

Bundle Audit Committee 15 September 2023

- 1 AC23.78 Welcome, introductions and apologies for absence
AC23.78AC Agenda 15.09.23 vf
- 2 09:30 – AC23.79 Declarations of interest on current agenda
- 3 09:32 – AC23.80 Draft Minutes of the meeting held on the 15 May 2023 and 24 August 2023
AC23.80a Draft AC Minutes 15.05.23 v3
AC23.80b Draft AC Minutes 24.08.23 v4
- 4 09:40 – AC23.81 Action Log
AC23.81 Audit Committee – Table of Actions Public session
- 5 AC23.82 ITEMS FOR APPROVAL OR ASSURANCE
- 6 09:45 – AC23.83 Special Measures Report
AC23.83 FINAL 2023–09–15 – Audit Special Measures Update
- 7 09:55 – AC23.84 Review and Approval of Frameworks –Risk Management
AC23.84a AC – Developmental Board Session Risk
AC23.84b Risk Appetite 2023 v2
AC23.84c Risk Management Framework 23
AC23.84d EqIA RM01 2023
- 8 10:10 – AC23.85 Review and Approval of Standing Orders & Standing Financial Instructions Update
AC23.85a Review of HB Standing Orders final
AC23.85b BCUHB Model Standing Orders Reservation and Delegation of Powers July 2023 v6 Final PM
AC23.85cBCUHB SFIs July 2023 v5 Final
- 9 10:25 – AC23.86 Update on Board Declaration of Interest Gifts and Hospitality
AC23.86a Annual Declarations of Interests Gifts and Hospitality vf
- 10 10:35 – AC23.87 Audit Tracker Update
AC23.87a Tracker Cover Sheet_September_23_V2.0 (004) final pm
AC23.87b Tracker Appendix 1_September_23 V4 final
- 11 10:50 – AC23.88 Policy on Policies
AC23.88a Policy on Policies Cover Sheet_September_23_Vf
AC23.88b OBS01 – Policy for the Management of Health Board wide Policies Procedures other Written Control Documents
AC23.88c PoP_EqIA_Aug 2023
- 12 11:05 – AC23.89 Financial Control Plan & Single Tender Actions Summary
AC23.89 Audit Committee – Financial Reporting Single Tender Waivers Losses payments
- 13 11:20 – AC23.90 Internal Audit Progress Report
AC23.90a IA progress report Cover Sheet_September23
AC23.90b BCUHB Audit Committee progress report September 2023
AC23.90c Final Internal Audit Report – Contracted Patient Services – Quality
AC23.90d Final Internal Audit Report Substantive Interim ESP Recruitment for HB issue
AC23.90e Final Internal Audit Report – Planned Care Recovery Transformation Group_for client issue
AC23.90f BCUHB Final Internal Audit Report Data analysis and Triangulation of data
AC23.90g Final Internal Audit Report_Performance Management
AC23.90h Final Internal Audit Report_BAF and Risk Management_for client issue_
AC23.90i BCUHB Final Internal Audit Report_HSE NoC Action Plan_for client issue
AC23.90j Final Internal Audit Report – Clinical Audit Tier 1 National Audits
- 14 11:35 – AC23.91 Internal Audit Plan for October 2023 to March 2024
AC23.91 Internal Audit plan 2023–24 Oct23toMar24v2
- 15 11:50 – AC23.92 Audit Wales (external audit) progress reports
AC23.92a Audit Wales Update v1
AC23.92b Audit Committee Update – Aug 2023
- 16 AC23.93 National Audit Reports for information
AC23.93c digital-inclusion-eng
- 17 AC23.94 Orthopaedic Report

AC23.94a Orthopedic Report

AC23.94b 3290A2022 BCUHB Organisational Response Form (July23) WAO Recommendations Responses

18 AC23.95 CLOSING BUSINESS



Agenda for Audit Committee

Date 15 September 2023
Time 09:30 -12:00
Location Boardroom, Carlton Court
Chair Karen Balmer

Agenda item	Item	Lead	Action	Paper/Verbal
1.0 OPENING ADMINISTRATION				
1.1	Welcome, introductions and apologies for absence	Chair	Information	Verbal report [2 mins]
1.2	Declarations of interest on current agenda	Chair	Decision	Verbal Report [1 mins]
1.3	Draft Minutes of the meeting held on the 15 May 2023 and 24 August 2023	Chair	Approval	Report [5 mins]
1.4	Action Log	Chair	Approval	Report [5 mins]
2.0 ITEMS FOR APPROVAL OR ASSURANCE				
2.1	Special Measures Report (Including consideration of Financial Control)	Director of Transformation & Improvement	Assurance	Report [10 mins]
2.2	Review and Approval of Frameworks -Risk Management	Interim Board Secretary	Recommend	Report (10 mins)
2.3	Review and Approval of Standing Orders	Interim Board Secretary	Approval	Report [20 mins]
	Standing Financial Instructions Update	Executive Director of Finance		
2.4	Update on Declaration of Interest and Gifts and Hospitality	Interim Board Secretary	Assurance	Report [10 mins]
2.5	Audit Tracker Update	Interim Board Secretary	Assurance	Report [10 mins]
2.6	Policy on Policies	Interim Board Secretary	Approval	Report [10 mins]
2.7	Financial Control Plan Single Tender Actions Summary	Executive Director of Finance	Approval	Report [20 mins]
2.8	Internal Audit Progress Report. (Including consideration of audits with limited or no assurance)	Internal Audit	Assurance	Report [25 mins]



Agenda item	Item	Lead	Action	Paper/Verbal
2.9	Internal Audit Plan for October to March 2024	Internal Audit	Assurance	Report [5 mins]
2.10	Audit Wales External Audit Progress Report	Internal Audit	Assurance	Report [5 mins]
3.0 ITEMS FOR NOTING				
3.1	National Audit Reports for information	Audit Wales	Noting	Report [5 mins]
3.2	Orthopaedic Report	Audit Wales	Noting	Report [5 mins]
4.0 CLOSING BUSINESS				
4.1	Reflections on meeting	Chair	Information	Verbal
4.2	Date of Next Meeting	Chair	Information	Verbal

MEMBERS	
Name	Title
Karen Balmer	Independent Member, Chair
Dyfed Jones	Independent Member
Gareth Williams	Independent Member
In attendance	
Russell Caldicott	Interim Executive Director of Finance
Richard Coxon	Interim Head of Corporate Affairs (minutes)
Andrew Doughton	Audit Wales
Dyfed Edwards	Independent Member/Health Board Chair
Matt Edwards	Audit Wales
Dave Harries	Head of Internal Audit
Andrea Hughes	Interim Director of Finance – Operational Finance
Nicola Jones	Deputy Head of Internal Audit
Nick Lyons	Executive Medical Director/Deputy Chief Executive Officer
Phil Meakin	Interim Board Secretary
Michelle Phoenix	Audit Wales Performance Lead
Carol Shillabeer	Interim Chief Executive Officer
Simon Monkhouse	Audit Wales
Paolo Tardivel	Director of Transformation & Improvement
Dave Thomas	Audit Wales
Karl Woodward	Head of Local Counter Fraud Services
Angela Wood	Executive Director of Nursing & Midwifery

Betsi Cadwaladr University Health Board

Minutes of the Audit Committee held on 15 May 2023, Meeting Room 1, Wrexham Medical Institute

Present	
Name	Title
Karen Balmer	Independent Member, Chair
Gareth Williams	Independent Member
In attendance	
Andrew Doughton	Audit Wales
Matt Edwards	Audit Wales
Dave Harries	Head of Internal Audit
Nicola Jones	Deputy Head of Internal Audit
Marty Mcauley	Deputy Board Secretary (minutes)
Phil Meakin	Interim Board Secretary
Tony Utley	Interim Director of Finance
Steve Webster	Interim Executive Director of Finance

Agenda item	Action
AC23.17 OPENING BUSINESS	
AC23.18 Welcome introductions and apologies	
<p>AC23.18.1 Karen Balmer, Independent Member (Chair) welcomed everybody to the meeting.</p> <p>AC23.18.2 There were apologies from counter fraud team. The chair set expectations for the meeting in terms of attendance, contribution preparation, workflow, paper production and conduct at meetings.</p>	
AC23.19 Declarations of interest on current agenda	
<p>AC23.19.1 Marty Mcauley (MM), Deputy Board Secretary confirmed that there were no declarations to be made for the agenda today but a further piece of work would be completed with the board to strengthen its assurance.</p>	
AC23.20 Minutes of Previous Meeting	
<p>AC23.20.1 The Chair noted that there were no independent members in attendance at this meeting that had been present at the previous meeting.</p> <p>AC23.20.2 The minutes were noted as an accurate summary of the previous meeting by the officers present. As such the minutes were noted as accurate but were not formally approved by the committee.</p>	



<p>AC23.20.3 The minutes were noted but not approved.</p>	
<p>AC23.21 Action Point Register</p> <p>AC23.21.1 MM presented the action point register explaining the presentation and format that we would be taking. He explained all actions would be updated prior to the meeting by the Executive and would be presented to the committee as either an action that had been completed and therefore the committee could close it or as a progress update. MM reiterated that only the Committee can agree that an action is closed.</p> <p>AC23.21.2 The committee closed the requested actions and noted progress with the others.</p>	
INTERNAL AUDIT ASSURANCE REPORTS	
<p>AC23.22 Internal Audit Progress Report</p> <p>AC23.22.1 There were four items taken under the internal audit suite of papers which were led by Dave Harries (DH) from the internal Audit team.</p> <p>AC23.22.2 The Internal Audit Progress Report which covered the 1 January to 30 April 2023. The progress report summarised:</p> <ul style="list-style-type: none">• Seven reviews which had been completed since the last committee in January 2023.• Seven reviews remain in progress.• The internal audit team highlighted the 20- day turn around challenging service level agreement for management to respond to draft reports.• The current compliance level is 58%. The audit chair reminded officers present of the importance of achieving the timescales that and expects a higher compliance rate in future reports.	
<p>AC23.23 Internal Audit Plan</p> <p>AC23.23.1 The internal audit team noted the trend that the health board was ahead of in moving to a six-month plan not a 12- month plan as this allows the Committee Chair, Accountable Officer and Board Secretary to identify any emerging risks and allow sufficient flexibility to respond accordingly.</p> <p>AC23.23.2 In year risks are based at a point in time and this approach will enable us to influence the plan accordingly. Phil Meakin (PM), Interim Board Secretary confirmed this plan had been shared with the executives and agreed by them. The Chair reminded everyone the importance of culture and how this links to the plan.</p> <p>AC23.23.3 The internal audit team presented the six-month internal audit plan which covered the period of April to September 2023 and detailed the audits to be undertaken. Contained within the internal audit plan is also the internal audit charter which defines the overarching purpose, authority and</p>	



responsibility of the internal audit and the key performance indicators for the service.

