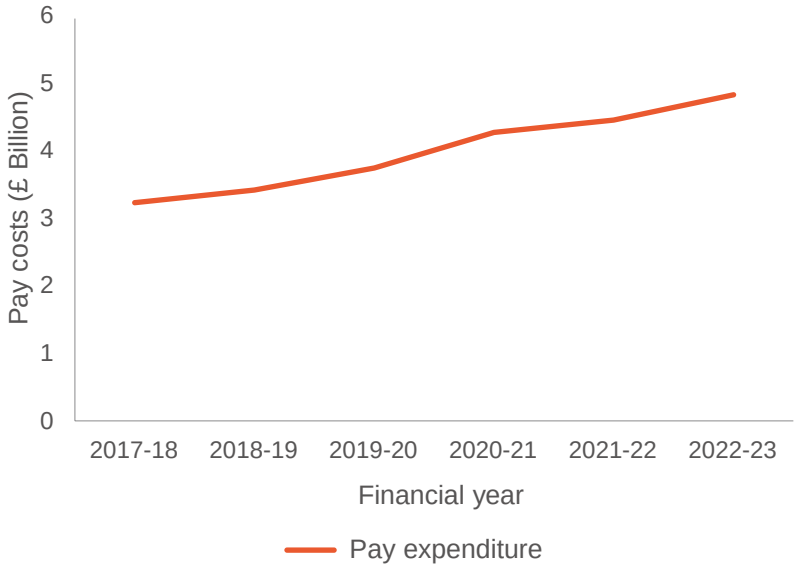
02 What is the cost of the NHS workforce?

Exhibit 9 shows the trend in actual total pay costs for Health Boards, with expenditure on pay increasing by 66% between 2017-18 and 2022-23.

Exhibit 9: NHS Wales Annual Health Board total pay costs



Source: Monthly Monitoring Returns reported to Welsh Government

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Average health board pay costs

Exhibit 10 shows the average Health Board pay costs across Wales. Overall, there is reasonable consistency in pay, although slightly lower pay costs in rural areas.

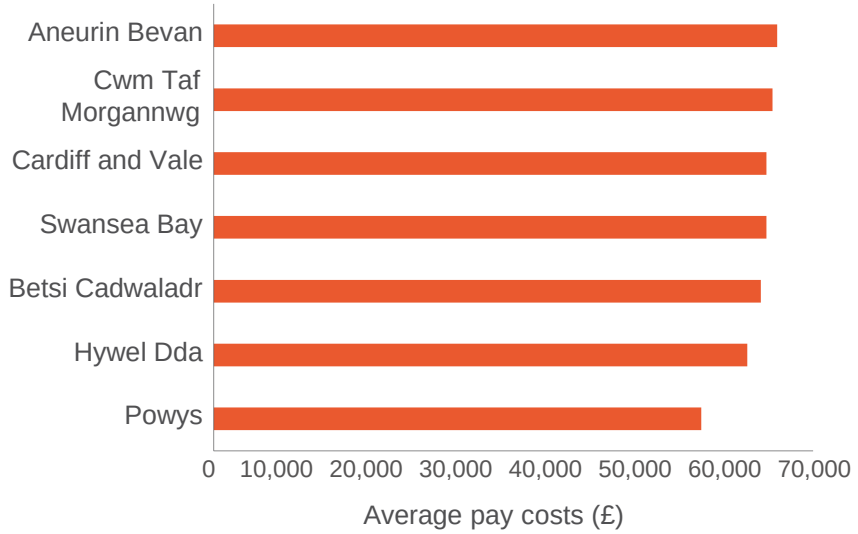
Notes:

Powys Teaching Health Board pay costs will be lower on average, because there is significantly lower medical staffing levels.

Average pay costs do not directly reflect average salary. Total pay costs are higher because they will include employers National Insurance and pension scheme contributions.

The chart shows Health Boards only. We have not analysed the other health bodies in Wales because they provide substantially different functions and would make unfair comparators.

Exhibit 10: Average staff pay, 2022-23



Source: Stats Wales workforce data and Monthly Monitoring Returns reported to Welsh Government

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03 How do NHS workforce levels in Wales compare to the rest of the UK

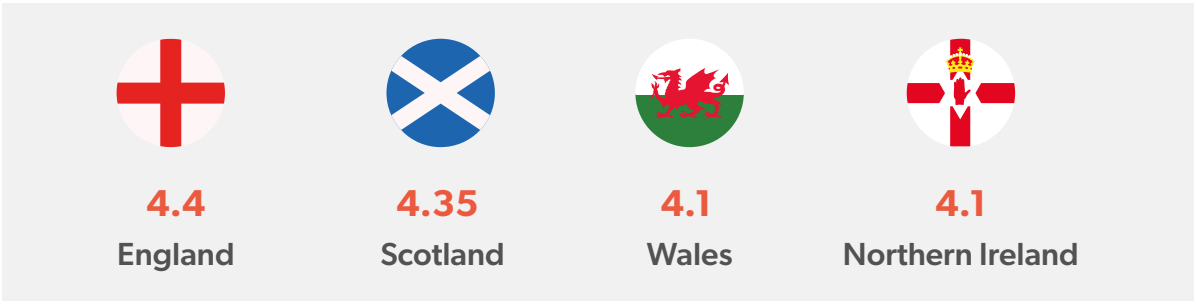
NHS medical and primary care dental staff comparison

Exhibit 11 shows the numbers of General Medical Council registered doctors in Wales, relative to population, is less than in England and Scotland and the same as Northern Ireland.

The data is based on numbers of doctors licenced and registered to practice in each country.

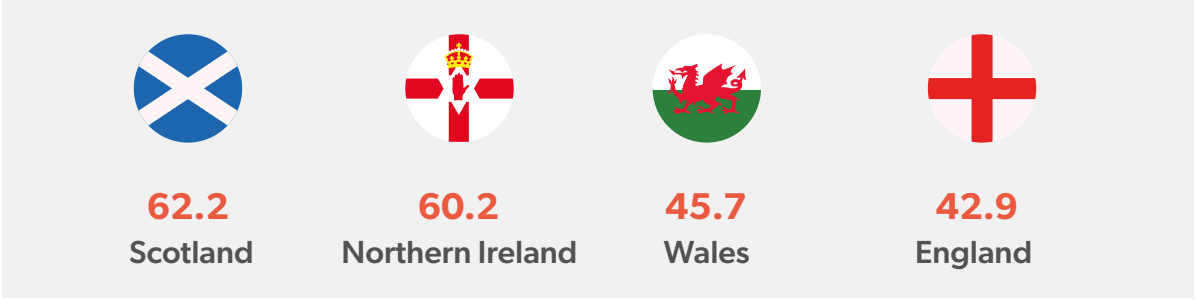
Exhibit 12 shows that comparatively, the numbers of primary care dentists are lower than Scotland and Northern Ireland but higher than England.

Exhibit 11: Number of Doctors (headcount) per 1,000 population, by country, January 2023



Source: Audit Wales analysis of GMC data explorer

Exhibit 12: Number of dentists registered to practice (per 100,000 population), by country, 2021-22



Source: Stats Wales, NHS Scotland, NHS Digital England, Health and Social Care Northern Ireland

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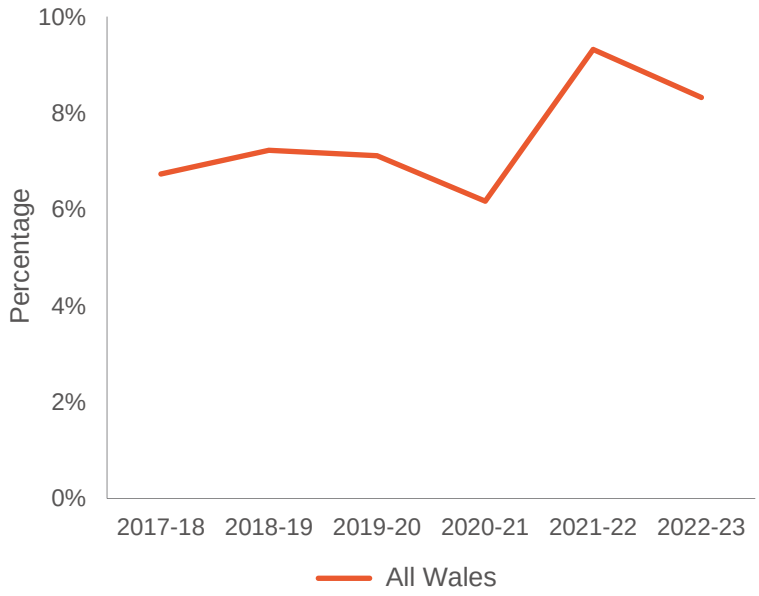
04 What is the recruitment challenge for NHS Wales?

Annual staff turnover

Staff turnover at an all-Wales level has increased in recent years, with a peak in 2021-22 linked in part to staff on short-term contracts employed during the pandemic. In total in 2021-22, over 10,000 FTE staff left NHS bodies in Wales with **Exhibit 14** showing the most common reasons. Highest turnover is seen for registered nursing and midwifery staff groups with over 2,500 leavers whilst **Exhibit 15** shows a variation across NHS bodies. High turnover presents a significant challenge for health bodies in terms of recruitment, induction and associated training costs and it may negatively affect service continuity.

Exhibit 13: All Wales staff turnover as of March of each financial year



Source: Health Education and Improvement Wales

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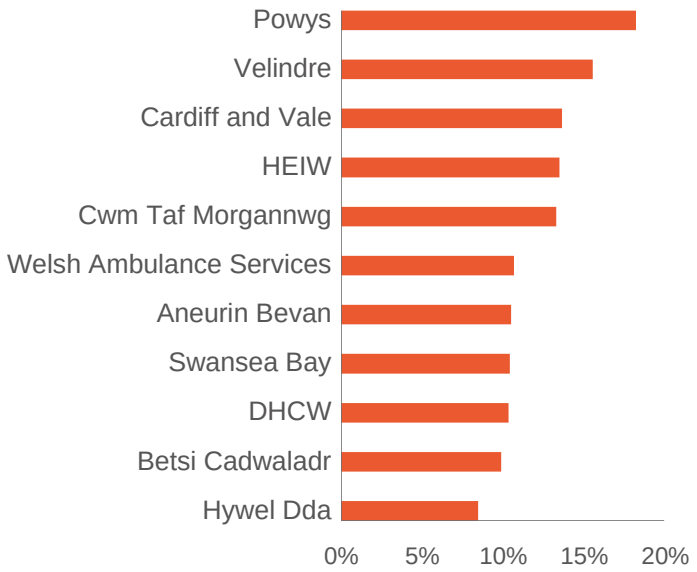
Annual staff turnover

Exhibit 14: 2021-22 staff leavers by reason

Voluntary Resignation - Other/Not Known	30%
Retirement Age	26%
End of Fixed Term Contract	13%
Voluntary Resignation - Relocation	12%
Voluntary Resignation - Work Life Balance	8%

Source: Returns from NHS Wales health bodies

Exhibit 15: Staff turnover by organisation, 2022-23



Source: Health Education and Improvement Wales

Note: individual organisation staff turnover is higher than all Wales because a staff member may move from one organisation in Wales and join another in Wales. This would count as turnover for an individual body. It would not count as turnover at an all-Wales level. All Wales turnover only includes staff leaving NHS Wales completely.

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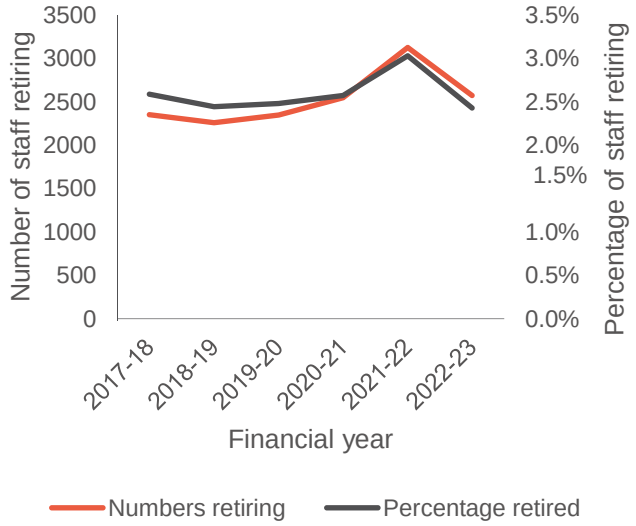
Retirement in NHS Wales

NHS Wales is seeing increasing numbers of staff retiring. While seemingly small compared to the circa 106,000 staff that were employed in 2022-23, it represents a loss of capacity, experience and knowledge.

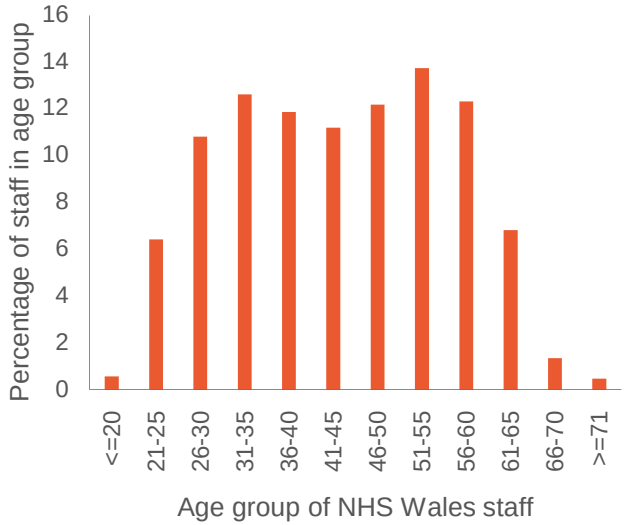
The age profile of the NHS workforce shown in **Exhibit 17** could also present a substantial challenge over the decade. Potentially around 35% of the workforce would reach or be above the current average retirement age of 61.

Exhibit 16: All Wales numbers and Percentage of NHS staff retiring annually, 2017-2023



Source: Health Education and Improvement Wales

Exhibit 17: NHS Wales workforce age profile, September 2022



Source: Stats Wales

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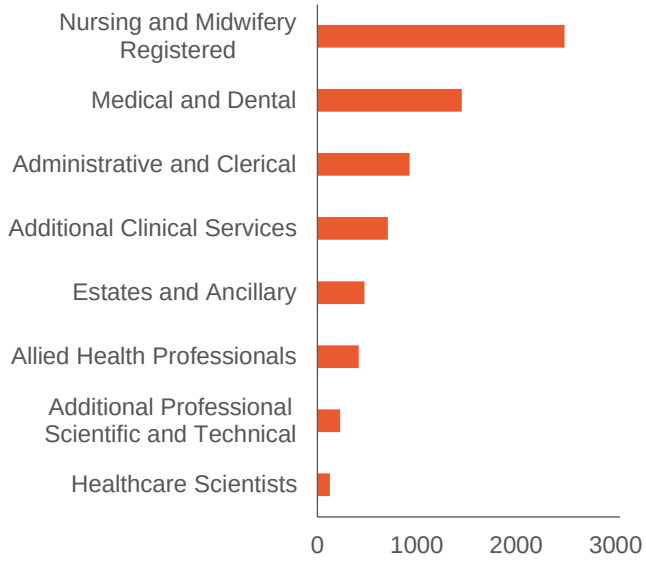
Vacancies in NHS Wales – by staff group

We asked NHS organisations to provide their agreed staffing establishment (agreed number of funded staff positions in an organisation) and the numbers of staff in post. As at March 2022, this indicated around 6,800 FTE equivalent vacancies, of which there were:

- Nearly 2,500 FTE registered nursing and midwifery vacancies
- 1,450 FTE medical and dental vacancies
- Over 900 admin and clerical vacancies.

Whilst some vacancies may only have limited impact on service delivery,the general picture of high service demand combined with high vacancy levels and reliance on temporary staffing will, in some areas, add pressures to the workforce, affect the wellbeing of staff and may compromise the quality of, or access to care.

Exhibit 18: Vacancies by staff group (FTE), March 2022, All NHS Wales (excluding primary care services)



Source: Returns from NHS Wales health bodies

Data quality notes:

- Vacancies has been counted as the gap between establishment and numbers of staff in place. Overstaffing in one staff group has not been counted against understaffing in another i.e. overstaffing by 50 admin and clerical workers does not counteract a shortfall of 50 doctors. We have therefore counted the understaffing against establishment for each staff group only and not offset this with overstaffing in another group.
- The recent Royal College of Nursing Wales 'Nursing in numbers' publication indicate nursing vacancies have increased to over 2,900 in the 2022-23 year.

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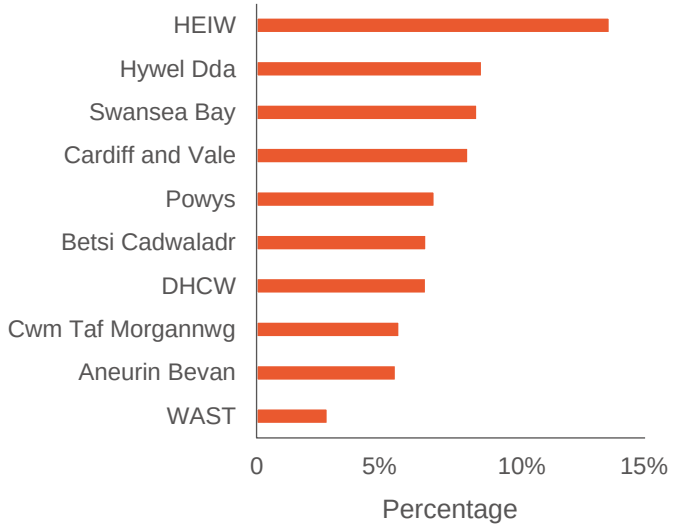
Vacancies in NHS Wales – by organisation

Exhibit 19 shows the percentage of vacancies against the total establishment. It shows that all bodies are operating in an environment where they are having to manage with fewer staff than they currently need.

Variation by health body may be a result of specific organisational challenges recruiting or retaining staff, approaches for calculating establishment, organisational size, and application of vacancy controls.

Note: Please see the previous slide regarding the calculation for vacancy levels.

Exhibit 19: Vacancies as a percentage of total establishment, March 2022



Source: : Returns from NHS Wales health bodies

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05 To what extent does the NHS in Wales rely on temporary staff?

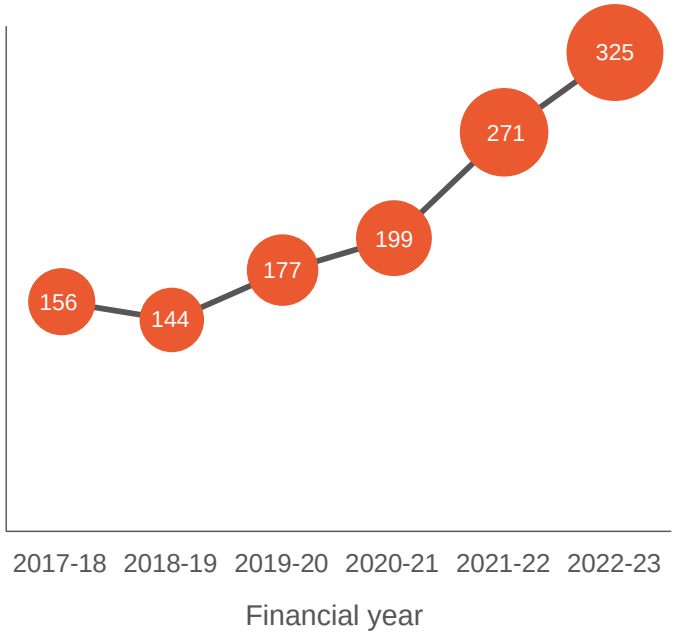
Annual trend in NHS Wales agency staffing use

There is a clear and substantial growth in the use of agency staffing by Welsh health bodies.

The consequences of the pandemic clearly has been a central factor in this increase. However, for 2022-23, agency use is continuing to rise.

Given that Covid-19 is having less of a direct impact than in previous years, it suggests the high agency use may be a feature of NHS workforce supply for some time as services are finding it difficult to recruit while service demand remains high.

Exhibit 20: All NHS Wales agency expenditure 2017-2023, £ million



Source: Monthly Monitoring Returns reported to Welsh Government

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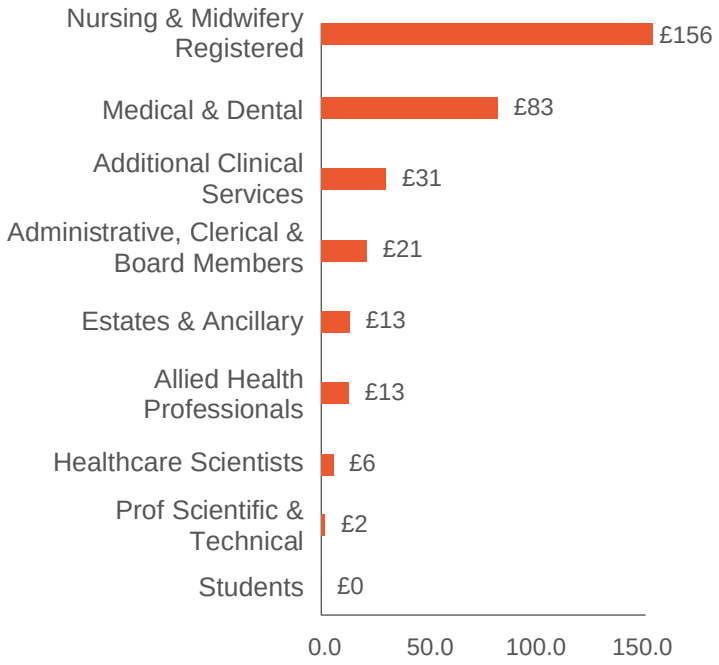
NHS Wales agency staffing use by role and reason

Exhibit 21 shows that the greatest areas of agency spending is on Nursing and Midwifery followed by Medical and Dental staff groups.

Our additional trend analysis indicates that nursing agency spend has more than tripled over the last 6 years from £51 million in 2017-18 to £156 million in 2022-23.

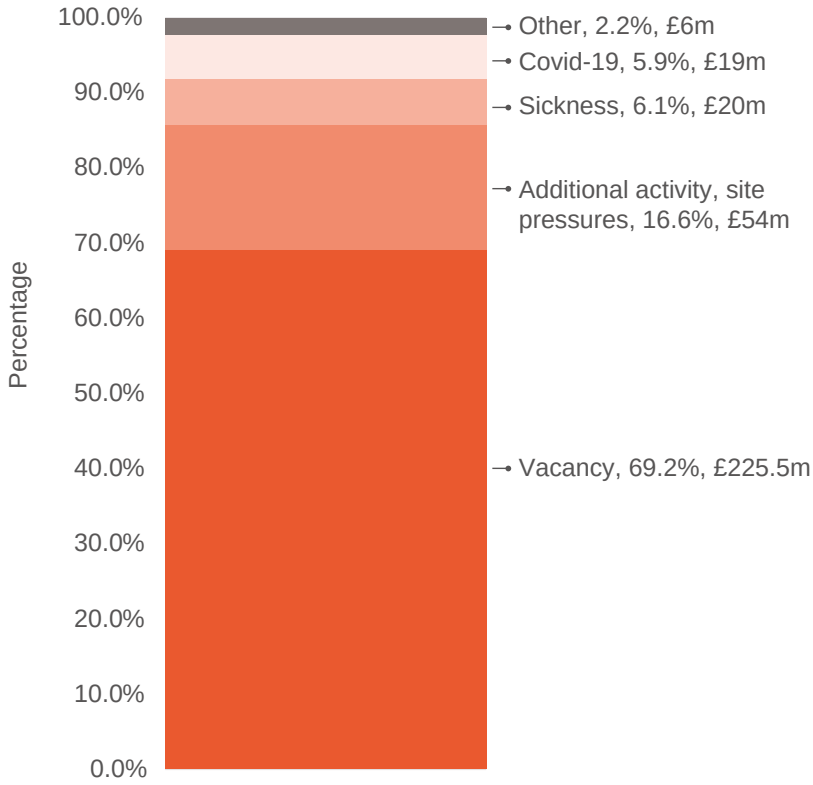
Exhibit 21: All NHS Wales agency spending, 2022-23 £ Million



Source: Monthly Monitoring Returns reported to Welsh Government

Exhibit 22 shows that vacancies are the main factor driving the use of agency staff.

Exhibit 22: NHS agency spend by reason, 2022-23



Source: Monthly Monitoring Returns reported to Welsh Government

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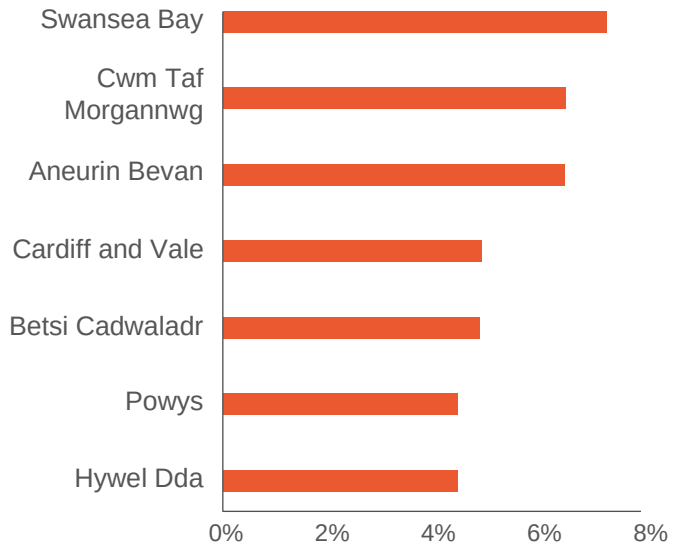
GP locums as a percentage of fully qualified GPs

Exhibit 23 shows the proportion of GP locums in use across Wales employed under the Primary Care General Medical Services contract.

There is clear variation across Wales albeit the overall use of GP locums is proportionately low for all bodies.

Exhibit 23: GP locum use (FTE) as a percentage of all fully qualified GPs, by Health Board, September 2022



Source: Stats Wales

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06 What is the position on sickness absence?

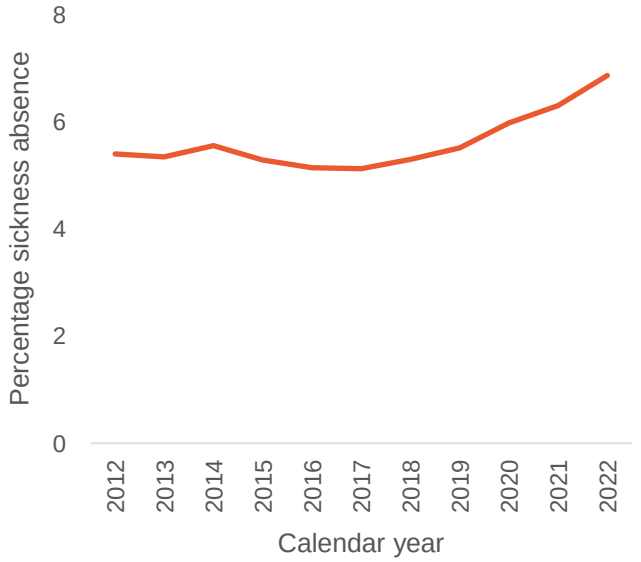
All Wales sickness absence trend

Levels of sickness absence present a substantial challenge for health bodies, particularly when service pressures are so great.