AC23.24 IA final report: Delivery of Health Board Savings

AC23.24.1 The internal audit team presented the final internal audit reports on the delivery of health board savings. The internal audit outcome report issued no assurance in this area and highlighted significant matters which required management attention. It also highlighted the high impact on residual risk exposure until it is resolved.

AC23.24.2 Four actions are noted in the final report all of which were agreed by management and all of which have a high priority status. SW gave an update on planned care. The Committee noted that utilisation was positive.

AC23.24.3 GW stated the importance to look at what we can learn in the preparation of business plan. Steve Webster (SW) Interim Executive Director of Finance confirmed it is important that we measure what we say we can and benchmark appropriately. The Chair requested that for all future meetings individuals attend to present and speak to internal audit reports in their area of expertise.

ACTION: MM to note the change in process to ensure all leads are present when their internal audit report is reviewed.

AC23.24.4 SW agreed the work around urgent care perspective needs to be brought back and debated at a future point in the right time.

AC23.25 IA final report: Business Case outcomes

AC23.25.1 The internal audit team presented the final internal audit report on the urgent primary care centres business case outcomes achieved. The internal audit team issued a limited assurance on this report and noted the moderate impact on residual risk exposure until it is resolved.

AC23.25.2 There were five recommendations were made all of which were agreed by management. This was made up of two high priority, two medium priority and one low priority. The Committee were asked to approve the draft audit plan and charter so that we were compliant with the Welsh government NHS Wales audit committee handbook. As a result of the information provided to the Committee, they confirmed that they were assured.

AC23.25.3 The Audit Assurance Committee approved the six-month internal audit plan. The Committee noted the rolling plan when risk is entered for October to March 2024.

AC23.25.4 The Committee noted the row gap in resource requirements to



<p>deliver the increase in assurance requested by the help all or dignity approved the internal audit charter and noted the associated internal key performance indicators.</p>	
<p>AC23.26 Internal Audit Recommendations</p> <p>AC23.26.1 MM presented the internal order actions tracker to the committee. This is a new report and sees the recommendations stripped out of the internal audit updates and managed as a separate item of audit business at the request of the new Chair of Committee. The Chair welcomed the separation and noted the report is a work in progress with further work to be undertaken.</p> <p>AC23.26.2 The Committee was pleased to see the direction of travel and requested further updates and strengthened assurance be added for the next presentation. This will enable the committee to better hold to account individuals for the timely delivery of internal audit recommendations.</p> <p>ACTION: MM to update the action tracker and share areas of non-compliance with the Committee.</p> <p>AC23.26.3 The Committee enquired about the Clinical Audit Programme SW then confirmed the internal audit will review clinical audit as part of the follow up plan. GW requested to further understand the Welsh translation and document requirements outside of the meeting and what we are signed up to and where we are falling short. PM mentioned that the Board receives a paper in this and will confirm timing,</p> <p>ACTION PM to confirm that the Welsh Language Compliance report is coming to Board.</p>	
RISK & GOVERNANCE	
<p>AC23.27 Risk Management</p> <p>AC23.27.1 MM presented the new look risk management reports to the committee. The report focuses on tier one risks which score between 15 and 25 on the corporate risk register. MM explained how the data could be cut and coordinated offering different views of risk and therefore allowing the audit committee to take assurance from the information provided.</p> <p>AC23.27.2 Next steps for the risk report will include a heat map a focus on assurance and development of risk appetite, there are currently 48 risks in tier one. GW endorsed the approach with last reporting and more quality as the focus noting some risks are very broad and some very narrow.</p> <p>AC23.27.3 The Committee agreed that was not changed to consolidate risks where appropriate. The Chair sought assurance that the escalation process was in place. It was confirmed that there is a risk management group process in place, PM confirmed there was evidence of the escalation</p>	



<p>in the register. It can be improved and this will be a focus moving forward.</p> <p>AC23.27.4 The Committee noted the report commending the presentation.</p> <p>AC23.27.5 The Committee noted the report.</p>	
<p>AC23.28 Board Assurance Framework</p> <p>AC23.28.1 MM presented the Board Assurance Framework which highlights and tracks the most significant risks that can prevent the organisation from achieving its corporate objectives. MM explained that due to the short time scale of the meeting only some of the board assurance framework had been updated – mainly the finance section.</p> <p>AC23.28.2 The Committee noted the further work required for the next meeting to enable the audit committee to take full assurance from the report</p> <p>AC23.28.3 The Committee noted the report action.</p>	
<p>AC23.29 Any other Business</p> <p>AC23.29.1 The Committee went into private session.</p>	
<p>AC23.30 Date of Next Meeting</p> <p>The date of the next meeting - TBC</p>	

Betsi Cadwaladr University Health Board

Minutes of the Extraordinary Audit Committee held on 24 August 2023, Conference Room, Optic Centre, St Asaph

Present	
Name	Title
Karen Balmer	Independent Member, Chair
Dyfed Jones	Independent Member
In attendance	
Jason Brannan	Deputy Director of Workforce and OD
Clare Budden	Independent Member
Russell Caldicott	Interim Executive Director of Finance
Simon Cookson	Director of Audit and Assurance, Internal Audit (via link)
Richard Coxon	Interim Head of Corporate Affairs (minutes)
Andrew Doughton	Audit Wales
Dyfed Edwards	Independent Member/Health Board Chair
Matt Edwards	Audit Wales
Andrea Hughes	Interim Director of Finance
Rhian Watcyn Jones	Independent Member
Dr Nick Lyons	Executive Medical Director
Phil Meakin	Interim Board Secretary
Simon Monkhouse	Audit Wales
Michelle Phoenix	Audit Wales Performance Lead
Carol Shillabeer	Interim Chief Executive Officer
Tony Utley	Interim Director of Finance
Angela Wood	Executive Director of Nursing & Midwifery

Agenda item	Action
OPENING BUSINESS	
AC23.54 Welcome introductions and apologies	
<p>AC23.54.1 Karen Balmer, Independent Member and Chair (Chair) of the Audit Committee welcomed everyone including her fellow Health Board members to the Extraordinary Audit Committee to approve the 2022/23 Annual Accounts. She thanked all parties for their efforts to get to this point and outlined a full agenda.</p> <p>AC23.54.2 Apologies were received from:</p> <ul style="list-style-type: none"> • Gareth Evans, Acting Director of Therapies & Health Science • Dave Harries, Head of Internal Audit • Nicola Jones, Deputy Head of Internal Audit • David Jenkins, Welsh Government Adviser • Prof Mike Larvin, Independent Member • Teresa Owen, Executive Director of Public Health 	



<ul style="list-style-type: none">• Fôn Roberts, Associate Member• Chris Stockport, Executive Director of Transformation and Planning• Gareth Williams, Independent Member• Karl Woodward, Head of Local Counter Fraud Services	
<p>AC23.55 Declarations of interest on current agenda</p> <p>AC23.55.1 There were no declarations of interest noted.</p>	
<p>AC23.58 ANNUAL ACCOUNTS 2022-23</p>	
<p>AC23.59 Annual Accounts 2022-23 and Publications</p> <p>AC23.59.1 Mr Russell Caldicott (RC), Interim Executive Director of Finance introduced the presentation which had been circulated prior to the meeting. RC had met with both Audit Wales and Welsh Government to ensure they were content with the approach being taken.</p> <p>AC23.59.2 The Annual Report and Accounts 2022/23 had been split into four sections for review:</p> <ul style="list-style-type: none">• Part A Audited Annual Accounts 2022/23• Part B Audit Wales• Part C Annual Report 2022/23• Part D Annual Governance Statement 2022/23	
<p>AC23.60 Audited Annual Accounts 2022/23</p> <p>AC23.60.1 RC presented the Annual Accounts 2022/23. The 2022/23 unaudited Annual Financial statements were submitted to Welsh Government and Audit Wales on 5 May 2023, with the draft accounts presented to Audit Committee in May 2023 and further reviewed at the Audit Committee Workshop on the 24 July 2023.</p> <p>AC23.60.2 RC confirmed that the Health Board was unable to file the audited accounts as required by Welsh Government on the 31 July 2023 due to some difficulties during the audit. Audit Wales findings identified a number of non-material adjustments/ unadjusted misstatements, with management actioning the changes where practical to do so. Two key findings from Audit Wales were:</p> <ul style="list-style-type: none">• The outturn for the year from draft to final remains consistent• The closing balances contained within the Balance Sheet for 2022/23 are supported by Audit Wales as being a true and fair view of the closing position for the Health Board <p>AC23.60.3 The Health Board Accounts for 2022/23 will receive an adverse opinion (Qualification) owing to the 2021/22 opinion and a regulatory breach in approval of an interim appointment. Carol Shillabeer, Interim Chief Executive Officer (CEO) added that it was a very difficult position for the Board to be in and to have the accounts qualified is a significant issue.</p>	



She acknowledged the Health Board open the new year accounts in a much stronger position but that there is more work to do to further strengthen the governance, recognising the challenges ahead.

AC23.60.4 Gareth Williams, Independent Member, had submitted comments and questions through the Interim Board Secretary as he was unable to attend the meeting.

AC23.60.5 Trade and other payables outstanding - £237m – this seems very high given achievement of 95% target in paying non-NHS bills. Largest item Non-NHS accruals – are these items not yet invoiced? RC responded, The 95% target relates to the public payment policy for invoices. The largest item relates to primary care payments which are direct payments not invoices and are paid in arrears hence the inclusion within the Trade Payables. This area also includes items such as HMRC and Pensions.

AC23.60.6 Expenditure on staff – up by over 10% compared to previous year. Number of staff though increased by only 3%. Do national pay awards really account for this – seems high? Or is mix of grades changing? RC responded, The pay awards for 22/23 do represent a significant part of the change – they include 4.95% plus a further 3.0% (1.5% non-consolidated and 1.5% consolidated). They also include the ENIC Levy for the April to October period.

AC23.60.7 Agency staff pay increase concerning as we know but it is striking that 41% or £30million (a 50% increase on previous year) is spent on 'other staff', Would be useful to know what proportion of this are patient-facing, allied professions and what back office. RC responded, The majority of Agency costs are incurred on patient facing and allied professional roles. Whilst there is Agency spend coded to A&C staff, many of these are also in patient facing roles.

AC23.60.8 Following consideration of Audit Wales findings on review of the Financial Statements, the Audit Committee agreed that they would recommend adoption of the 2022/23 Annual Accounts to the Health Board.

AC23.61 Audit Wales

AC23.61.1 Matt Edwards, Audit Wales presented the report and it was noted that a significant amount of work had been undertaken post submission to resolve accuracy issues, and a significant number of amendments had been made in appendix four.

AC23.61.2 The Committee were briefed that the Auditor General for Wales intends to issue a qualified "true and fair" audit opinion as he has been unable to obtain sufficient appropriate audit evidence that the opening balances of accruals and payables brought forward from the 2021/22 financial year, along with related expenditure, has been accounted for in



the correct accounting period. The audit opinion will also be qualified as the Health Board incurred irregular expenditure and breached its standing financial instructions in making payments to an Interim Executive member of the Board.

AC23.61.3 ME alerted the committee to the volume of adjustments/corrections to the accounts which was higher than normal due to staff turnover/ capacity issues and a higher volume of staff without the historical knowledge of the financial year in question. It was unanimously agreed that the situation was unacceptable and that the health board could not find itself in this position again. Furthermore, the audit committee would be monitoring recruitment and retention issues within the finance dept going forward.

AC23.61.4 The Chair invited questions from the Committee. RC confirmed we wanted an open and transparent set of accounts and there were three uncorrected misstatements that were not changed. The three adjustments were not material and the Committee were drawn to page 15 of the letter of representation for further rationale. In response to a direct question from the Chair, Audit Wales confirmed that the uncorrected misstatements were not material and that as BCUHB's auditors were not recommending any further action to correct these.

AC23.61.5 Gareth Williams had submitted a question which was "how confident are we that we can reduce the level of errors below the materiality threshold". RC highlighted the opportunities that are available to resolve some of these issues in the future, which included sharing information, strengthening the technical team in finance and communicating with Audit Wales and Audit Committee.

AC23.61.6 The Chair acknowledged where we were and the balance of needing to be open and transparent. Progress had been made and more things for the Board to explore and recognised the additional time that had been taken to correct the errors and thanked all of the colleagues at Audit Wales for their effort and support who went above and beyond what was asked of them.

AC23.61.7 Gareth Williams had submitted: Noting staff changes and shortages have not helped the current situation, what assurance is there that any systemic issues have been addressed? The CEO also recognised the efforts of the finance team to deliver these accounts. Planning, tracking and escalation needs to be in place so we fundamentally change the system and processes around the SO, SFI, SoRD and senior managers will have the same training as well as procurement training. These will be undertaken as a matter of priority.

AC23.61.8 The Chair of the Audit Committee endorsed the considerable effort of all parties involved.



<p>AC23.61.9 ME advised that the annual audit had been undertaken under the new revised standard which was more granular in its approach. The new standard had been adopted as a result of the collapse of Carillion.</p> <p>AC23.61.9 The Audit Committee noted the content of the report and any recommendations included within the Auditor General for Wales report to the Senedd.</p>	
<p>AC23.62 Annual Report 2022/23</p> <p>AC23.62.1 The CEO presented the Annual Report for 2022/23 recognising that she has not been in post during the time period but thanked colleagues for their support. It is a requirement to produce an Annual Report and an Annual General Meeting (AGM) which would be on the 27 September 2023 and offers the public with an opportunity to engage and ask questions of the Health Board.</p> <p>AC23.62.2 The CEO confirmed that the Annual Report was compliant but drew attention to the performance section where there were a significant number of performance issues which align to the special measures' activity.</p> <p>AC23.62.3 It was agreed that sustainability was important and the Board should revisit.</p> <p>ACTION: The Executive Director of Finance to consider where this is best placed to enable the Board to look at sustainability.</p> <p>AC23.62.4 The CEO reminded the Committee that it is currently in the stabilisation phase of work.</p> <p>AC23.62.4 Gareth Williams submitted a question about the length of the report. It was confirmed that this was a statutory duty but looking forward to the AGM, a user-friendly public facing version would be produced along with a translated Welsh version.</p> <p>AC23.62.5 Gareth Williams noted that NHS Wales had adopted the National Living Wage of £9.90 an hour. Assurance was sought that this wasn't what used to be called the national minimum wage. If it, was it was inappropriate to say we adopted it as it was mandated?</p> <p>ACTION: Confirmation to be sought outside of this meeting</p> <p>AC23.62.6 The Committee approved the content of the Annual Report for submission to Welsh Government and for publication.</p>	<p>RC</p> <p>JB</p>
<p>AC23.63 Annual Governance Statement 2022/23</p> <p>AC23.63.1 Phil Meakin (PM), Interim Board Secretary presented the item</p>	



and confirmed that the most current version of the Annual Governance Statement had been uploaded to iBabs. He explained that the Annual Governance Statement and the Annual Accounts all became part of the Annual Report. It was highlighted that there had been a number of amends to get the report right both from Audit Wales and the Office of the Board Secretary.

AC23.63.2 PM highlighted that the section on the standing orders had been strengthened and the risk section had updated controls. There were significant rewrites in the committee and membership attendance and the remuneration sections to improve its accuracy and this has been verified with Audit Wales.

AC23.63.3 It was noted that there were two sections both given the number 23.2.

ACTION: The Board Secretary to amend

PM

AC23.63.4 The CEO drew out the weaknesses that exist in the risk management arrangements and what was being done about it, culminating in a new framework being submitted to the Board in September for approval as well as some board effectiveness work which is being planned with Audit Wales. The current internal controls have some limitations which are clear as well as some services that require significant improvement

AC23.63.5 The CEO confirmed that they intend to bring an integrated planning framework to the Board shortly. Whilst the year started with targeted intervention, and ended with special measures, there is progress and more can be made. The CEO advised of the internal audit's limited assurance opinion, the improvements recommended by HCIWand that the IMTP had not been approved. The CEO added that it will take time and energy but the improvement journey has already begun.

AC23.63.6 The Audit Committee agreed that they would recommend adoption of the 2022/23 Annual Governance Statement to the Health Board and reiterated the plan to retain oversight of the improvement plans in train through special measures.

AC23.64 Head of Internal Audit Opinion

AC23.64.1 Simon Cookson, Director of Audit and Assurance, Internal Audit presented the report. He explained that the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the Health Board's risk management, control and governance processes. SC confirmed that Internal Audit were providing a Limited Assurance opinion for 2022/3.

AC23.64.2 SC added that there were a number of areas where there was



<p>limited or no assurance taken from the audit work that was undertaken:</p> <p>AC23.64.3 The Chair of the Audit Committee stressed the need to work through these considering how the Health Board can strengthen controls through the next audit programme.</p> <p>AC23.64.4 The Audit Committee noted and received the Head of Internal Audit opinion and annual report for 2022/23.</p>	
<p>AC23.65 Structured Assessment 2022/23</p> <p>AC23.65.1 2022/23 structured assessment is a review undertaken across all statutory bodies across Wales looking at governance including finance, planning and strategy. The structured assessment review was completed by Audit Wales and first submitted to the Audit Committee in May 2023.</p> <p>AC23.65.2 The report has now been updated to include the management response. The Committee were mindful of not duplicating effort and so the board effectiveness report is now in the board effectiveness review.</p> <p>AC23.65.3 PM thanked the team at Audit Wales for their flexibility with an acknowledgement for their support during a busy period and in particular, the positive working relationship with the administration teams was noted.</p> <p>AC23.65.4 The CEO added that the work to be done aligns to the special measures work and we can avoid duplication. The findings were clear and will be addressed. Dyfed Edwards, Chair of the Health Board as an observer (not a member of Audit Committee) addressed the committee adding that the SAR is a very important piece of work for the committee. Clarity was sought by DE that the report referred to 2022/23 rather than a calendar year. ME confirmed that the finances refer to a financial year and the other work to a point in time when the work was undertaken</p> <p>AC23.65.5 The Committee Chair confirmed our commitment to timely responses and apologised to our colleagues on behalf of the Health Board.</p> <p>AC23.65.6 The Audit Committee received the Structured Assessment 2022–23.</p>	
<p>AC23.66 Audit Wales - Audit Committee Update</p> <p>AC23.66.1 Michelle Phoenix, Audit Wales, presented the Audit Wales Update report which provided the Audit Committee with an update on the work Audit Wales were undertaking with the Health Board.</p> <p>AC23.66.2 It was noted that the Charitable Funds audit will occur towards the end of the year due to financial reporting window to the Charity Commission.</p>	



<p>AC23.66.3 Andrew Doughton, Audit Wales noted that there would be some follow up work on the board effectiveness review . The Chief Executive welcomed this but reminded that we must be realistic in terms of improvement trajectories.</p> <p>AC23.66.4 The Audit Committee received the Audit Wales Update Report.</p>	
ITEMS FOR NOTING	
AC23.67 Annual Report of Local Counter Fraud Service Work 2021 - 2022	
<p>AC23.67.1 Karl Woodward, Head of Local Counter Fraud Services, had presented the report which should have gone to the Audit Committee meeting in October 2022 in the Audit Workshop in July. He was unable to attend today's meeting but would bring the Annual Report of Local Counter Fraud Service Work 2022 – 2023 to the next meeting.</p> <p>AC23.67.2 The Committee received and noted the report.</p>	
AC23.68 CLOSING BUSINESS	
AC23.69 Reflections on meeting	
<p>The Chair thanked all those in attendance for their contribution to the meeting discussions.</p>	
AC23.70 New Risks	
<p>There were no new risks identified during the meeting.</p>	
AC23.71 Date of Next Meeting	
<p>The date of the next meeting – 15 September 2023.</p>	