Since 2017, the level of sickness absence has increased, and understandably grew at a greater rate at the onset of the pandemic but has continued to increase since.

While a sickness absence rate of around 6.9% seems proportionately small, the impact is substantial. A loss of 6.9% staff equates to around 6,300 FTE staff lost to sickness absence in 2022-23, equivalent to around 1.4 million working days.

Exhibit 24: All NHS Wales sickness absence, 2012-2022



Source: Stats Wales

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Reasons for sickness absence

NHS Wales records the reasons for sickness absence on a common system across Wales, the Electronic Staff Record. From 2016-17 onwards, anxiety and stress has been the top reason for staff taking sickness absence, averaging over 27% of cases over the last 7 years.

As would be expected there was a substantial rise in the numbers of staff taking sickness absence because of infectious diseases and a growth of chest and respiratory problems during the pandemic.

Exhibit 25: Sickness absence by reason, top four highest reasons in 2022-23

28%
Anxiety/Stress

8%
Infectious diseases

12%
Other Musculoskeletal

8%
Unknown causes

Source: Health Education and Improvement Wales

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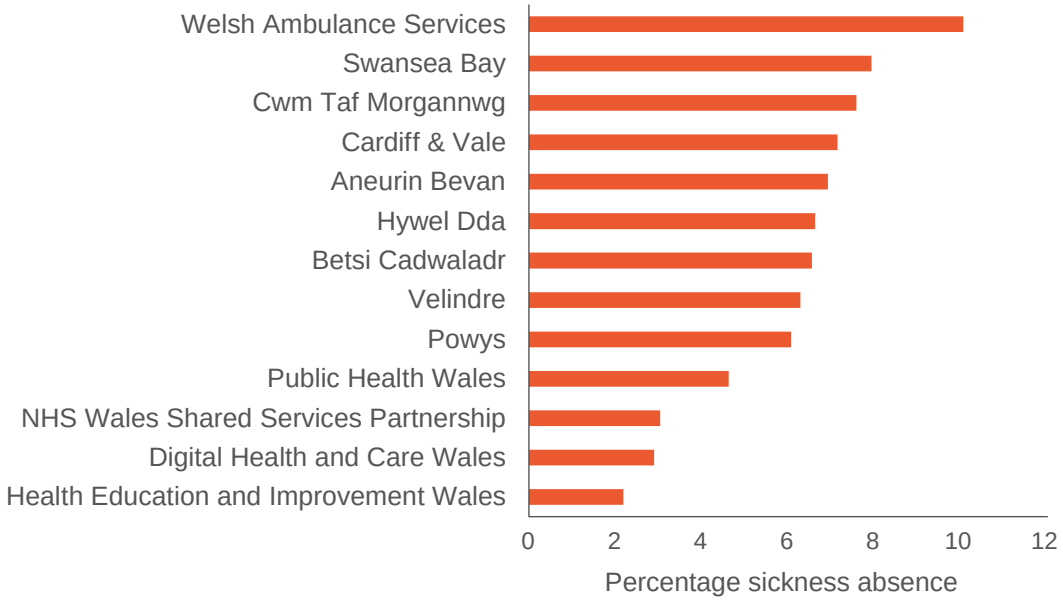
Sickness absence rates by body

Exhibit 26 shows significant sickness absence variation by health body. This may in part relate to differing working environments, service pressures, application of controls and effectiveness of preventative measures and support.

Audit Wales has previously reported on staff wellbeing support in the NHS, in our report on Taking Care of the Carers? The report focusses on wellbeing during the pandemic, but many findings are equally relevant now.

Exhibit 26: Sickness absence percentage by organisation, 2022 (calendar year)



Source: Stats Wales

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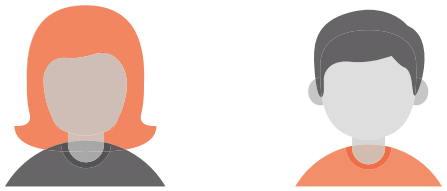
07 Is the NHS a more flexible and equal employer?

Part-time working in NHS Wales – Participation rate

The 'participation rate' is a measure of part-time working across an organisation's workforce. The higher the participation rate the more hours on average, an individual will work each week.

100% participation would mean that all staff are working full working weeks. An 80% participation rate for an organisation would mean that on average their workforce works 4 out of 5 days of a working week.

Exhibit 27: NHS Wales Participation Rate, by gender, March 2023

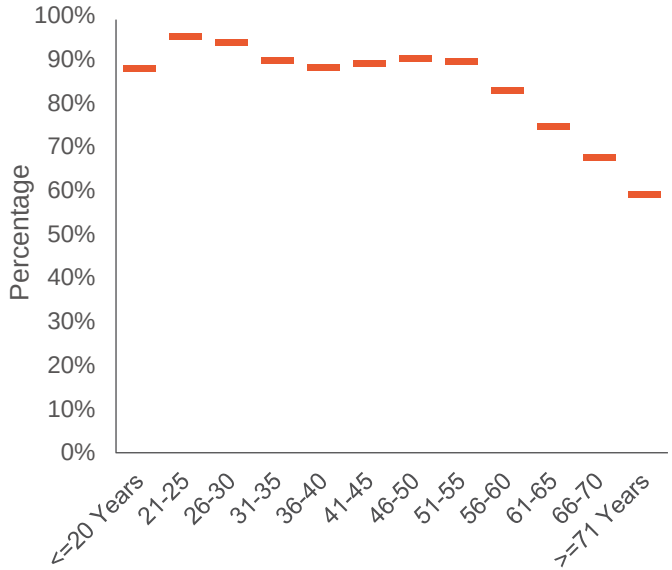


86% female **94% male**

Source: Health Education and Improvement Wales

Exhibit 28: Participation rate (a measure of the extent of part time working), March 2023, by age

The chart shows generally fewer people are working part time up to the age of 30. Between the ages of 30 and 55 part time working is increasing and beyond the age of 56, there is a clear movement to more staff working part time.



Source: Health Education and Improvement Wales

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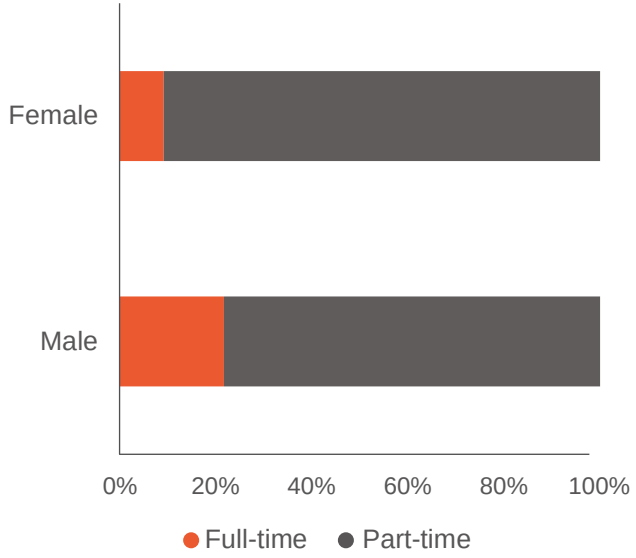
GP flexible working and GP gender

A large proportion of fully qualified GPs in primary care are working part-time. In terms of training, we estimate that for every 10 full-time GPs needed in Wales, around 15 people would need to be trained to accommodate current working styles.

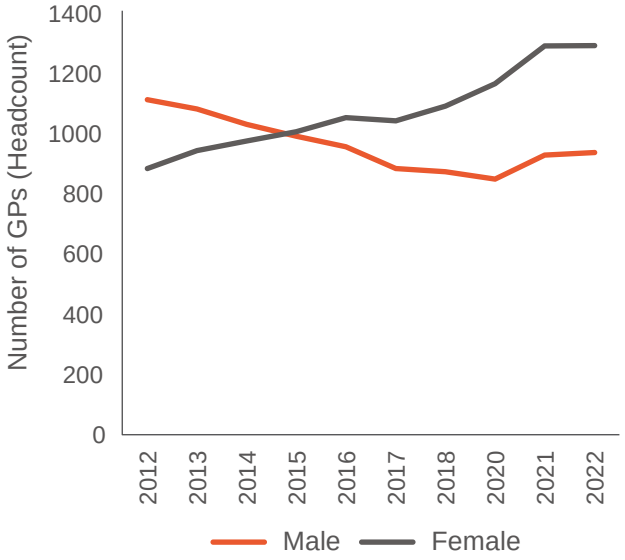
Exhibit 29: Percentage of GPs working full time versus part time by gender, September 2022



Source: Stats Wales

NHS Wales has seen a long-term shift in the gender of GPs working in primary care in Wales. It is difficult to explain the cause of these changes, but it may in part be attributed to the ability to adopt flexible working practices in primary care settings.

Exhibit 30: GPs working in primary care by gender, All Wales, 2012-2022



Source: Stats Wales

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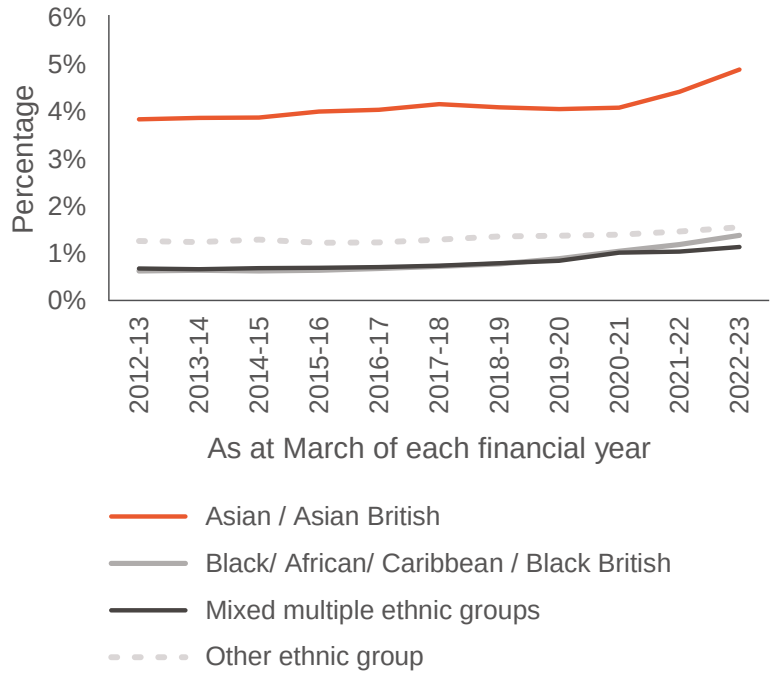
Ethnicity of NHS Wales workforce

NHS data on the ethnicity of the total workforce shows increasing employment of minority ethnic groups.

Note: Ethnicity data is collected by health bodies. More people are completing this data field which is improving reliability over time. In 2022-23, only 3.7% did not provide their ethnicity. Nevertheless, work undertaken by the NHS highlighted that in some cases the accuracy of the ethnicity data should be treated with caution.

Exhibit 31: Proportion of the workforce by ethnicity (excluding white ethnic group)



Source: Health Education and Improvement Wales

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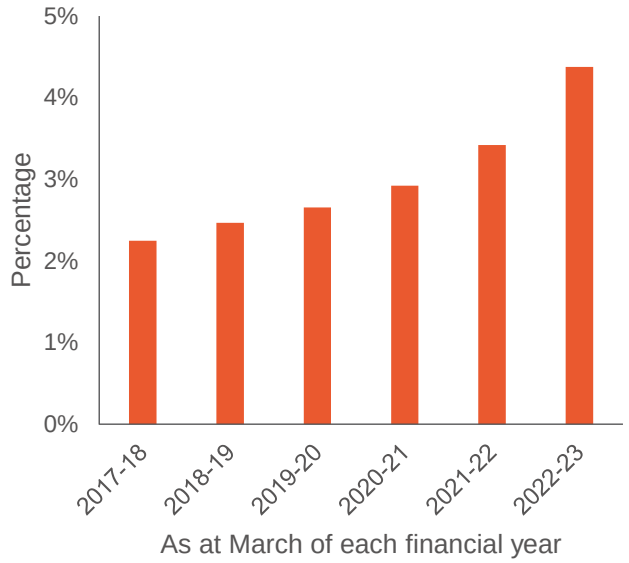
Disability in the NHS Wales workforce

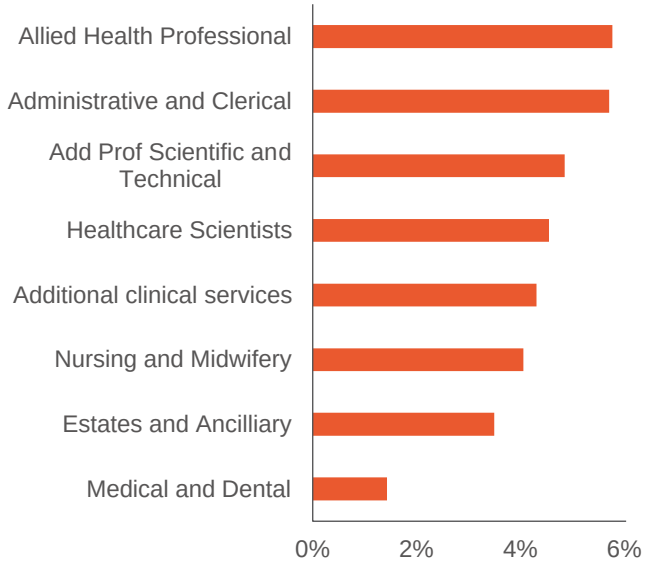
The percentage of staff identifying as disabled has increased over the last 5 years across Wales. The highest proportion of staff identifying as disabled are in Allied Health Professional (4.6%) and Admin and Clerical (4.3%) staff groups.