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						
	Interim Director of Finance	Internal Audit Progress Report - AC23.08 Remind colleagues engaged with wealth projects to engage with the capital audit team	1 Jan 2023	All teams have been briefed.	Action closed	
	Board Secretary	Internal Audit Progress Report - AC23.08 It was agreed that future internal audit programmes would be set out for periods of six months, rather than twelve.	15-May-23	New Audit Programme is 6 months and not 12	Action closed	
	Board Secretary	Internal Audit Progress Report - AC23.08 Set date for Audit Committee workshop in May and review committee effectiveness / terms of reference	01-Feb-23	Proposed action closed as Standing Orders going to the Board and OBS review replaces effectiveness review.	Proposed Action closed	
	Board Secretary	Board and Committee reporting - AC23.08.5F The Terms of Reference and Cycle of Business would be reviewed with Committee chairs later in Q1. There would also be a round of committee effectiveness reviews	30-Jun-23	Proposed action closed as OBS review replaces effectiveness review.	Proposed Action closed	
	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	

	Audit Wales	Equality Impact Assessments - AC23.09 Audit Wales agreed to provide some individual examples of good practice.	15-May-2023	This was a historic action and not recognised and so agreed at Committee it would be closed.	Action closed	
	Interim Director of Finance	Performance Accountability Framework - AC23.11.01 Finalise the Performance Assessment Framework for 2023/24 and take it through PFIG	21-Mar-23	A report went to the May 2023 PFIG agenda to brief the committee on this programme of work	Action closed	
	Executive Medical Director	North Wales Dental Services Assurance Report - AC23.12 It was agreed that any updates on this matter should no longer be reported to the Audit Committee, but should come to PFIG.	15-May-23	Discussed with Nick Lyons and reporting route noted. Future updates will go to PFIG	Action closed	
	Board Secretary	Issues of Significance for reporting to Board - AC23.14 The Chairman confirmed that the Limited Assurance reports reported today would be escalated to the Board	15-May-23	Added to the agenda for the next Board meeting on 25 May 2023	Action closed	
Actions from 15 May 2023						
	Deputy Board Secretary	IA final report: Delivery of Health Board Savings - AC23.24 MM to note the change in process to ensure all leads are present when their internal audit report is reviewed.	15-May-2023	Added to the agenda for the next Board meeting on 25 May 2023	Action closed	
	Deputy Board Secretary	Internal Audit Recommendations - AC23.26 Update the action tracker and share areas of non-compliance with the Committee	15-May-2023	Action tracker on agenda for 15 September 2023. Propose this action is closed post Audit Committee meeting.	Action closed	
	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.	Action ongoing	

Actions from 24 August 2023						
	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.	Action ongoing	
	Deputy Director of Workforce and OD	Annual report - AC23.62 AC23.62.5 Gareth Williams noted that NHS Wales had adopted the National Living Wage of £9.90 an hour. Assurance was sought that this wasn't what used to be called the national minimum wage. If it, was it was inappropriate to say we adopted it as it was mandated? Confirmation to be sought outside of this meeting.	15 Sep-2023	Deputy Director of Workforce and OD to provide an update at the meeting.	Action ongoing	
	Deputy Board Secretary	Annual Governance Statement 2022/23 - AC23.63 It was noted that there were two sections both given the number 23.2. Report to be updated.	15-Sep-2023	Deputy Board Secretary	Action completed	

Teitl adroddiad: <i>Report title:</i>	Special Measures Update			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	15 th September 2023			
Crynodeb Gweithredol: <i>Executive Summary:</i>	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: <i>Recommendations:</i>	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 Portfolio Management Office (PMO), along with which elements of the plan will be required to roll forward to the 2 nd 90-day cycle.			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
Awdur yr Adroddiad: <i>Report Author:</i>	Geraint Parry, Special Measures Programme			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
<p>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:</p> <p><i>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:</i></p>				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	To support Special Measures			
Goblygiadau rheoleiddio a lleol:	Not applicable			

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

Audit Committee

Special Measures Update

1) Introduction

This report presents an update on the Special Measures deliverables aligned to this Committee. This is the first update to this committee, building upon an approach that has been established at QSE and PFIG.

The report reviews the progress of the first 90-day cycle, highlighting the areas of success along with the challenges that have emerged, and how this will be taken forward to the next 90-day cycle that commenced on the 1st September.

2) Background

The background to the Health Board escalation into Special Measures and the resultant organisational response has been covered in previous committees including the Health Board, QSE and PFIG.

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.

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.

A number of independent reviews have taken place in cycle 1. This includes a review of the Office of the Board Secretary (OBS) which falls under the auspices of this committee, and a separate session has been arranged to receive those findings.

4) Portfolio Management Office (PMO) Assessment

The table provides details of the progress against deliverables and milestones. In line with EPPM (Enterprise project portfolio management) best practice governance, individual progress reports are subject to PMO assessment and verification that is independent of the team responsible for the deliverable. This process is maturing as we work through the cycles, as part of strengthened overall governance.

Overall, solid progress has been made across all areas. Some areas of challenge have emerged in relation to the breadth of underpinning work required and the pace of change, along with some interdependencies that prevented full completion of planned activities. A process of continual learning and improvement is in place allowing us to evolve the approach into cycle 2 so that plans remain 'ambitious but realistic'.

5) 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 Portfolio Management Office (PMO), along with which elements of the plan will be required to roll forward to the 2nd 90-day cycle.

Table 1: Audit Committee Oversight Report – 15 September 2023

Key:	Completed	Off track, but with an acceptable plan to course correct and complete within 4 weeks or original completion date	Off track and unlikely to complete within 4 weeks of original completion date
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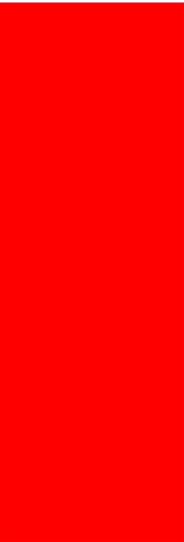
Outcome 1: A well-functioning board			
Deliverable brief summary	Lead Executive	Delivery Confidence	Update
<p>1.1 Strengthen Board Governance and Effectiveness: Support and enable review of Office of Board Secretary (Governance),</p> <ul style="list-style-type: none"> - refresh committee terms of reference and - embed special measures in all committees 	Phil Meakin	High	<p>Summary extracted from team updates</p> <p>The main Committees (QSE, PFIG, Audit and Remuneration) have been re-established. One of the key outcomes of the Office of the Board Secretary (OBS) review, is to review and finalise the Terms of Reference for each of the Committees at the next Board meeting on the 28th September.</p> <p>The Special Measures Report format was piloted at QSE on the 20th June and at PFIG on the 29th June and was modified following feedback. The current version was used at QSE on the 22nd August and at PFIG on the 1st September and received positive feedback in both sessions. This version of the report is intended to be rolled-out across other Committees.</p> <p>PMO Assessment</p> <p>Progress made across all milestones. Evident that the agreed committees have met, and whilst initial plan was to amend terms of reference 'where necessary', an active decision was made to await the outcome of the OBS review in order to avoid introducing confusion or potential error by making multiple changes in short succession. The review has been received and digested at a local level and fed into a thematic overview. A development session for members of Audit committee to receive the review in detail is scheduled for the early part of September. The cycle 1 scope for this deliverable has been fully completed.</p>

<p>1.2 IM Recruitment: Complete recruitment to IM roles (temporary appointments)</p>	<p>Phil Meakin</p>		<p>Summary extracted from team updates The positions of the Interim Chair and six Independent Member (IM) roles have been filled.</p> <p>PMO Assessment Evidence received confirming the appointments. The cycle 1 scope for this deliverable has been fully completed.</p>
<p>1.3 Board Inductions: Implement phase 1 induction for all Board members</p>	<p>Phil Meakin</p>		<p>Summary extracted from team updates The induction packages from other NHS organisations in Wales have been reviewed and considered, and a revised BCUHB version is in development.</p> <p>The Interim Board Secretary has met with all IM's regarding the induction received, in order to build this feedback into an assessment around gaps and opportunities to improve the quality of induction for when permanent appointments are made. The induction pack will encompass a SharePoint site and a Handbook.</p> <p>Once the refreshed induction programme is complete, further iterative enhancements will be made to the induction for current IM's.</p> <p>PMO Assessment Evidence provided showing how documentation from other Health Boards and a review of learning from elsewhere has taken place. Evidence provided showing that this work has translated into a refreshed approach locally. The actual launch has not yet taken place as final formatting is occurring during September. Based on evidence received a high degree of confidence can be placed that this will be ready for launch within one month of the original completion date.</p>

<p>1.4 Board Development: Develop phase 1 Board development programme</p>	<p>Phil Meakin</p>		<p>Summary extracted from team updates The proposal for the Board Development Programme is being formulated between the Interim Board Secretary, CEO and Chair. The proposal for Phase 1 of the board development programme will go to the September Board. Phase 2 will go to the November Board.</p> <p>Board development sessions continue to take place as originally scheduled, with a recent session held on the 31st August and a further session planned on the 26th October.</p> <p>PMO Assessment It is evident that work has taken place in relation to a wider Board development, complemented by constructive Board development sessions. Set against the original scope and timescale this deliverable has not yet concluded and will need to be carried forward to cycle 2. There is high confidence that this deliverable will deliver against scope within the revised timescale set out above.</p>
<p>1.5 Board Committees: Establish Board committees, complete committee induction and development of work plans</p>	<p>Phil Meakin</p>		<p>Summary extracted from team updates Due to the number of IM's in post it has not been possible to re-establish all committees at this stage. Agreement was made regarding which committees required initial prioritisation (QSE, PFIG, Audit, Remuneration and Board). Where agenda items have not been able to be transacted, they will be prioritised for the first available committee once full re-establishment has been achieved.</p> <p>The cycle of business for the committees have been shared and the Corporate Calendar is in the final stages of completion. It was not possible to appoint vice chairs for all committees due to the number of IM's in post. Regular support and liaison is in place via the OBS. The OBS review recommended that all Committee work plans go to the September Board for approval.</p> <p>PMO Assessment Work in this area has progressed well with evidence received relating to proposed work plans for the Board and Committees. All committees have chairs in place. The initial deliverable scope did include the need to appoint vice chairs to committees. This was identified to be undeliverable until further IMs were in place, and a decision taken to remove that from the cycle 1 scope. This is recorded on the PMO change control log.</p>

1.7 Permanent Board:
Commence plans for the recruitment of a permanent Board - including progressing the recruitment of the permanent Chief Executive

Phil Meakin



Summary extracted from team updates

An update on the permanent CEO recruitment process will be received by the Remuneration Committee in September.

The Public appointments process for permanent independent members, including a Vice Chair is underway, led by Welsh Government.

This deliverable did include Executive appointments with interdependencies related to the Executive Portfolio review. That review has not yet been received, resulting in a delay to those elements.

PMO Assessment

A range of activities are underway in this area, with supporting evidence received. However the totality of this deliverable has not completed within the original timelines. Work is ongoing to recast a realistic timescale within cycle 2 to reflect the interdependent delays.

Outcome 4: Improved access, outcomes and experience for citizens

Deliverable brief summary	Lead Executive	Delivery Confidence	Update
<p>4.6 Mental Health Stocktake Review: Prepare for and support commencement of an external stocktake of progress against previous Mental Health Reviews</p>	<p>Teresa Owen</p>		<p>Summary extracted from team updates A meeting was conducted with the Royal College of Psychiatrists (RCPsy) in August during which the finalised Terms of Reference were provided to the Health Board. The Welsh Government has expressed satisfaction with the progress achieved, which encompasses preliminary arrangements for interviews involving essential Divisional personnel. An evidence log has also been shared with RCPsy reviewers.</p> <p>PMO Assessment Clear evidence of progress and good collaboration in line with the scope of the deliverable. An action plan has been developed and a briefing report has been received with draft plans for cycle 2 formulated.</p>

Outcome 5: A learning and self-improving organisation

Deliverable brief summary	Lead Executive	Delivery Confidence	Update
<p>5.6 Special Measures assurance approach: Develop and commence implementation of an Assurance Approach for the Special Measures response. Including the implementation of an organisational Maturity Matrix.</p>	<p>Phil Meakin</p>		<p>Summary extracted from team updates</p> <p>An Assurance Approach for the Special Measures response has been defined and a Special Measures support team has been assembled for the implementation phase.</p> <p>The proposed approach encompasses three lines of defence: 1) The evidence supplied including the monitoring of Key Performance Indicators (KPIs) will be scrutinised by the relevant Executive Lead and Special Measures team, 2) Subject Matter Experts will scrutinise the evidence and where appropriate specific subject matter groups will provide assurance, 3) There will be independent external reviews.</p> <p>The procedure for presenting Independent Reviews at specific Committees is still in the process of being finalised. Upon completion, the Interim Board Secretary will give a presentation at the September Board meeting.</p> <p>The implementation of elements of the Assurance Approach has commenced, however the outcome of the independent reviews will form part of the assurance process via the Committees.</p> <p>PMO Assessment</p> <p>Progress has been made and elements of the assurance approach have commenced and are functioning well. The approach in its entirety is yet to be formally ratified and fully implemented and therefore work is required early into cycle 2 to conclude this work and continue to strengthen the overall approach.</p>



Teitl adroddiad: <i>Report title:</i>	Developmental Board Session: Risk Management Framework & Risk Appetite			
Adrodd i: <i>Report to:</i>	Audit committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Friday, 15 September 2023			
Crynodeb Gweithredol: <i>Executive Summary:</i>	The purpose of this report is to enable the Audit Committee to formally approve the risk appetite following the Developmental Board Session on the 24 Aug 2023 and discuss/approve the draft risk management framework.			
Argymhellion: <i>Recommendations:</i>	<ol style="list-style-type: none"> 1. Receive and consider the 23/24 Board appetite for risk types. 2. Receive and consider the draft risk management framework. 			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Carol Shillabeer, CEO			
Awdur yr Adroddiad: <i>Report Author:</i>	Nesta Collingridge Head of Risk Management Phil Meakin, Interim Board Secretary			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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: <i>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</i>				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	Risks appetite set in relation to risk types and association to the strategic objectives.			
Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i>	It is essential that the Board has robust governance arrangements in relation to risk management, as failure to do so could have			

	legal implications for the Health Board. It is widely accepted that organisations employing an enterprise risk management model should set the Board's risk appetite on an annual basis.
<p>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></p>	Appendix 3- EqlA in relation to RM01- Risk Management Framework
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	N
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>Risk appetite is related to all the risks that are reported as part of the Health Board's risk management approach.</p> <p>Risk management framework sets out the approach and management of the BAF and CRR.</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	It is essential that the Board has robust governance arrangements in relation to risk management, as failure to do so could have financial penalties for the Health Board.
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	N
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	During the conclusion of the developmental session the Board members heard the consensus of all risk type and respective scoring which has been presented here, feedback inrelation to the risk management framework has been summarised below and reflected in the risk management framework attached.
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	RM01 informs the management of the BAF
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Amherthnasol</p> <p>Not applicable</p>
<p>Camau Nesaf: Gweithredu argymhellion</p>	

Next Steps:

The Board to receive the risk appetite scoring in relationship to types. This will continue to be repeated annual and inform risk management practices.

The Board to receive the draft risk management framework.

Rhestr o Atodiadau:**List of Appendices:**

Appendix 1 2023/24 Risk Appetite

Appendix 2 Draft RM01 Risk Management Framework

Appendix 3 EqIA

Introduction/Background

A developmental board session was held on the 24 of August 2023 to determine the 23/24 risk appetite and discuss the approach to risk management, in order to inform the risk management framework.

The risk management framework was due for review following limited assurances noted from internal auditors in June 23 and feedback was received on the Health Board's approach which has been summarised in the body of this report.

During the developmental session Board members heard last year's 'minimal-cautious' appetite to risk management in relation to the 21/22 strategic objectives. This conservative stance aimed to minimize exposure in key risk areas like financial, regulatory, quality, reputation and people.

Executives and Independent Members (IMs) participated in the session (Apologies received from Gareth Williams and Mike Larvin), facilitated by the Risk Management Team.

The session was split into two parts. The objectives were to:

Part 1: Feedback and collaborate on the risk management framework setting out the Board's approach to risk.

Part 2: Consider last year's cautious approach to risk and agree the current risk appetite across the five risk types.

Feedback was received on the Risk Management Framework to inform a draft. A consensus was set on risk appetite scores in relation to risk types.

Body of report

Part 1: Risk Management Framework Feedback

Feedback was received around the Board's approach to risk management and the contents of the framework, key points have been summarised below and informed the draft Risk Management Framework.

- Taking opportunities should also be weaved into the framework to better support the positive stance on risk approach.
- Staff need to feel empowered to raise risks and have confidence they will be actioned.
- The purpose should address duty of care to service users, patients, communities, not just the Health Board's commitment.
- The description of different risk levels (strategic, operational, project) was an improvement, but more clarity was needed on risk identification.
- Concerns were heard that framework focuses on closing the loop, managing and mitigating risks, not just identifying them. Focus needed on outputs and outcomes.
- The ward to board risk journey needed to be better explained.
- Roles and responsibilities should reference involvement of associate members and clinical staff. The reference to an integrated approach was noted as key and welcomed.

- Further clarity was needed on the framework statement. Language on responsibility and accountability needs clarity on where risks sit once raised.
- Risk escalation/de-escalation governance mapping needed further development.
- Committee roles need clear definitions.
- Issues of 'static' risks stuck in development need to be addressed, including escalation processes.

In summary, key gaps seem to be around risk identification, staff involvement, clear accountability, closing the loop on risks, and explaining the risk management architecture.

Part 2: Risk Appetite

Executives and IMs participated in a risk appetite assessment to define the organisation's willingness to accept risk across key domains including financial, regulatory, quality, reputational, and people as recommended from the nationally accepted scoring matrix from the Good Governance Institute. The discussion revealed a desire to take a more open, progressive approach to risk compared to a more cautious historical stance.

Key Findings

Financial Risk: There was an agreed consensus on an **'open'** appetite to accept some financial risk with controls, balancing value for money with price not the overriding factor. There was recognition that past caution has not yielded desired results.

Regulatory Risk: There was an agreed consensus supporting an **'open'** risk appetite to accept some regulatory scrutiny, provided there is confidence the organisation can successfully respond to any challenges.

Quality Risk: There was willingness to be **'open'** and accept some short-term quality impacts for long-term gains, signalling an open appetite for innovation and improvement.

Reputational Risk: There was an agreed consensus to **'seek'** some reputational risks if there is potential for stakeholder outcomes to improve.

People Risk: There was an agreed consensus to **'seek'** and accept some workforce risks in the hope to be innovation, provided there are staff recruitment, retention, and development opportunities.

In summary, the Board members expressed interest in moving to an 'open' risk appetite across finance, regulation and quality risk type domains as compared to the previous cautious stance. There was a consensus to 'seek' innovation and accept a considered level of risk in relation to reputation and people risk types. The discussion emphasised context and managing risks appropriately rather than avoiding them altogether.

Next Steps

1. Formally approve the new risk appetite statements across each domain.
2. Communicate the updated risk appetite in the risk management framework and to provide clarity for staff on expected parameters.
3. Align the Board Assurance Framework and controls to the new risk appetite levels.
4. Ongoing monitoring of implementation of the risk appetite and evaluate impacts on organisational risk-taking and results.
5. Annually reassessing risk appetite as part of recommended best practice for enterprise risk management.

Recommendations

1. **Receive and consider the risk appetite statements prior to Board.**

2. Receive and consider the draft risk management framework prior to Board.

Appendix 1-Risk Appetite

Appendix 2-Risk Management Framework

Appendix 3-EQIA RM01

Board Development Session 24 August 2023

Risk Appetite 2023



Risk Appetite

1. Risk Appetite Types and Scoring 2023
2. Previous Strategic Objectives and Risk Appetite 2022
3. Reference Good Governance Institute Risk Appetite Matrix



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
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Risk Appetite and Risk Types 2023

Risk Type	Risk Appetite	Risk Statement
<i>Financial: How will we use our resources?</i>	<p>OPEN</p> 	<i>We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.</i>
<i>Regulatory: How will we be perceived by our regulator?</i>	<p>OPEN</p> 	<i>We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.</i>
<i>Quality: How will we deliver safe services?</i>	<p>OPEN</p> 	<i>We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.</i>
<i>Reputational: How will we be perceived by the public and our partners?</i>	<p>SEEK</p> 	<i>We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.</i>
<i>People: How will we be perceived by the public and our partners?</i>	<p>SEEK</p> 	<i>We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.</i>



Previous Risk Appetite and Strategic Objectives 2022

Strategic Objective	Risk Appetite	Risk Statement
SO1: <i>Improve physical, emotional and mental health and well-being for all.</i>	MINIMAL 	<i>The Health Board will seek to minimise short-term impact on quality outcomes in order to achieve longer term rewards that will result in outstanding care.</i>
SO2: <i>Target our resources to people who have the greatest needs and reduce inequalities</i>	CAUTIOUS 	<i>The Health Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Health Board is an employer of choice.</i>
SO3: <i>Respect people and their dignity</i>	CAUTIOUS 	<i>The Health Board will proactively minimise its risk exposure in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.</i>
SO4: <i>Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being</i>	CAUTIOUS 	<i>The Health Board will proactively minimise risk faced with collaboration and partnerships but this will ultimately provide a clear benefit and improved outcomes for the population of Betsi Cadwaladr University Health Board.</i>
SO5: <i>Improve the safety and quality of all services, whilst listening to people and learning from their experience</i>	CAUTIOUS 	<i>The Health Board will proactively mitigate risks pertaining to the implementation of digital systems and infrastructure to support better outcomes and experience for patients and public.</i>
SO6: <i>Support children to have the best start in life</i>	CAUTIOUS 	<i>The Health Board will proactively reduce risk in pursuit of options that will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.</i>

Applying risk appetite matrix

RISK APPETITE LEVEL	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
RISK TYPES						
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.