Exhibit 32: NHS Wales staff identifying themselves as disabled (2017-2023)



Source: Health Education and Improvement Wales

Exhibit 33: Percentage staff declaring as disabled, by staff group, 2022-23



Source: Health Education and Improvement Wales

Note: Disability data is collected by health bodies. The completion rates for this data field is increasing which is improving reliability over time. Nevertheless, the data should be treated with caution.

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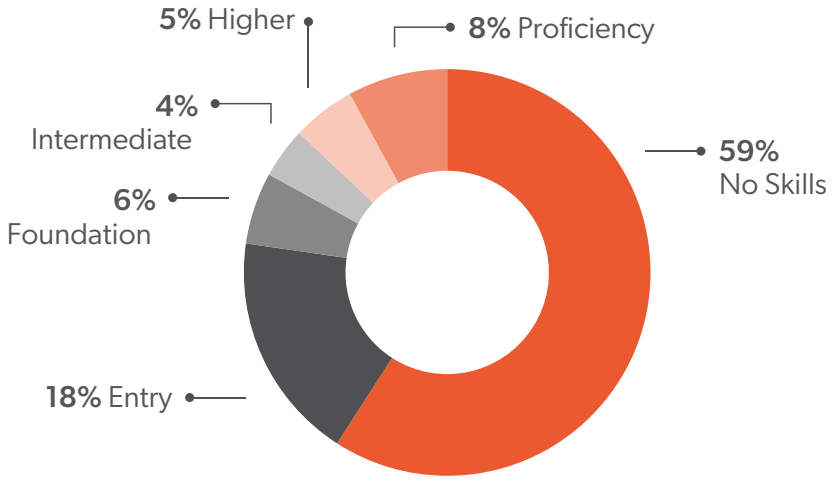
Welsh speaking ability

Around third (30%) of NHS Wales staff have not stated their Welsh language competency in ESR. But of those who have, 59% of staff have indicated that they have no skills and only around 13% have identified that they have higher or proficient Welsh language skills.

For patients who are first language Welsh speakers, it may affect their experience. It may affect their ability to understand their diagnosis, what it might mean for their lifestyle and the treatment options if they cannot communicate in their first language.

There may be further opportunity to encourage those individuals with Welsh language skills to train within Wales to help build a sustainable and thriving Welsh NHS workforce and enhance Welsh language skills.

Exhibit 34: Welsh Speaking Ability, 2022-23*



Source: Health Education and Improvement Wales

Note: NHS Wales records 6 levels of Welsh speaking ability

- No skills
- Entry
- Foundation
- Intermediate
- Higher Level
- Proficient.

See: Learning levels | Learn Welsh for more information

Note: *Analysis of those who have stated their Welsh speaking ability. As identified above 30% of staff have not stated their Welsh language competency.

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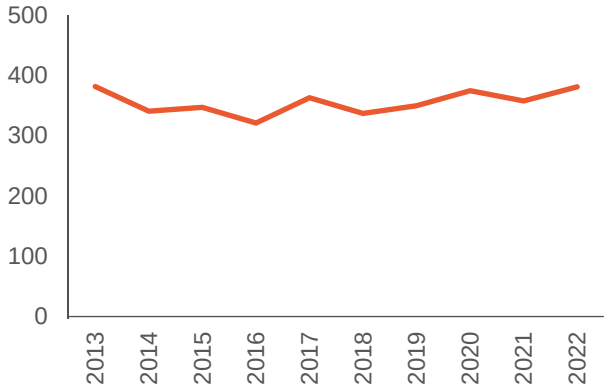
08 Is NHS Wales growing its own staffing?

Medical training in Wales

On average, since 2016, there has been a slight growth in the number of people completing their medical staff training in Wales each year. However, projected growth in demand for care arising from an increasingly elderly population, brings a significant risk that future supply will not meet demand.

Exhibit 35: Numbers of graduates completing their primary medical qualification 2013-2022



Source: Audit Wales analysis of GMC data explorer, Accessed February 2023

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Many of the doctors that undertook their primary medical qualification in Wales end up practising outside of Wales. Of the 9,153 doctors that undertook their primary medical qualification in Wales and currently registered by the General Medical Council, well over half of them are now practicing elsewhere in the UK.

Exhibit 36: Destination of registered doctors who completed their primary medical qualification in Wales, as of February 2023

9,153 doctors on the GMC register trained in Wales

3,975	doctors remained in Wales
169	doctors are registered in Scotland
4,959	doctors are registered in England
50	doctors are registered in Northern Ireland

Source: Audit Wales analysis of GMC data explorer, Accessed February 2023

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Medical training in Wales

Exhibit 37 shows the where doctors working in Wales undertook their primary medical training. As of February 2023, 29% of doctors working in Wales undertook their primary medical qualification in Wales. In England, Scotland and Northern Ireland, the corresponding figures were 55%, 63% and 63% respectively. This indicates that in Wales there is a greater reliance on medical staffing from those who originally trained outside of Wales.

Exhibit 37: Percentage of doctors registered to work in Wales by location of their primary medical qualification, as of February 2023

29%	2%	34%	0.4%	6%	29%
trained in Wales	trained in Scotland	trained in England	trained in Northern Ireland	trained in the European Economic Area	trained Internationally

Source: Audit Wales analysis of GMC data explorer, Accessed February 2023

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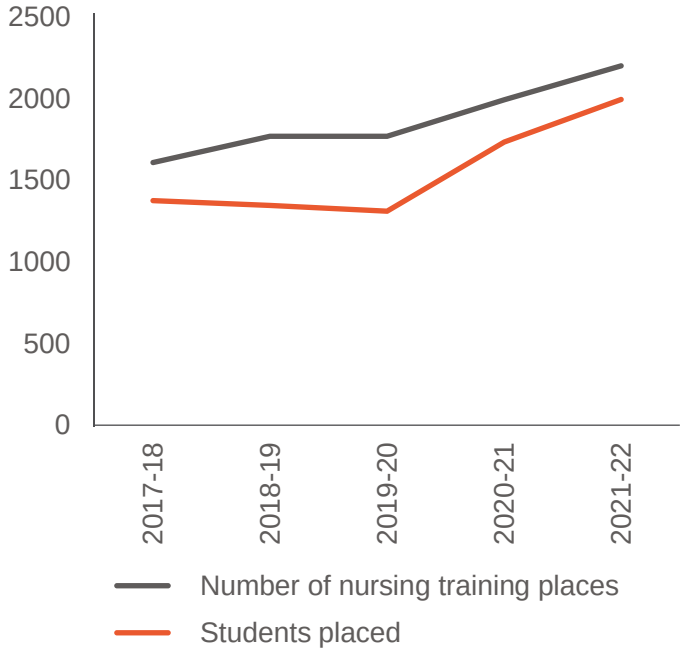
Nursing education in Wales

Exhibit 38 shows a steady growth both in the numbers of nursing education places made available and the numbers of students placed in training. While the growth is positive, not all available places are filled, not all those of those entering training will complete it and some who do will not stay in Wales.

Exhibit 39 shows the 'fill rate'. This is the proportion of education places that are filled, which stood at 91% in 2021-22

Exhibit 38: Numbers of people entering nursing education in Wales



Source: Health Education and Improvement Wales

Exhibit 39: Nursing education fill rate 2021-22

Source: Health Education and Improvement Wales

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Where do nurses go after receiving nursing education in Wales?

Exhibit 40 shows that most nurses receiving education in Wales, stay in Wales. But a large minority move outside of Wales after completing their education.

*Notes:

The Nursing & Midwifery Council register records location of nurse residence rather than location of employment. Not all nurses in registered in Wales work in Wales. There will be some cross border commuting to work outside of the country of residence. The Nursing and Midwifery Council database does not provide cross-border working breakdown and therefore registration data used for this analysis should be considered an estimate.

Some nurses registered will not be actively working.

Exhibit 40: Destination of nurses educated in Wales, as of September 2022*

31,025 nurses on the NMC register trained in Wales

26,707	remained in Wales
110	nurses are registered in Scotland
4,048	nurses are registered in England
48	nurses are registered in Northern Ireland
112	nurses are registered outside of the UK

Source: Nursing and Midwifery Council register

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Nursing in Wales – where do nurses come from?

As of September 2022, there were 38,901 registered nurses in Wales of which 26,707 (69%) received their nursing education in Wales. Although to a lesser extent than medical staffing, Wales is reliant on a significant number of nurses (around 30 percent) from outside of the country.

Exhibit 41: Percentage of nurses located in Wales by their country/location of nursing education, as of September 2022*

69%	1%	21%	0.1%	1%	8%
trained in Wales	trained in Scotland	trained in England	trained in Northern Ireland	trained in the European Economic Area	trained Internationally

Source: Nursing and Midwifery Council register

Note: *The Nursing & Midwifery Council register records location of nurse residence rather than location of employment. Not all nurses in registered in Wales work in Wales. There will be some cross border commuting to work outside of the country of residence. The Nursing and Midwifery Council database does not provide cross-border working breakdown and therefore registration data used for this analysis should be considered an estimate.

Abbreviations and terminology

Terms used in this report

Term	Explanation
Advanced practitioners	Advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and therapists. They are healthcare professionals with skills and knowledge that enabled them to take on expanded roles and responsibilities when caring for patients.
Agenda for change (A4C)	Agenda for Change refers to a pay and conditions structure for the NHS introduced in 2004.
Agency staffing (NHS)/GP locums	Agency staff are temporary staff members that are not directly contracted by a health body. Health bodies often use commercial agencies to fill short term vacancies and cover sickness absence. Similar to NHS agency staffing, GP locums are staff practising in primary care that do not have a full contract of employment with a GP practice.
Establishment	The agreed number of funded staff positions in an organisation.

Term	Explanation
Full time equivalent or whole time equivalent	Full-Time Equivalent (FTE) is a standardised measure of the workload of an employed person and allows for the total workforce workload to be expressed in an equivalent number of full-time staff. 1.0 FTE equates to full-time work of 37.5 hours per week, an FTE of 0.5 would equate to 18.75 hours per week.
General dental services	General dental services (GDS) contracts came into effect in 2006. General dental services are provided by general dental practitioners who are independent contractors i.e. high street dentists.
General Medical Council	The General Medical Council's remit is defined by the Medical Act 1983 and covers five areas including: Maintaining a medical register, setting standards for doctors, ensuring quality of training, revalidating doctors to ensure they meet standards and provide good care, and investigating concerns of about doctors.
General Medical Services	The General Medical Services (GMS) Contract Wales became effective from 1st April 2004. Is the standard contract between general practice (GPs) and NHS Wales for delivering primary care services to local communities.
Headcount	The actual number of people working in an organisation. Two people working 18.75 hours a week would count as 1 full time equivalent, but have a headcount of 2.

Term	Explanation
Participation rate	The ‘participation rate’ is a measure of part-time working across an organisation’s workforce. It is the average of Full Time Equivalent (FTE) across the workforce. 100% participation would mean that all staff are working full working weeks. An 80% participation rate for an organisation would mean that on average their workforce works 4 out of 5 days of a working week.
Primary medical qualification	Primary medical qualification is the undergraduate medical degree entitling provisional registration to the general medical council.
Registered and Licensed Doctors	Doctors practicing in Wales must be licensed and registered with the General Medical Council.
Staff skill mix/grade mix	The profile of the skill and agenda for change grades working within an organisation or part of it. A guide to the medical register - GMC (gmc-uk.org)
Staff turnover	This is the number or percentage of staff leaving the organisation in a given year.

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NATIONAL COMMISSIONING IMPLEMENTATION PROGRAMME

PROGRAMME INITIATION DOCUMENT (PID)

1. Purpose

This purpose of this paper is to present the final PID for the National Commissioning Implementation Programme, which was approved by the Welsh Government Oversight Board at its meeting on 06 September 2023.

The PID establishes the oversight and programme arrangements to implement the recommendations made as an outcome of the independent review of national commissioning functions in Wales.

2. Background

In early 2023, an independent review was conducted to reflect upon the experiences of the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC), which also includes the National Collaborative Commissioning Unit (NCCU), and to further build upon national commissioning arrangements. This included horizon scanning to explore other national commissioning functions and opportunities.

The review found that whilst there is good evidence of evolution and growing maturity in both WHSSC and EASC, there remain gaps and potentially lost opportunities in the current national commissioning arrangements in Wales. In particular, the review found scope to improve and strengthen decision making and accountability arrangements.

In summary, the recommendations made are:

- WHSSC, EASC and NCCU should be combined into a single Joint Committee. This would simplify and streamline the current arrangements. It would also create one central point of NHS commissioning expertise in Wales.
- This new Joint Committee should be given a new name to highlight that it is a new committee rather than just a merger of existing bodies.
- The term “specialist” [or “specialised”] should not be used in any new name, but the scope and responsibilities of the service should be defined.
- The new Joint Committee should take on an expert supportive role to health boards in developing Regional and Inter Health Board commissioning. This would help build commissioning capacity across the health system in Wales.
- The new Joint Committee should be responsible for commissioning the 111 service. This could provide a model for managing other commissioned services within NHS Wales going forward.
- The current hosting agreement should be retained but would need to be reviewed after the new Joint Committee is established. (This single, new joint committee would be hosted by Cwm Taf Morgannwg UHB as the UHB is the current host and employer for the two existing Joint Committees).