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University Health Board

Version 10

RM01

Risk Management Framework

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Approved by:										
Date approved:										
Date activated (live):										
Documents to be read alongside this document:	Risk Management Procedures (RM02) Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Information Governance Policy Health and Safety Policy Board Assurance Framework SOP Corporate Risk Register SOP Terms of Reference RMG									
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PROPRIETARY INFORMATION

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Glossary of Terms

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

Distinguishing between a risk and an issue: A risk is an event that might occur and that could have an effect (usually negative) upon the organisation and/or its stakeholders. A risk is characterised by uncertainty. An issue is something that has already happened or will definitely happen. An issue is a certainty. e.g., If we are short staffed now or lack money to deliver a service, the shortage of staff or lack of money are issues (as these are already happening) and the risk will be the implications of staff shortage or the lack of money to the successful delivery of our operational and strategic objectives. The uncertainties these may cause is what will constitute the risks in both cases.

Assurance: This is a process to provide evidence that the controls in place are effective and working and that the Health Board is doing its best to appropriately reduce and manage risks to the achievement of its operational and strategic objectives.

Levels of Assurance:

1. The first level of assurance comes from the department that performs the day-to-day activity, for example the data is available;
2. The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance;
3. The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, and HSE etc.

Actions: Actions are steps which the Health Board is required to implement to reduce the likelihood and/or consequence of a risk were it to be realised. Actions are also the things the Health Board is doing or planning to do that will help us achieve the target risk score and thus reduce the risk to a tolerable and/or minimal level or even eliminate it altogether.

Board Assurance Framework (BAF): The BAF comprises of strategic risks that could prevent the Health Board's from fulfilling its strategic objectives.

Business Continuity: Business continuity gives organisations a framework for identifying and managing risks that could disrupt normal service. The holistic process of business continuity management is an essential tool in establishing an organisation's resilience.

Controls: 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. Impact could range from negative to positive. Some types of controls used in reducing risks include preventive, corrective, detective and directive controls.

Corporate Risk Register (CRR): A corporate risk register is a repository used to record all significant risks that could negatively impact the strategic objectives and operations of the Health Board. The register provides a comprehensive overview of the key risks facing the organisation. It is a pivotal tool to help proactively strengthen risk oversight and management.

Datix: Datix is a incident and risk management software platform designed to help organisations record, manage and report on risks.

Risk Assessment: This is the overall process of risk analysis and risk evaluation. This is achieved by comparing the individual risk against the Health Board's risk appetite. Risk assessment techniques include questionnaires and checklists, workshops and brain storming sessions, and inspections and audits.

Risk Mitigation: 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).

Terminate: The only response to some risks is to terminate the activity giving rise to the risk or by doing things differently.

Tolerating: The decision to accept the risk and the impact should the following risk occur without taking any further steps to mitigate it. This is often to avoid significant investment or resources as the response would be disproportionate to the potential harm.

Transfer: Risks may be transferred for example by conventional insurance or by sub-contracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets.

Treating: Taking proactive measures to reduce and mitigate the likelihood and or impact allowing for reduction, risk avoidance, risk transfer as to having a less of an impact on the organisation.

DRAFT

RISK MANAGEMENT FRAMEWORK

Risk Framework Statement

- The Health Board endeavours to establish a positive risk and safety culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.
- The Health Board is committed to ensuring a robust infrastructure to manage risks ensuring an integrated approach, and where risks crystallise, to evidence improvement.
- The Health Board's intention is to **minimise** the risk to the delivery of quality services in the Health Board's accountability and compliance frameworks, **maximise** performance and is **open** to opportunity with considered risk taking.
- To deliver **safe, quality** services, the Health Board will encourage staff to work in collaborative partnership with each other and service users and carers to **minimise** risk to the greatest extent possible and promote patient well-being as a duty of care to the population.

The Board intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation by:

- Ensuring a dynamic approach to strategic risk management to support achievement of the Health Board's vision, aims, and strategic objectives;
- Promoting considered risk taking, within authorised and defined limits in-line with the Board's appetite for risk (see Appendix 1-Risk Appetite Statement);
- Adopting an integrated approach to risk management in order to facilitate a cross-functional collaboration of system-wide risks that includes risks related to: clinical care, health and safety, staff wellbeing, financial and business planning, workforce planning, corporate and information governance, performance management, project / programme management, research and development;
- Embedding effective risk management systems and processes within the organisation and promoting the ethos that risk management is everyone's business, with clearly defined roles and responsibilities;
- Creating an environment that is as safe as is reasonably practicable, by ensuring that risks are continuously identified, assessed and well managed, i.e. where possible eliminate, transfer or treat risks to an acceptable level;
- Fostering an organisational culture of openness and willingness to report risks, incidents and near misses to ensure organisation wide learning;
- Establishing clear and effective communication mechanisms that enable a comprehensive understanding of risks at all levels of the organisation by the use of directorate, specialist and organisational-wide risk registers; and

- Providing appropriate training to staff to ensure effective implementation of risk management arrangement

1. Purpose of this Framework

The Framework seeks to ensure:

- that the Health Board's risks in relation to the delivery of services (provided and commissioned) and care to patients are minimised;
- that the wellbeing of patients, staff and visitors is optimised;
- that opportunities are maximised;
- that the assets, business systems and finances of the Health Board are protected; and
- the implementation and ongoing management of a comprehensive, integrated (clinical and non-clinical) approach to the management of risk across the organisation.

2. Scope of the Risk Management Framework

This framework applies to Board members; all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business. It applies to all activities of the Health Board, including those related to the commissioning of services. Managers at all levels within the Health Board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the Health Board.

This framework will:

- Outline the risk management philosophy through our risk statement, identifying arrangements for embedding risk management;
- Explain the role, expectations and appetite of the Board in relation to risk and risk management;
- Detail the high-level roles and responsibilities for implementing and complying with this framework;
- Explain the arrangements for complying with all relevant legislation;
- Detail risk priorities for the present year;
- Detail the high-level Committee structure accountability in relation to risk, internal reporting requirements, assurance arrangements and external reporting controls;
- Signpost the specific policies, procedures and terms of reference and which the Health Board will publish to ensure that all staff understand what is required of them.

3. The Board's Appetite for Risk

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

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk. The Board is prepared to accept some financial risk and regulatory challenges if appropriate controls and defence strategies are in place. The Board support innovation despite potential short-term quality impacts and reputational risks, as long as there is potential for long-term rewards like improved outcomes for stakeholders and opportunities for staff recruitment, retention and development. The Board takes a holistic view of value for money, with price not being the sole determining factor.

The Board seeks innovation, and will challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated. The Board's annual Risk Appetite, detailing acceptable levels of risk across five risk types (financial, regulatory, quality, reputational and workforce), is outlined in Appendix 1.

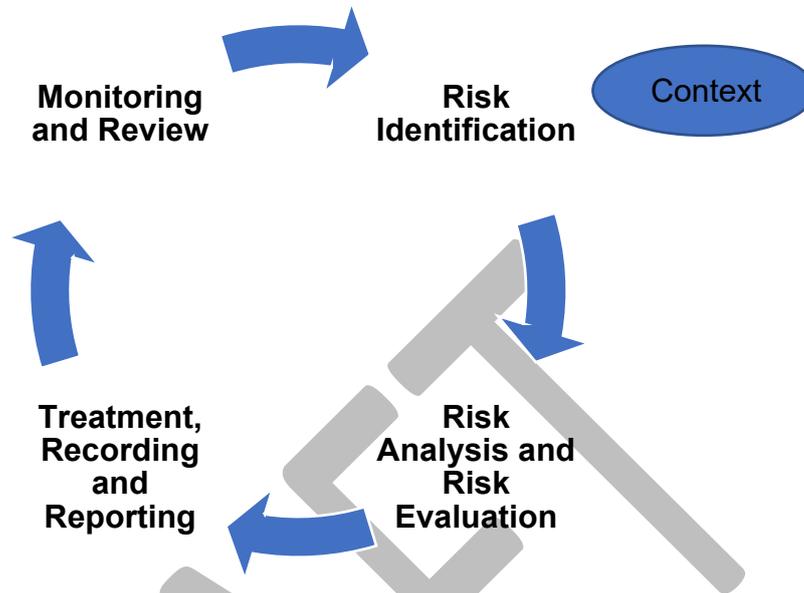
4. Risk Management Process

Risk Management is the systematic application of management policies, practices and procedures to identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation. The process is defined in four key steps:

Figure 1 - Risk Management Process



1. Risk Identification

The Health Board cannot manage risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the organisation's risk management process, and ultimately the safe delivery of care. This should be done within context.

2. Risk Analysis and Risk Evaluation

Assessment and scoring of risk are used to determine the level of risk, using the Health Board's risk matrix to ensure a consistent approach is adopted across the organisation.

3. Treatment, Recording and Reporting

Treatment is how the risk will be managed, and what the required actions are to achieve an acceptable level of risk. All risks are recorded on a Datix risk register, which is a formal record of all risks raised, which makes up the Operational Risk Register.

4. Monitoring and Review

Part of managing risk is to continually review and update, and to capture the changes and progress of mitigation.

5. Risk Architecture

The current enterprise risk architecture within the Health Board is shown below in a risk management model.

Levels of Risk

The Risk Management Framework defines three levels of risk:

1. Strategic Risks – Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder.
2. Operational Risks – Risks that arise as a result of the day-to-day running of the Health Board and include a broad spectrum of risks comprising clinical risk (e.g., arising from incidents and complaints), financial risk (including fraud); legal risks (e.g., arising from employment law or health and safety regulation); regulatory risk; risk of loss or damage to assets or system failures; etc.
3. Project Risks – Risks that may impact on the delivery of a programme of work or project. All significant projects must be risk assessed before they are progressed, with each project required to have a separate risk register.

Risk Registers

Board Assurance Frameworks, Corporate Risk Registers and Operational Risk Registers can work together in an integrated risk management model:

Board Assurance Framework (BAF)

- Focuses on the top <10 strategic risks that could impact achievement of the Health Boards objectives and priorities.
- Owned by the Board and tied directly to the strategic plan.
- Risks reflect external and internal issues affecting strategy.
- Regularly reviewed by Board and Executive leadership.
- Held by the risk team.

Corporate Risk Register (CRR)

- Consolidates key risks escalated up from the operational level based on the possible impact on Boards objectives and priorities. May include 20-50 major corporate-wide risks.
- Provides Executives with enterprise view of significant operational and strategic risks.
- Enables corporate risk reporting, monitoring and oversight.
- Risk flows to BAF as appropriate.
- Held by the risk team, maintained on Datix.

Operational Risk Registers

- Day to day operational risks which impact on service delivery. Includes clinical, financial, compliance, IT risks etc
- Mandatory for all services to have a register on Datix.
- Service Risk Leads or Risk Champions responsible for maintaining and managing service risk register and escalates higher risks through Executives and Corporate Risk Team for awareness and where appropriate consideration on the CRR.

Project Risks

- Project lead responsible for ensuring risks are captured and maintained.
- Acceptable for the project risk register to be held locally (not on Datix) but significant risks which could impact on day to day operations or have a wider impact on the Health Board should be escalated to a Datix risk register to allow for overview and consistency of reporting.
- Project team escalate higher risks through Executives and Corporate Risk Team for awareness.

This model provides top-down and bottom-up connectivity to enable robust risk management at all levels and alignment to strategy.

All staff should be aware of the potential for risks to emerge which may affect the business of the Health Board and all staff should be prepared to identify and report risks as appropriate. When a possible risk is identified, staff should aim to discuss it first with their line manager, or for pan BCU risks which have been identified this should also be escalated to the Corporate Risk Management Team and Executives. This is to avoid duplication of effort, as sometimes risks are identified which are already being managed but have perhaps been articulated differently. Once it is confirmed that a new risk has been identified, the details should be entered onto the Datix system. This will normally be achieved through a service risk lead/champion.

Once correctly identified and assessed, the risk should be logged on a risk register, depending on the seriousness of the risk. Where possible risks should be managed at the lowest level possible, proportionate to the level of exposure to which the risk.

Risks scored ≥ 15 should be sent to the Executive Director for awareness and consideration on the CRR, if strategic in nature.

Risks scored $9 > 12$, Risk owners are expected to ensure that there are appropriate processes, systems and governance arrangements in place to regularly review, scrutinise and effectively manage all risks within their areas. They will be required to periodically present their Divisional risk register reports and assurance at the Risk Management Group.

Risks scored 1-8 should be regularly reviewed, scrutinised, approved, reduced and managed at the service or departmental levels while those which score above 8

should be escalated in accordance with guidance and the approval of either the relevant quality and safety meeting and/or the triumvirate.

Escalation/De-escalation

Risks should be regularly reviewed and escalated or de-escalated to the appropriate risk register within the Committee or divisional meeting which reviews the risk. Before a risk is presented to an Executive for approval, it should be quality assured by the risk management team and take the assurance that robust action plans are in place.

For escalation of a risk on to the CRR the service risk lead should contact their Executive Director through the appropriate channels and the corporate risk team via their regional risk manager.

Figure 2 - Risk Management Meeting & Escalation/De-escalation

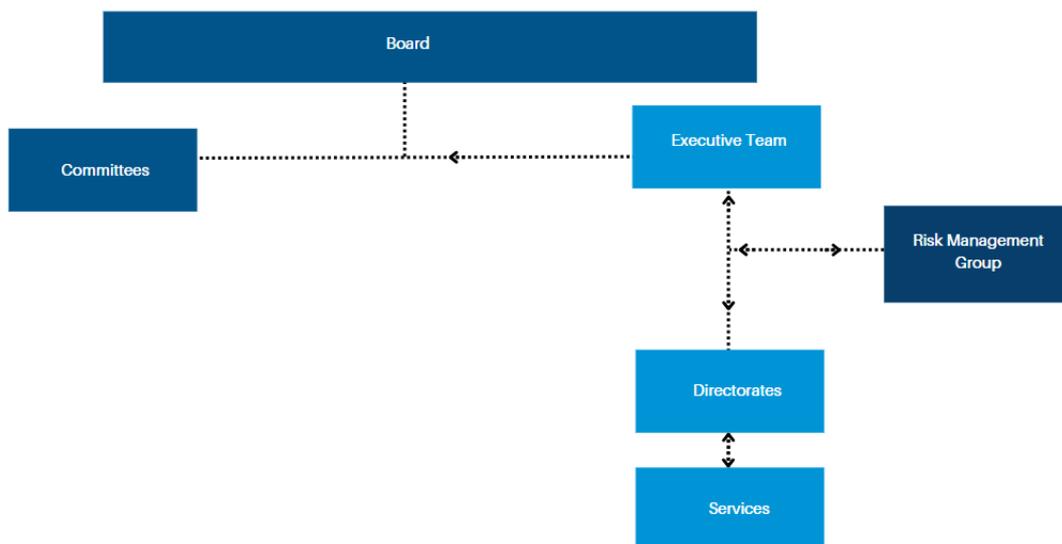
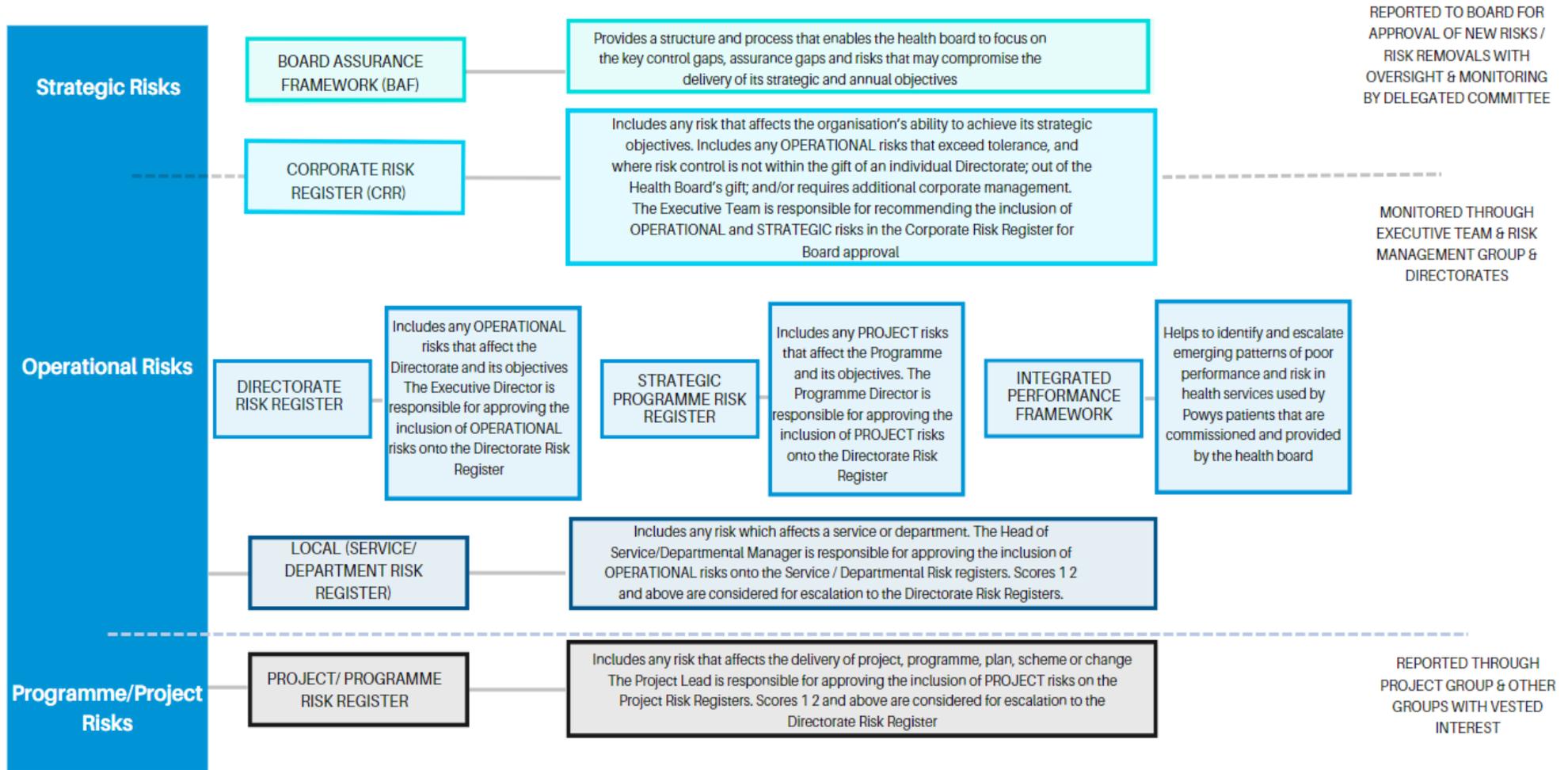


Figure 3 - Risk Management Register



6. Risk Strategy

To effectively manage risks, our organisation will take a comprehensive approach across several areas. This will include robust reporting mechanisms to keep leadership and the Board apprised of risks, using systems like risk registers to log and track risks, ensuring staff have adequate training and clear responsibilities, implementing standardised risk management processes, fostering a culture of openness around risks, and continuously monitoring and improving through quality assurance. Together these initiatives across reporting, systems, people, processes, culture and improvement will enable us to better anticipate, manage and mitigate the risks we face in alignment with our values and strategic objectives.