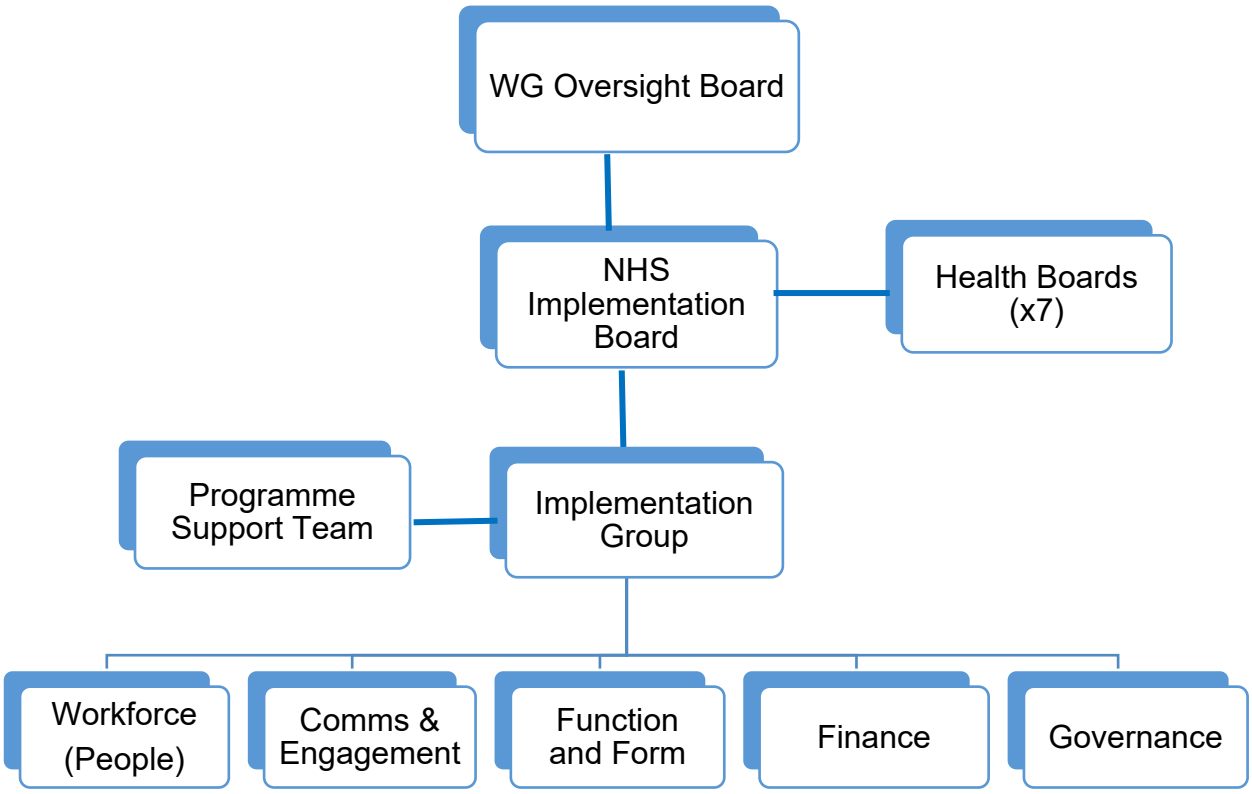
- There is currently a lack of Public Health input around population needs assessment etc. and this should be remedied in line with the requirement in the Memorandum of Agreement.
- An organisational development programme should be put in place, including a behaviour framework. This would help ensure the new Joint Committee creates its own identity.
- The establishment of strengthened governance arrangements for the Joint Committee, as set out in further detail in the report.

Whilst the commissioning of 111 services was not explicitly included in the initial scope of the review, this falls under the opportunities that were explored as part of the horizon scanning. This was a strong view put forward by health boards. This recommendation will therefore be tested and explored further, alongside the proposed transition of the 6 Goals Urgent & Emergency Care Programme into the NHS Wales Executive.

The planned transfer of the Sexual Assault Referral Centres (SARC) commissioning service from the NHS Executive to the NCCU on 1 April 2024 will also be included within the remit of the project.

3. Programme Structure

A programme structure with five supporting workstreams has been established to ensure all required preparatory work and engagement has been undertaken in order for the new Joint Committee to be operational and fit for purpose by 1 April 2024.



Alongside the PID, a set of terms of reference have been developed and approved through the programme structure, which can be found as Appendix 1.

The arrangements and products to be put in place to facilitate ‘go-live’ on 1 April 2024 include:

- The appointment of a new single Joint Committee with a single Chair, for national commissioning
- A functional model and operational specifications
- Completion of the organisational change process
- Governance model and necessary supporting mechanisms
- Documented legacy statements to enable evaluation of the new Joint Committee overtime
- A clear identity
- Confirmed interim hosting agreement subject to review post implementation
- Delegation of functions by health boards
- Relationship with NHS Executive clarified

Whilst the PID provides a summary of the key milestones and critical timelines to achieve the 1 April 2024 deadline, detailed action plans have been developed for each of the workstreams, with specialist leads identified.

The programme is well underway and progress against actions are being monitored and reported through the structure and to the Oversight Board which is accountable to the Minister for Health & Social Services and the Director General/ Chief Executive of NHS Wales.

4. Recommendation

Members are asked to:

- **Receive** and **note** the final PID for the National Commissioning Implementation Programme, which was approved by the Welsh Government Oversight Board at its meeting on 06 September 2023.

Llywodraeth Cymru
Welsh Government

PROGRAMME INITIATION DOCUMENT

Programme Name: National Commissioning Functions Implementation Programme
Programme: National Commissioning Functions Programme

Release Version:
Date:

Author:	Maxine Evans Programme Manager
Owner:	Samia Edmonds Senior Responsible Officer
Client:	Minister for Health and Social Services
Document Number:	Version 0.9

Document History

Revision History First Draft 21 June 2023

Revision Date	Previous Revision Date	Summary of Changes
22-6-23		KP additions
12-07-23	21-07-23	SE and Policy Leads comments and amendments
28-07-23		KP Additions NB Appendices not available in this draft
16-08-23	28-07.23	ME additions reflecting feedback from Oversight Board 09/08/23 and individual comments received
24-08.23	16-08-23	ME additions reflecting feedback from Implementation Board 22/08/23
06-09-23	24-08-23	ME amendments to all references of 'new body' within review recommendations (section 2) replaced with 'new (joint committee) Me amendments – added a high level summary of the workstreams main roles (made clear that legislation requirements fall under the Governance workstream) Me amendments to programme organogram moving programme support team to the side

Approvals This document has been approved by:

Name	Date of Issue	Version
Oversight Board subject to amendments agreed at its meeting on 06-09-23	13-09-2023	0.9

Distribution This document has been distributed to:

Name	Date of Issue	Version
Oversight Board	06-09-2023	0.9
Implementation Board	19-09.2023	0.9
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Programme Support Team	19-09-2023	0.9
Health Boards x7	26-09-2023	0.9

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1. Purpose

This Programme Initiation Document (PID) establishes oversight and programme arrangements to implement the recommendations made as an outcome of the independent review of national commissioning functions in Wales.

The PID addresses the following fundamental aspects of the programme:

- The stages and phasing of the programme.
- The aims and objectives of the programme.
- The expected benefits and outcomes of the programme.
- The roles and responsibilities of those involved in managing the programme.
- Delivery of the programme.

2. Background

An independent review was conducted in early 2023 to reflect upon the experiences of the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC), which also includes the National Collaborative Commissioning Unit (NCCU), and to further build upon national commissioning arrangements. This has included horizon scanning to explore other national commissioning functions and opportunities.

The review found that whilst there is good evidence of evolution and growing maturity in both WHSSC and EASC, there remain gaps and potentially lost opportunities in the current national commissioning arrangements in Wales. In particular, the review found scope to improve and strengthen decision making and accountability arrangements.

In summary, the independent review recommendations made are:

- WHSSC, EASC and NCCU should be combined to form a single Joint Committee. This would simplify and streamline the current arrangements. It would also create one central point of NHS commissioning expertise in Wales.
- This new Joint Committee should be given a new name to highlight that it is a new committee rather than just a merger of existing bodies.
- The term “specialist” [or “specialised”] should not be used in any new name, but the scope and responsibilities of the service should be defined.
- The new Joint Committee should take on an expert supportive role to health boards in developing Regional and Inter Health Board commissioning. This would help build commissioning capacity across the health system in Wales.
- The new Joint Committee should be responsible for commissioning the 111 service. This could provide a model for managing other commissioned services within NHS Wales going forward.
- The current hosting agreement should be retained but would need to be reviewed after the new Joint Committee is established. (This single, new joint committee would be hosted by Cwm Taf Morgannwg UHB as the UHB is the current host and employer for the two existing Joint Committees).
- There is currently a lack of Public Health input around population needs assessment etc. and this should be remedied in line with the requirement in the Memorandum of Agreement.

- An organisational development programme should be put in place, including a behaviour framework. This would help ensure the new Joint Committee create its own identity.
- The establishment of strengthened governance arrangements for the Joint Committee, as set out in further detail in the report.

Whilst the commissioning of 111 services was not explicitly included in the initial scope of the review, this falls under the opportunities that were explored as part of the horizon scanning. This was a strong view put forward by health boards. This recommendation will therefore be tested and explored further, alongside the proposed transition of the 6 Goals Urgent & Emergency Care Programme into the NHS Wales Executive.

The planned transfer of the Sexual Assault Referral Centres (SARC) commissioning service from the NHS Executive to the NCCU on 1 April 2024 will also be included within the remit of the project.

3. Programme Relationships

Key to the programme is the recognition of the relationship between the extant two Joint Committees and the seven Local Health Boards (LHBs).

Local health boards have a statutory responsibility for the commissioning and provision of services to meet the needs of their populations. Whilst they remain accountable, two Joint Committees were established as national, hosted bodies to support LHBs in discharging their commissioning function for an agreed portfolio of services. Health Boards provide the funding for these Joint Committees who have been given delegated responsibility for decision making via the seven Chief Executives on behalf of their individual Boards.

- **Welsh Health Specialised Services Committee (WHSSC)** - established in 2010 to ensure that the population of Wales has fair and equitable access to the full range of specialised services. WHSSC is responsible for the joint planning of specialised and tertiary services of the LHBs.
- **Emergency Ambulance Services Committee (EASC)** - established in 2015 with responsibility for planning and securing sufficient emergency and non-emergency ambulance services for the population. It includes the Welsh Ambulance Services NHS Trust (WAST) and Emergency Medical Retrieval and Transfer Service (EMRTS Cymru – Wales Air Ambulance).
- **The National Collaborative Commissioning Unit (NCCU)** - responsible for delivering national commissioning programmes for mental health and learning disability services. The NCCU is managed by the Chief Ambulance Services Commissioner (CASC).

4. Programme Definition

The Programme is defined as:

Implementation of the recommendations made as an outcome of the independent review of national commissioning functions in Wales.

5. Programme Scope

The Programme will include the following:

- WHSSC, EASC, NCCU commissioning bodies (the services that are currently commissioned by these bodies is included at appendix 4 – to be finalised in final draft)
- NHS 111 Wales Service – commissioning (not service delivery)
- Sexual Assault Referral Centres (SARC) commissioning (not service delivery)

6. Programme Aim and Objectives

The overall **aim** is:

To fully implement the Ministerial Directive following the independent review into national commissioning. Within this aim, the following principles from the original terms of reference will need to be considered:

- Improving outcomes and reducing inequalities
- Adding further value to the NHS system in Wales
- Strengthening and streamlining of commissioning functions, and associated decision making
- Building on evidence of good practice
- Supporting the development of commissioning expertise within the NHS in Wales
- Maximisation of national commissioning capacity and capabilities
- Minimal disruption to the system
- Minimal disruption to the existing workforce within WHSSC, EASC/ NCCU, the NHS 111 Wales programme and the SARC commissioning service
- Any changes to be implemented should be resource neutral as a minimum and will maximise the value and efficiencies delivered by current commissioning arrangements as the new Joint Committee matures (post April 2024)
- Exploit where possible, economies of scale through the establishment of a new Joint Committee by 1 April 2024.
- Enhanced improvement in transparency, rigour and accountability to the delivery of commissioned services through the new Joint Committee to health boards

The overall **objective** of the programme is to provide strategic direction and control to ensure all required preparatory work and engagement has been undertaken in order for the new Joint Committee to be operational and fit for purpose by 1 April 2024.

The arrangements and products to be put in place to facilitate ‘go-live’ on 1 April 2024 include:

- The appointment of a new single Joint Committee with a single Chair, for national commissioning
- A functional model and operational specifications
- Completion of the organisational change process
- Governance model and necessary supporting mechanisms
- Documented legacy statements to enable evaluation of the new Joint Committee overtime

- A clear identity
- Confirmed interim hosting agreement subject to review post implementation
- Delegation of functions by health boards
- Relationship with NHS Executive clarified

7. Programme Structure

See **Appendix 1** for organigram of the programme and workstream structure

7.1 Welsh Government Oversight Board

An Oversight Board will be established by Welsh Government, which will provide the strategic oversight, assurance and control of the overall strategic direction of the programme to create a new national commissioning Joint Committee, which will act on behalf of the seven health boards. It will champion the vision and objectives of the new Joint Committee at a senior level to oversee progress and to lead on the statutory, regulatory and legislative requirements for the establishent of the new committee by 1 April 2024. The Oversight Board will be accountable to the Minister for Health & Social Services and the Director General/ Chief Executive of NHS Wales. Its terms of reference (draft) can be found in **Appendix 2.**

7.2 NHS Implementation Board

The Joint Committees of WHSSC and EASC will form the basis of the programme's Implementation Board. It will lead on the execution of the programme providing assurance and advice to the Oversight Board. Within its responsibilities, it will ensure delivery of the programme of activities as set out in the PID, to facilitate the co-ordination, delivery and timescale for the development of a single commissioning joint committee for Wales in line with the review's recommendations and the decision of the Minister for Health and Social Services. Membership will be adapted to reflect and further explore other national commisisoning oportunities, including the commissioning of 111 services and SARC services. The Implementation Board will be provide assurance and make recommendations to the WG Oversight Board. It will retain some delegated decision making on minor matters to ensure the timely progression of certain milestones. Through its membership, the Chief Executive Officers will provide assurance to their individual Health Boards and CEO Leadership Board, on the direction and decisions of the programme. Its terms of reference (draft) can be found in **Appendix 3.**

7.3 Implementation Group

The Implementation Group will act as the sounding board between the Programme Support Team and the Implementation Board. It will be responsible for generating ideas and providing support and guidance to the workstream leads on an operational level, and for reviewing the outcome of activities and recommendations to be taken to the Implementation Board. Membership will be drawn from WHSSC, EASC, the NCCU, 111 and SARC services, and will meet monthly. Its terms of reference (draft) can be found in **Appendix 4.**

7.4 Programme Support Team

The Programme Support Team will be responsible for carrying out the programme activities through five dedicated workstreams, ensuring that timescales are met. Within its responsibilities, it will ensure all risks and issues are identified, logged and flagged

through the programme structure as appropriate. The Programme Support Team will undertake all administrative tasks associated with the programme including the production of workstream highlight reports, papers and action notes for the Implementation Group and Implementation Board. Membership will be drawn from WHSSC, EASC, the NCCU, 111 and SARC services.

7.5 Workstreams

1. Workforce (People) –
    a. Management of the Organisational Process (OCP)
    b. Values and Behaviours
2. Comms and Engagement
    a. All communication and engagement with staff
3. Function and Form
    a. Functions and future structure of the new Joint Committee
4. Finance
    a. Merger of budgets, financial systems and supporting standing financial instructions
5. Governance
    a. Supporting legislation and governance framework for the new Joint Committee

8. Product Breakdown and Deliverables

The following are the high-level deliverables within the programme:

- Programme approval.
- Development of programme infrastructure.
- Reporting of risks, mitigations and progress to the WG Oversight Board.
- Scoping the current commissioning Joint Committees.
- Communication and engagement with affected staff.
- Communication with external stakeholders.
- Completion of Organisational Change Process (OCP).
- Establishment of infrastructure for new single commissioning Joint Committee and its management structure including any required statutory or regulatory instruments.
- Establishment of governance arrangements.
- Recruitment of single Chair and independent members to the new Joint Committee.
- Development and agreement of Model Standing, Reservation and Delegation of Powers and Standing Financial Instructions for issue to new Joint Committee and Health Boards.
- Launch of the new Joint Committee

9. Programme Activities and Timeline

A summary of key milestones, by month and workstream, can be found in **Appendix 5.** Each workstream lead will develop its own detailed work plan to underpin the delivery of the programmes activities within the agreed timescales.

10. Constraints

- Capacity of programme implementation team.
- Timeframe for Ministerial decision.
- Timeliness and availability of information and documentation required from each organisation affected (WHSSC, EASC, NCCU, 111 and SARC).
- Capacity of workforce to focus on the establishment of the new Joint Committee whilst performing current roles and responsibilities.
- Availability of resources to deliver programme.

11. Assumptions

Assumptions made in the planning of this programme are:

- This is a priority for Welsh Government and the organisations affected.

12. Tolerances

To be agreed by the Oversight Board but deadline for go live of 1st April 2024 is a fixed point.

Shadow running period can be flexed.

13. Risk

A risk register for the programme will be developed and maintained as the programme progresses. This will assess and identify actions to mitigate the constraints highlighted above.

14. Reporting

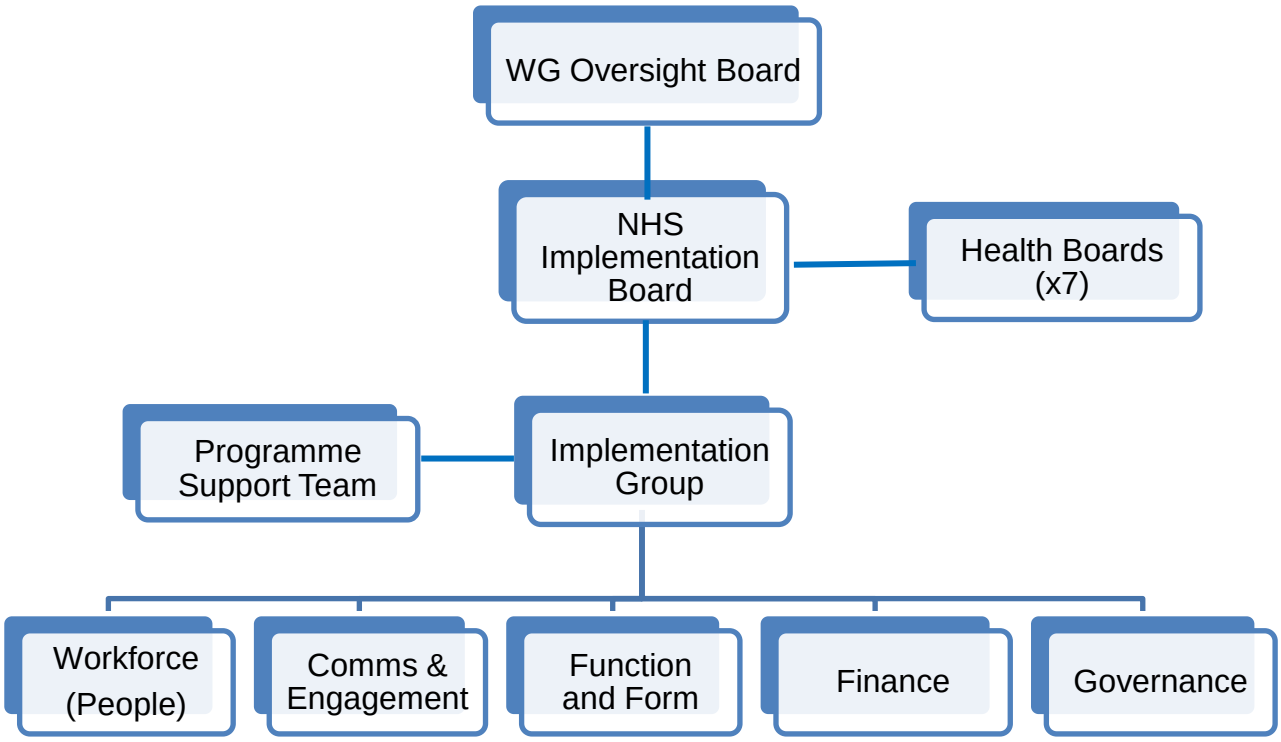
The programme will report to the Implementation Board, which will feed into the Oversight Board which has overall accountability for the delivery of the programme.

Update reports will be taken to both Boards on a monthly basis.

15. Footnote

This programme is separate to the Care and Support programme which is pending establishment. However, shared learning that can be brought into this programme will be considered.

Appendix 1 - National Commissioning Implementation Programme/Workstream Structure



Appendix 2 - Oversight Board Terms of Reference

National Commissioning Functions
Oversight Board

Terms of Reference v0.5

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1. Context

An independent review was conducted in early 2023 to reflect upon the experiences of the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC), which also includes the National Collaborative Commissioning Unit (NCCU), and to further build upon national commissioning arrangements. This has included horizon scanning to explore other national commissioning functions and opportunities.

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In summary, the recommendations made are:

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- This new Joint Committee should be given a new name to highlight that it is a new committee rather than just a merger of existing bodies.
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- An organisational development programme should be put in place, including a behaviour framework. This would help ensure the new Joint Committee) creates its own identity.
- The establishment of strengthened governance arrangements for the Joint Committee, as set out in further detail in the report.

Whilst the commissioning of 111 services was not explicitly included in the initial scope of the review, this falls under the opportunities that were explored as part of the horizon scanning. This was a strong view put forward by health boards. This recommendation will therefore be tested and explored further, alongside the proposed transition of the 6 Goals Urgent & Emergency Care Programme into the NHS Wales Executive.

The planned transfer of the Sexual Assault Referral Centres (SARC) commissioning service from the NHS Executive to the NCCU on 1 April 2024 will also be included within the remit of the project.

2. Purpose of the Oversight Board

The overall objective of the programme is to provide strategic direction and control to ensure all required preparatory work and engagement has been undertaken in order for the new Joint Committee to be operational and fit for purpose by 1 April 2024.

The arrangements and products to be put in place to facilitate 'go-live' on 1 April 2024 include:

- The appointment of a new single Joint Committee for national commissioning
- A functional model and operational specifications
- Completion of the organisational change process
- Governance model and necessary supporting mechanisms
- A clear identity
- Confirmed hosting agreement
- Delegation of functions by health boards
- Clarify the alignment and interface with the NHS Executive, particularly in relation to the commissioning of 111 services and the relationship with national programmes more broadly

In this context, the Board will provide the strategic oversight, assurance and control of the overall strategic direction of the programme to create a new national commissioning Joint Committee, which will act on behalf of the seven health boards. It will champion the vision and objectives of the new Joint Committee at a senior level to oversee progress and to lead on the statutory, regulatory and legislative requirements for the establishment of the new Joint Committee by 1 April 2024.

The Oversight Board will be accountable to the Minister for Health & Social Services and the Director General/Chief Executive of NHS Wales.

Updates will also be provided to the Health & Social Services Group Executive Directors Team and the NHS Wales Leadership Board.

Specifically, the Board will:

- Provide assurance to the SRO about the deliverability of the programme, including the designated workstreams.
- Support the SRO with decision making.
- Enable the SRO to provide briefings to the Minister for Health & Social Services, the Director General/ CEO of NHS Wales and the Public Bodies Unit.

- Support the programme with the management of key stakeholders.

3. Remit of the Board

- The NHS Implementation Board will report to the Oversight Board which, in turn, will support the SRO with assurance and decision making.
- Ensure the resources required are regularly reviewed and considered against agreed programme deliverables.
- To provide scrutiny and seek assurance from the Implementation Board to enable the Oversight Board to support the SRO in decision making and provide assurance to the Minister for Health and Social Services and the Director General/Chief Executive for NHS Wales
- Provide a point of escalation and resolution for significant risks and issues which cannot be managed or mitigated within the implementation arrangements that may impact on delivery.
- Provide a point of escalation and resolution for areas of dispute which cannot be managed or agreed within the implementation arrangements that may impact on delivery.
- Provide the SRO with advice, guidance, and assurance on matters of governance to ensure the programme is managed in line with Welsh Government PPM requirements.
- Provide the assurance mechanism to the Minister for Health & Social Services and the Director General/ CEO of NHS Wales on the implementation of the recommendations from the independent review of national commissioning functions.

4. Membership

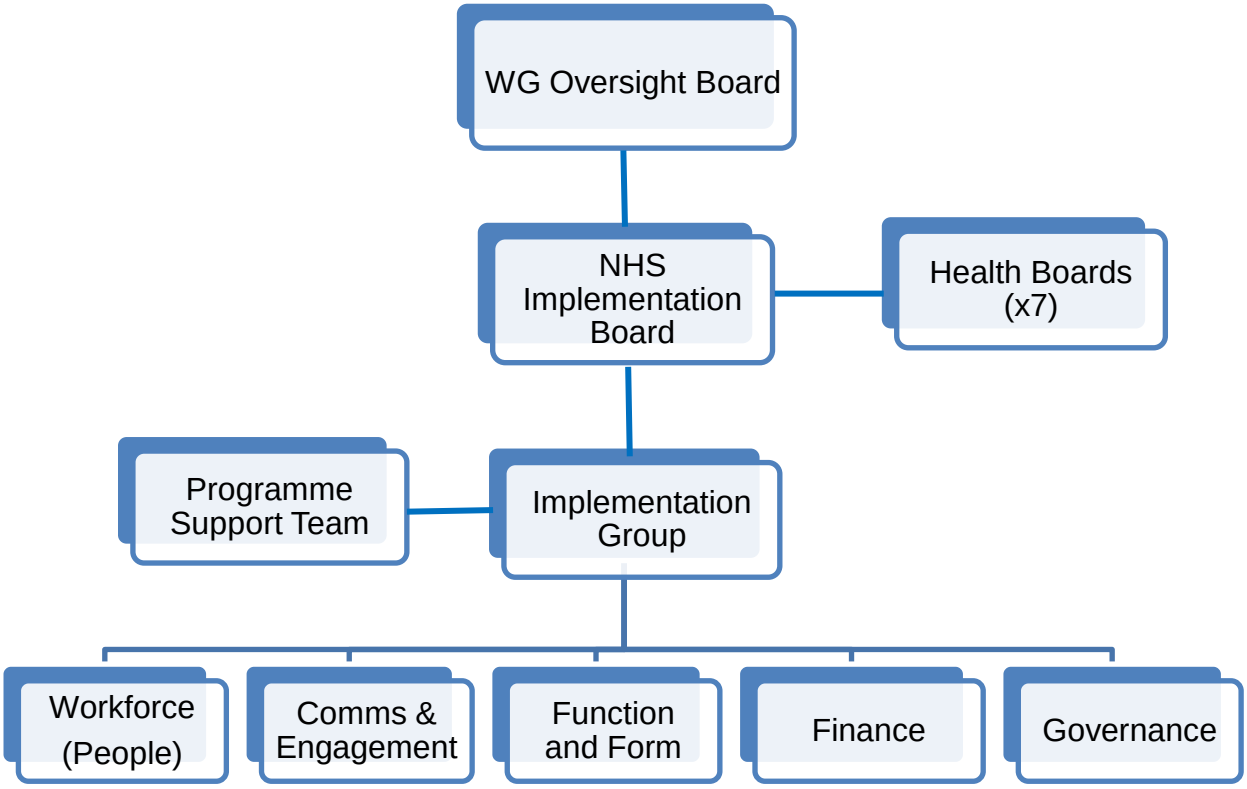
- **Chair/SRO:**
  - Samia Edmonds
- **Deputy Chair:**
  - Chris Jones, DCMO
- **Hosting body representatives and lead CEOs**:
  - Paul Mears
  - Nicola Prygodzicz
- **Chairs of the current national commissioning functions:**
  - Kate Eden
  - Chris Turner
- **Directors of the current national commissioning functions:**
  - Sian Lewis
  - Stephen Harrhy
  - Richard Bowen
- **Policy Leads:**
  - Melanie Westlake (NHS Wales Governance)
  - Aled Brown (Urgent & Emergency Care)
  - Pat Vernon (WHSSC)
  - Iain Hardcastle (Planning)
  - Finance (tbc)
  - Workforce?

- **Independent members**:
    - Mari Williams (Legal Services)
    - Christopher Griffiths (Legal Services)
- **Observers**:
    - Programme Director
    - Programme Lead

Audit Wales will act as an independent strategic advisor. Papers of all meetings will be shared routinely.

Additional members will be co-opted as necessary to ensure the Board fully meets its purpose and work plan.

5. Accountability/ Structures



6. Meetings

- The Oversight Board will meet monthly, and as required to meet the requirements of the programme.
- Members are permitted to send a deputy if unavailable to attend. Notification must be provided to the Chair in advance.
- It will be quorate with the following members present:
- Chair or Deputy Chair; at least two WG policy leads; at least two representatives from the national commissioning bodies; and one representative from a hosting body.

- Other WG & NHS directors / senior leaders to be invited to oversight board meetings as necessary, depending on subject matter to be discussed.
- Standing agenda items will include:
    - programme update;
    - highlight reports;
    - risks and issues;
    - programme decision log;
    - communications and engagement.
- Secretariat will be provided by the Health & Social Service Group Planning Team with a record maintained of actions and decisions, and progress monitored through the overall programme plan.

7. Agenda/Papers

- The agenda will be based on items agreed with the chair.
- Members may submit agenda items with notice as far in advance as possible.
- The agenda and papers will be circulated three days prior to the meeting.
- Programme overview and workstream highlight reports will be prepared in the prescribed format.

8. Close

The programme board will conclude upon completion of its business and as agreed by the SRO.

Appendix 3 - Implementation Board Terms of Reference

National Commissioning Functions
IMPLEMENTATION BOARD

Terms of Reference v0.10

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9. Context

An independent review was conducted in early 2023 to reflect upon the experiences of the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC), which also includes the National Collaborative Commissioning Unit (NCCU), and to further build upon national commissioning arrangements. This has included horizon scanning to explore other national commissioning functions and opportunities.

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The planned transfer of the Sexual Assault Referral Centres (SARC) commissioning service from the NHS Executive to the NCCU on 1 April 2024 will also be included within the remit of the project.

10. Purpose of the Implementation Board

The overall objective of the programme is to provide strategic direction and control to ensure all required preparatory work and engagement has been undertaken in order for the new Joint Committee to be operational and fit for purpose by 1 April 2024.

The arrangements and products to be put in place to facilitate ‘go-live’ on 1 April 2024 include:

- The appointment of a new single Joint Committee with a single Chair, for national commissioning
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- Governance model and necessary supporting mechanisms
- Documented legacy statements to enable evaluation of the new Joint Committee overtime
- A clear identity
- Confirmed interim hosting agreement subject to review post implementation
- Delegation of functions by health boards

In this context, the Implementation Board will lead on the execution of the programme providing assurance and advice to the Oversight Board.

Within its responsibilities, it will ensure delivery of the programme of activities as set out in the PID, to facilitate the co-ordination, delivery and timescale for the development of a single commissioning Joint Committee for Wales in line with the review’s recommendations and the decision of the Minister for Health and Social Services.

11. Remit of the Implementation Board

The Implementation Board will report, provide assurance and make recommendations to the Oversight Board. It will be responsible for the delivery of the programme, providing assurance to the SRO about the deliverability of the key milestones through the designated workstreams.

Specifically the Implementation Board will:

- Provide expertise to enable the establishment of a single commissioning Joint Committee for NHS Wales, ensuring it is supported by a robust governance structure and remains within the constraints of legislation, regulations and standing orders.
- Review the appropriate level of resources for transfer to the new Joint Committee to ensure it can effectively discharge its functions as a platform for a once for Wales commissioning function.
- Provide assurance to the Oversight Board that the programme is being managed and controlled effectively through the Implementation Group.
- Provide a steer and direction to the Implementation Group to ensure progression of the programme within the agreed timescales.
- Provide assurance to the Oversight Board that the change is managed within best practice guidelines, including the NHS Wales Organisational Change Policy, and that staff affected by the change feel supported and valued.
- Monitor programme risks and issues and escalate as appropriate to the Oversight Board.
- Ensure interdependencies across the workstreams are being managed and optimised.
- Escalate significant risks and issues to the Oversight Board which cannot be managed or mitigated within the implementation arrangements that may impact on delivery.
- Escalate areas of dispute to the Oversight Board which cannot be managed or mitigated within the implementation arrangements that may impact on delivery.
- Through routine reporting, providing assurance to the Oversight Board that all project and workstream activities, including critical milestones have been delivered effectively and on time.
- Ensuring timely communication with external key stakeholders.
- Ensure effective management of the project/programme budget,

12. Membership

Recognising that the new commissioning Joint Committee will remain a joint committee of Health Boards membership of the Implementation Board will be drawn from the most senior leaders within the current Joint Committees of WHSSC and EASC, adapted to reflect wider potential national commissioning opportunities, including the commissioning of 111 and SARC services. It will be co-chaired by the chairs of EASC and WHSSC and will have the following membership. The CEO of PHW has been added as a full member given that one of the recommendations from the Independent Review was to secure public health input to the new commissioning Joint Committee.

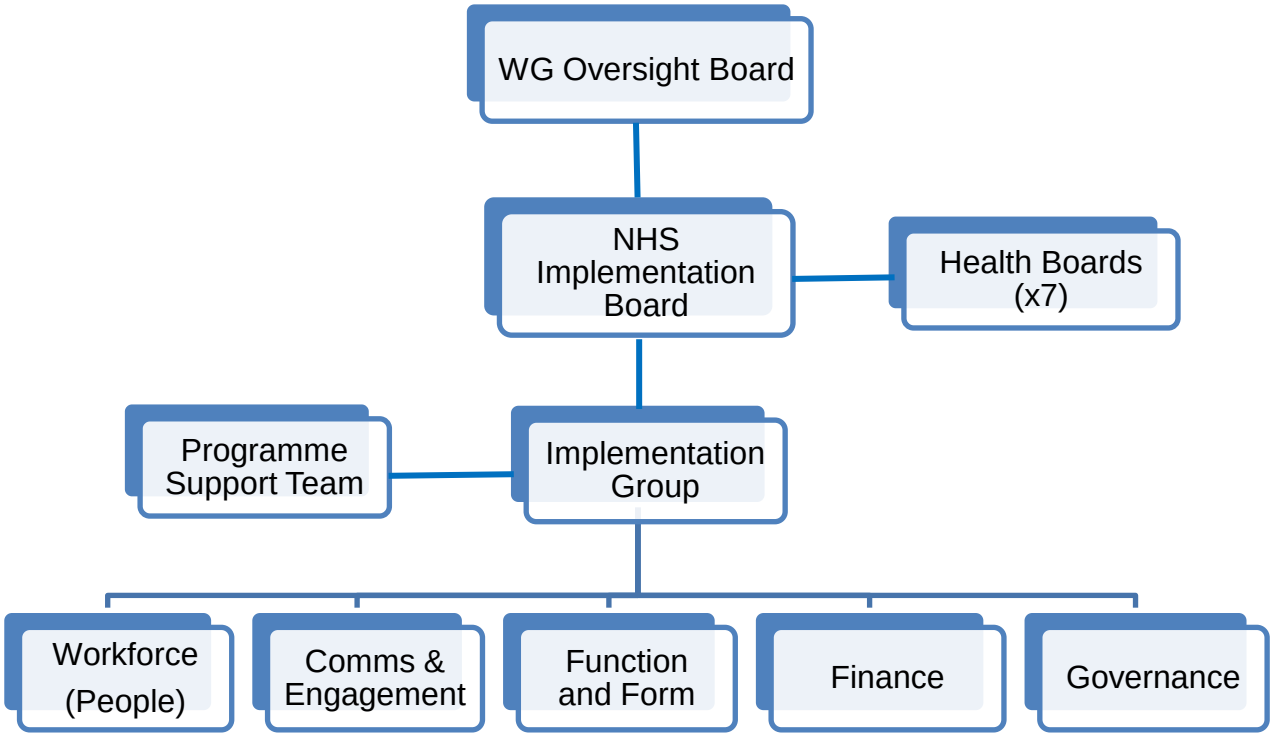
- **Members:**
  - Co-Chairs x 2
  - WHSSC Vice Chair and Independent Members (x 2)
  - Health Board Chief Executive Officers (x 7)
  - Chief Executive Officer Public Health Wales
  - Chief Ambulance Services Commissioner

  - Managing Director WHSSC
  - Chair of all Wales Directors of Planning
  - Director of the National Programme for Urgent & Emergency Care 111 and Six Goals Programme
  - Director of Finance WHSSC, EASC/NCCU

- **In Attendance:**
  - Programme Director for Project
  - Committee Secretaries x 2
  - Chief Exec WAST
  - Chief Exec Velindre
  - Programme Manager for Project

Additional members will be co-opted as necessary to ensure the Board fully meets its purpose and work plan.

13. Accountability/ Structures



14. Meetings

- The Implementation Board will meet monthly, and as required to meet the requirements of the programme.
- Members are permitted to send a deputy if unavailable to attend. Notification must be provided to the Chair in advance.
- It will be quorate with the following members present:
  - One of the Chairs

  - 4 Health Boards (in line with EASC and WHSSC Standing Orders)
  - 1 person representing WHSSC,
  - 1 person representing EASC and the NCCU
  - 1 person representing 111 Programme Board
  - At least one of the programme support team will be expected to be present.
- Standing agenda items will include:
  - Programme update;
  - Highlight reports;
  - Risks and issues;
  - Programme decision log;
  - Communications and engagement.
- Secretariat will be provided by the programme support team with a record maintained of actions and decisions, and progress monitored through the overall programme plan.
- Members of the Implementation Board will be responsible for ensuring that their own organisation is kept fully briefed on the programme. Written briefings will be provided following each meeting to aid this process.

15. Agenda/Papers

- The agenda will be based on items agreed with the chair.
- Members may submit agenda items with notice as far in advance as possible.
- The agenda and papers will be circulated three days prior to the meeting.
- Programme overview and workstream highlight reports will be prepared in the prescribed format.

16. Review

The Terms of Reference will be reviewed within 3 months of the start to ensure purpose remain extant for the duration of the project.

Appendix 4 - Implementation Group Terms of Reference

National Commissioning Functions
Implementation Group

Terms of Reference v0.4

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17. Context

An independent review was conducted in early 2023 to reflect upon the experiences of the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC), which also includes the National Collaborative Commissioning Unit (NCCU), and to further build upon national commissioning arrangements. This has included horizon scanning to explore other national commissioning functions and opportunities.

The review found that whilst there is good evidence of evolution and growing maturity in both WHSSC and EASC, there remain gaps and potentially lost opportunities in the current national commissioning arrangements in Wales. In particular, the review found scope to improve and strengthen decision making and accountability arrangements.

In summary, the recommendations made are:

- WHSSC, EASC and NCCU should be combined into a single Joint Committee. This would simplify and streamline the current arrangements. It would also create one central point of NHS commissioning expertise in Wales.
- This new Joint Committee should be given a new name to highlight that it is a new committee rather than just a merger of existing bodies.
- The term “specialist” [or “specialised”] should not be used in any new name, but the scope and responsibilities of the service should be defined.
- The new Joint Committee should take on an expert supportive role to health boards in developing Regional and Inter Health Board commissioning. This would help build commissioning capacity across the health system in Wales.
- The new Joint Committee should be responsible for commissioning the 111 service. This could provide a model for managing other commissioned services within NHS Wales going forward.
- The current hosting agreement should be retained but would need to be reviewed after the new Joint Committee is established. (This single, new joint committee would be hosted by Cwm Taf Morgannwg UHB as the UHB is the current host and employer for the two existing Joint Committees).
- There is currently a lack of Public Health input around population needs assessment etc. and this should be remedied in line with the requirement in the Memorandum of Agreement.
- An organisational development programme should be put in place, including a behaviour framework. This would help ensure the new Joint Committee creates its own identity.
- The establishment of strengthened governance arrangements for the Joint Committee, as set out in further detail in the report.

Whilst the commissioning of 111 services was not explicitly included in the initial scope of the review, this falls under the opportunities that were explored as part of the horizon scanning. This was a strong view put forward by health boards. This recommendation will therefore be tested and explored further, alongside the proposed transition of the 6 Goals Urgent & Emergency Care Programme into the NHS Wales Executive.

The planned transfer of the Sexual Assault Referral Centres (SARC) commissioning service from the NHS Executive to the NCCU on 1 April 2024 will also be included within the remit of the project.

18. Purpose of the Implementation Group

The overall objective of the programme is to provide strategic direction and control to ensure all required preparatory work and engagement has been undertaken in order for the new Joint Committee to be operational and fit for purpose by 1 April 2024.

The arrangements and products to be put in place to facilitate ‘go-live’ on 1 April 2024 include:

- The appointment of a new single Joint Committee with a single Chair, for national commissioning
- A functional model and operational specifications
- Completion of the organisational change process
- Governance model and necessary supporting mechanisms
- Documented legacy statements to enable evaluation of the new Joint Committee overtime
- A clear identity
- Confirmed interim hosting agreement subject to review post implementation
- Delegation of functions by health boards

In this context, the Implementation Group will act as the sounding board between the Programme Support Team and the Implementation Board. It will be responsible for generating ideas and providing support and guidance to the workstream leads on an operational level, and for reviewing the outcome of activities and recommendations to be taken to the Implementation Board.

Specifically the Implementation Group will:

- Provide a steer and direction to the Programme Support Team to ensure progression of the programme within the agreed timescales and provide operational advice to support activities where they are off-track
- Review the outcome of workstream activities to ensure they are fit for purpose prior to reporting to the Implementation Board
- Review all highlight reports and papers prior to sharing with the Implementation Board
- Ensure the programme is being managed and controlled effectively through the Programme Support Team.

- Ensure that the change is managed within best practice guidelines, including the NHS Wales Organisational Change Policy, and that staff affected by the change feel supported and valued.
- Ensure significant risks and issues are being tracked and managed effectively by workstream leads and support them in their risk management activities
- Escalate areas of dispute to the Implementation Board which cannot be managed or mitigated within the implementation arrangements that may impact on delivery.
- Identify interdependencies across the workstreams are identified, managed and optimised.
- Ensure the Programme Support Team is adequately resourced to deliver the programme

19. Membership

- **EASC/NCCU:**
  - Chief Ambulance Services Commissioner EASC/NCCU – Co-Chair
  - Deputy Chief Ambulance Service Committee
  - Clinical Director for NCCU
  - Deputy Director Communications and Engagement (EASC/NCCU)
  - Deputy Director and Head of Nursing (NCCU)
  - Committee Secretary

- **WHSSC:**
  - Managing Director WHSSC – Co-Chair
  - Director of Finance WHSSC and EASC/NCCU
  - Medical Director WHSSC
  - Director of Nursing WHSSC
  - Director of Planning WHSSC
  - Director for Mental Health & Vulnerable Adults WHSSC
  - Committee Secretary

- **111 and Six Goals Programme:**
  - Head of the National Programme for Urgent & Emergency Care 111 – Nicola
  - Workforce and Commissioning Lead for the 111 Programme Board

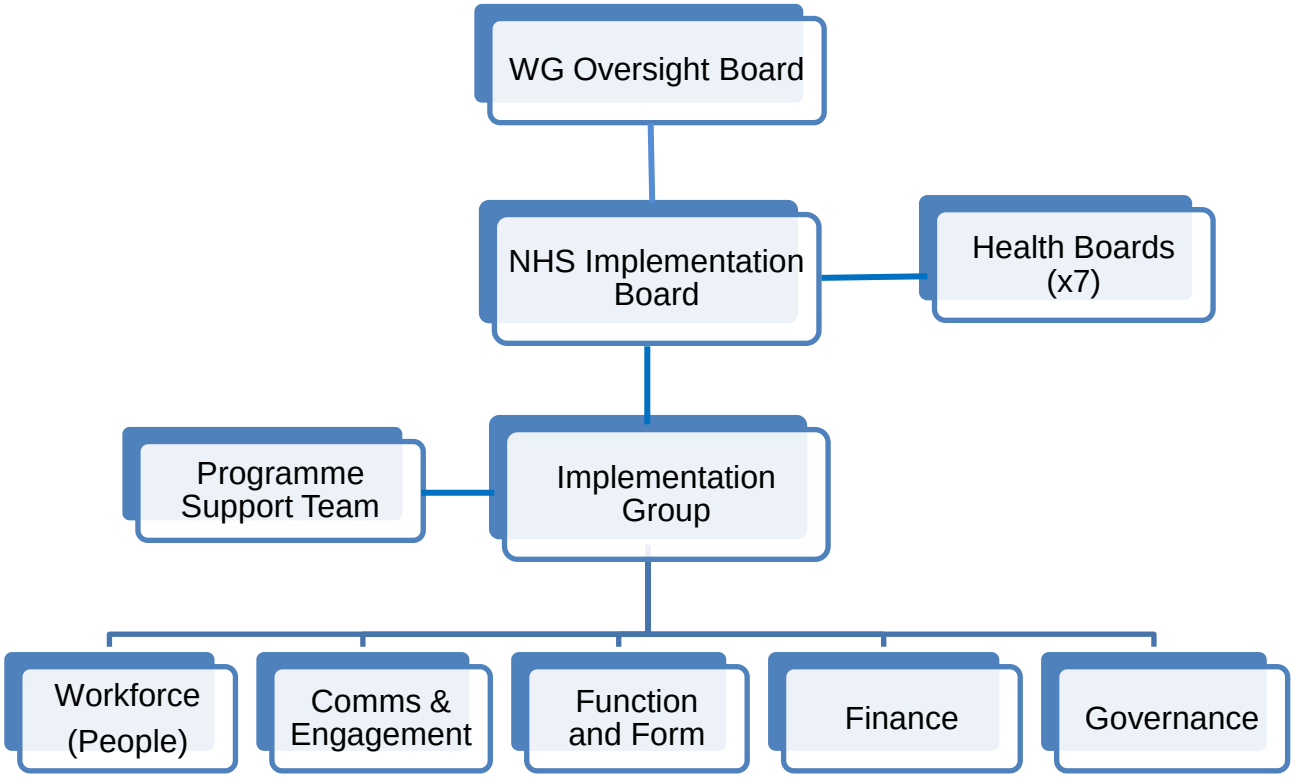
- **Health Boards:**
  - Director of Strategic Planning, or nominated deputy
  - Director of Finance, or nominated deputy
  - Board Secretary

- **Provider:**
  - Executive Director of Operations, WAST
  - Executive Director of Strategic Transformation, Planning and Digital, Velindre

- Programme Director for Project
- Programme Finance Director for Project
- Programme Manager for Project

Additional members will be co-opted as necessary to ensure the Group fully meets its purpose and work plan.

20. Accountability/ Structures



21. Meetings

- The Implementation Group will meet monthly, and as required to meet the requirements of the programme.
- Members are permitted to send a deputy if unavailable to attend. Notification must be provided to the Chair in advance.
- It will be quorate with the following members present:
  - 1 person representing WHSSC,
  - 1 person representing EASC and the NCCU
  - 1 person representing 111 Programme Board
  - 1 person representing Health Boards
  - At least one of the Programme Support Team will be expected to be present.
- Standing agenda items will include:
  - Programme update;
  - Highlight reports;
  - Risks and issues;

    - Programme decision log;
    - Communications and engagement.
- Secretariat will be provided by the programme support team with a record maintained of actions and decisions, and progress monitored through the overall programme plan.

22. Agenda/Papers

- The agenda will be based on items agreed with the chair.
- Members may submit agenda items with notice as far in advance as possible.
- The agenda and papers will be circulated three days prior to the meeting.
- Programme overview and workstream highlight reports will be prepared in the prescribed format.

23. Review

The Terms of Reference will be reviewed within 3 months of the start to ensure purpose remain extant for the duration of the project.

Appendix 5 - Key Programme Activities and Timeline

Month	Key Activities	Workstream
Aug – Sept 23	Sign off PID	
Aug – Sept 23	Establish and provide sign off to programme structure, sub-structure, and terms of reference	
Aug 23	Fully explore opportunities for national commissioning functions with health boards and key stakeholders	Function & Form
Aug 23	Scope 111 and SARC commissioning functions to determine inclusion within the new Joint Committee	Function & Form
Aug 23	Map committee structures, where appropriate, of WHSSC, EASC and NCCU	Workforce
Aug 23	Engage with Trade Unions on proposed new Joint Committee and planned OCP	Workforce
Aug 23	Develop Communication & Engagement Plan, including staff survey, FAQ sheet and staff bulletin to share with affected staff and wider key stakeholders	Comms' & Engagement
Aug 23 – Mar 24	Schedule joint staff meetings for the duration of the programme, to provide key updates and listen to feedback	Comms' & Engagement
Sept 23	Agree name for new Joint Committee (will require Ministerial approval)	Function & Form
Sept 23	Develop and agree commissioning functions for new Joint Committee	Function & Form
Sept 23	Produce legacy statements for WHSSC, EASC, NCCU, 111 and SARC commissioning to support future evaluation of new Joint Committee	Function & Form
Sept 23 – Oct 23	Develop structure for new Joint Committee	Function & Form
Sept 23 – Oct 23	Undertake financial assessment of WHSSC, EASC, NCCU, 111 and SARC commissioned services, and identify a budget for transfer to the new Joint Committee	Finance
Sept 23 – Oct 23	Map all fixed assets and lease arrangements	Finance
Sept 23	Map staffing structures of WHSSC, EASC, NCCU, 111 and SARC commissioning, and gather job descriptions in readiness for OCP process	Workforce
Sept 23 – Oct 23	Confirm structure for Tier 1 (Executive and Senior Management AfC 8c and above)	Workforce

Month	Key Activities	Workstream
Sept 23	Produce Staff Consultation paper for phased OCP process (Tiers 1, 2 and 3)	Workforce
Sept 23	Board secretaries advised of decision-making process and timelines for approval of delegation of functions to their individual Health Boards, and built in to Board agenda's	Governance
Sept 23 – Oct 23	Seek Ministerial approval to proceed with recruitment of a single Chair and Independent Members for the new Joint Committee	Governance
Oct – Nov 23	Develop branding for new Joint Committee in line with guidelines	Function & Form
Oct – Dec 23	Scope IT infrastructure and IG requirements, including transfer of documents, for new Joint Committee (NWSSP and DHCW support required)	Function & Form
Oct – Nov 23	Map all new sources of information re: 111 and SARC	Finance
Oct – Nov 23	Map all contracts for commissioning	Finance
Oct 23	Scope statutory instruments and legislation required for the establishment of the new Joint Committee	Governance
Oct – Nov 23	Scope Governance Framework and identify products for development (SO's, SFI's, Reservation and Delegation of Powers, MoU's, Policies and Procedures)	Governance
Oct 23 – Nov 23	Chief Executives to take agreed delegation of functions of the new Joint Committee to their individual Health Boards (supporting SO's and SFI's under development)	Governance
Oct 23	Carry out 4 week OCP consultation with affected staff and trade unions	Workforce
Oct 23 – Nov 23	Where required, produce and approve through HR process, job descriptions for Tier 1	Workforce
Oct 23 – Jan 24	Commence recruitment process for new Chair	Workforce
Nov – Dec 23	Undertake Tier 1 OCP process (job matching / slotting-in / prior consideration / TUPE)	Workforce
Nov 23	Confirm structure for Tier 2 (Snr/Middle Management AfC 8b - 7)	Workforce
Nov 23	Where required, produce and approve through HR process, job descriptions for Tier 2	Workforce
Nov – Dec 23	Prepare for transfer of documents to new website as appropriate (NWSSP and DHCW support required)	Function & Form
Nov 23 – Jan 24	Develop SO's, SFI's, Reservation and Delegation of Powers and MoU's for approval by committee and boards of Local Health Boards on establishment	Governance
Dec 23 – Jan 24	Undertake Tier 2 OCP process (job matching / slotting-in / prior consideration / TUPE)	Workforce

Month	Key Activities	Workstream
Dec 23	Commence recruitment process for Independent Members	Workforce
Jan 24	Confirm structure for Tier 3 (Officer AfC 6 - 3)	Workforce
Jan 24	Where required, produce and approve through HR process, job descriptions for Tier 3	Workforce
Jan 24	Commence process for securing Public Health involvement to support the commissioning functions of the new Joint Committee	Workforce
Jan 24	Develop OD Programme, including a Behaviour Framework, to support the principles and values of the new Joint Committee	Governance
Jan – Feb 24	Chief Executives to take Governance Framework including SO's, Reservation and Delegation of Powers and SFI's to the individual Heath Boards for approval	Governance
Feb – Mar 24	Undertake Tier 3 OCP process (job matching / slotting-in / prior consideration / TUPE)	Workforce
Feb 24	Interview process and appointment of Independent Members	Workforce
Mar 24	OCP process concluded	Workforce
Mar 24	Public Health support in place	Workforce
Mar 24	Chair and Independent Members in post	Workforce
Mar 24	Health Board approved delegation of functions in place	Governance
Mar 24	OD and Behavioural Framework in place	Governance
Mar 24	Website live	Function & Form
Mar 24	Go live of new Joint Committee	Function & Form