Reporting

- Quarterly Quality Assurance reports to Risk Management Group (RMG) to monitor risk metrics and oversee processes.
- Bi-monthly corporate risk report to Executive team/Board/Committees on risk actions plans and updates.
- Board Assurance Framework (BAF) quarterly for review by the Board
- Services to provide their directorates on assurances over the management of the local service risk register.

Systems

- Datix to log risks.
- Risk priorities will influence integrated planning.

Processes

- Process in relation to of risk management are detailed in RM02 risk management procedures and throughout this framework. Risk identification, assessment and treatment processes as detailed in section 4.
- Risk monitoring and review processes, risk reporting and escalation processes.

Culture

- The cultural tone is detailed in the statement and approach to risk as well as supported by the way in which processes are carried out, dynamic and diligence. Risk clearly noted as everyone's business and supported by detailing responsibilities.

People

- Risk management responsibilities are clear for all staff and have been further detailed in section 7.
- Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management. To support this, a programme of training will be delivered as follows:

Staff Group	Training Need	Frequency
Board Members & Directors & Deputies	Strategic Risk Management Training	Every 2 years
Service managers/Risk owners/Service Risk Leads	Mandatory Operational Risk Management Training	Every 2 years
All staff	Basic awareness on corporate induction as well as a bespoke offer of face to face or virtual risk training	On starting and ad hoc offer as required

7. Roles and Responsibilities

Effective risk management requires clear definition of the roles, responsibilities, and accountabilities across the organisation. This section outlines the duties and obligations relating to risk for the Board, relevant Committees, key groups and individuals within the Health Board.

The Board:

The Board (Executive Directors and Independent Members) being the governing body responsible for strategy, performance, governance, risk management, and ensuring statutory duties are met. The Board is accountable for effective oversight per NHS (Wales) Act and other healthcare regulations.

The cycle of business for the Board is set to receive the CRR and BAF on a quarterly basis. It is the duty of the Board to discuss and advise on the content and progress of action plans in the BAF. It is also the duty of the Board to appropriately monitor BCUHB's significant risks noted in the CRR, associated controls and assurances outline as well taking a view on the overall decision of tolerating a risk or challenging the possible lack of progression.

The Board is responsible for ensuring that the Health Board consistently follows the principles of good governance; ensuring that the systems, policies and people are in place to manage risks and its effectiveness. The Board will be focused on key risks and driving the delivery of the Health Board's strategic objectives. Gaining assurance demonstrates good oversight of effective risk identification and management; risk architecture as well as due diligence including robust governance. It is a key principle of accountability.

The workplans for the Board and each of its Committees will be aligned to the BAF and CRR, ensuring appropriate focus on areas of risk. In the context of this Framework the Board will:

- demonstrate its continuing commitment to risk management through the application and interest in the overall compliance with this Framework;

- ensure, through the Chief Executive, that the responsibilities for risk management outlined in this document are communicated, understood and maintained;
- take a proactive role in 'horizon scanning' for emerging threats/risks to the delivery of the Health Board's strategic objectives, and ensuring that controls put in place in response, manage risks to an acceptable level;
- commit financial, managerial, technological and educational resources necessary to adequately control identified risks;
- ensure that lessons are learned and disseminated into practice from complaints, claims and incidents, and other patient experience data;
- oversee and participate in the risk assurance process;
- allocate strategic risks to Committees for oversight;
- ensure communication with partner organisations on problems of mutual concern including risks;
- ensure that appropriate structures are in place to implement effective risk management; and
- receive reports from the Committees of the Board in line with terms of reference and workplans of those committees.

Audit Committee (AC):

Provides assurance on governance, risk management, internal controls, financial reporting and internal/external audits. The Committee is responsible for points 1-5 as noted above.

The cycle of business for the Committee is set to receive the CRR and BAF in its entirety on a quarterly basis. The Audit Committee, on behalf of the Board, will be responsible for providing oversight of: the adequacy and management of the CRR and BAF arrangements.

Performance, Finance and Information Governance Committee (PFIG):

Oversees financial and operational performance, information governance, and delivery of plans/targets. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

Quality Safety and Experience Committee (QSE):

Reviews quality of care, patient safety issues, clinical effectiveness and outcomes, patient experience. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

Risk Management Group (RMG):

The Risk Management Group reports to the Executive Team and advises on any risk management issues, including all significant risks arising from activities within the organisation. The Group is responsible for leading the implementation of the risk, control and assurance processes established within the organisation. The Group will review the processes and report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.

Specifically, the Group is responsible for:

- Coordinating the achievement of the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;
- Coordinating all clinical and non-clinical risk management issues affecting the Health Board (scored 12 and above), making recommendations to, and advising the Executive Team and Board accordingly;
- Reviewing, updating and monitoring the CRR, and maintaining clear links with the BAF;
- Recommending the escalation and de-escalation of risks from/to the CRR for Executive Team approval, ensuring significant risks are appropriately prioritised;
- Reviewing proposed significant risks from risk leads, escalating to the Executive Committee for inclusion in the CRR where appropriate;
- Reviewing risks arising from the results of investigations into losses, untoward incidents, near misses and accidents;
- Reviewing high risk recommendations made by the Internal Audit Service, ensuring that where appropriate they are acted upon and recorded through risk registers and the BAF appropriately.

Executive Team Meeting

The Executive team are the accountable leads on each of the corporate risks and support the regular review of the register, noting any risks for escalation and de-escalation. Executives will provide updates on action plans associated with mitigating and controlling the risks they are accountable for.

6.1 Individual Responsibilities

All members of staff, and those working on behalf of the Health Board, have an individual responsibility for managing risk. They must understand and adhere to this Risk Management Framework. The following individuals have specific responsibility, accountability and authority for risk management, as part of their existing roles:

Chief Executive

The CEO is the Accountable Officer of the Health Board and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements, and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management; health and safety; financial and organisational controls; and, governance. The CEO has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974. The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Executive Directors

Executive Directors have overall responsibility for the operational management of risks within their Directorates and are the named senior responsible officer for individual risks on the CRR and BAF.

They are also responsible for the effective allocation of resources to timely reduce risks within their remit, while ensuring prompt escalation and de-escalation of risks where appropriate. They shall also be responsible for ensuring that senior managers under their portfolio have effective risk management systems and processes in place in their directorates, divisions, sites, and services to demonstrate robust identification, assessment, mitigation and management of all risks.

They are responsible for ensuring that best practice in risk management and a positive risk-aware culture are fully embedded in their portfolio. Executives will work with the risk management team to ensure the appropriate use of the BAF and CRR.

Executives play a pivotal role in setting the expected cultural tone, one which is positive and encourages identification, risk is not to be considered as negative or to be avoided. The Executives Directors will do so by ensuring communication is open, and transparent where all staff have the confidence to raise a risk. Executives will seek assurances that risk training is well attended for their regions and departments. Good risk awareness, awareness of roles and responsibilities, timely management of action plans, and a sense of accountability. Executives will seek assurances respective risk registers are maintained regularly, action plans are well managed, well communicated and actions which have blocks are escalated in a timely manner. Registers are expected to be agile and reflective of the service. Executives will foster a culture of continuous improvement supporting teams to engage with Better by Betsi, a community of continuous improvement, enhancing innovation with risk identification, mitigations strategies for their service.

In addition, Clinical Executive Directors (Executive Medical Director, Executive Director of Nursing & Midwifery, Executive Director of Therapies & Health Sciences, and the Executive Director of Public Health) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework.

Board Secretary / Director of Corporate Governance

The Board Secretary is the delegated lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the integrated BAF and Risk Management Framework.

The Board Secretary will:

- lead the embedding of an effective risk management culture throughout the Health Board;
- work closely with the Chair; Chief Executive; Chair of the Audit Committee; and, Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;
- lead the ongoing development of the Risk Management Group (established by the Executive Team).

Head of Risk Management & Assurance

The Head of Risk and Assurance is accountable to the Board Secretary, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the Health Board, which link to the BAF;
- support the management and development of the BAF and Risk Management Framework;
- work with directorates and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the CRR and BAF, for Board;
- support the development and functioning of the Risk and Assurance Group; and
- provide training, information and advice to operational staff and corporate functions on risk management and risk registers, ensuring linkage to the BAF.

Corporate Risk Management Team

The risk management team will facilitate and ensure effective risk management practices are in place throughout the organisation. The team will support the escalation of risks the CRR and BAF. The risk management team will support services by validating risk registers, including the adequacy of the risk descriptions, controls, and assurances and justification of the risk scoring and take a lead on assurances of compliance pan BCU.

They will advise all colleagues and Executive Directors in managing their risks. The risk team will lead the development of procedures as required under this framework. They will ensure the delivery of training to staff who have responsibilities under this policy. They will be responsible for the overall management of the risk module in Datix.

Senior Managers

Senior managers will take the lead on risk management within their divisions, sites and areas and set the example through visible and exemplary leadership.

They are also responsible for supporting the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit. The risk service lead and risk team will work with senior managers to ensure

risks are articulated appropriately and described in line with procedures and will further support organisational wide learning.

The risk management team will provide healthy challenge and support to those risks that do not have adequate actions or action plans and have not progressed in a timely manner with a route to escalation to Executives. Senior manager will provide Executives with regular assurances around effective management of risk registers.

Service Risk Leads

Services are required to nominate a risk lead/champion on behalf of the service to ensure the risk register is well maintained and risk is championed throughout the service facilitating good identification processes. Service risk leads will support the operational management of their respective service risk register and will liaise with the risk management team around escalation or de-escalations of risks and will work on any feedback around the quality assurance of the risk register. Service managers and service risk leads will be responsible for ensuring activities and action plans within risks are regularly maintained. All leads and champions will have regular risk management training.

All Staff

All staff including, Trade Union colleagues and contractors are required to comply with this Risk Management Framework, raise any issues of concern to the attention of their line manager and to appropriately minimise and manage risks to the best of their knowledge and ability. Controls and actions implemented in mitigating risks must be timely disseminated to all staff involved with the management of the risk. All staff are expected to share intelligence around any potential risks with contractors providing services within and on behalf of the Health Board. Risk is the responsibility of all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business.

Independent Members (IMs)

Independent Members have an important role in risk management in seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust, positive and effective challenge to the Executive Directors and senior management. IMs are expected to satisfy themselves that the Health Board's risk management arrangements are effective, efficient and fit-for-purpose. IMs will provide healthy challenge on those risks that are not treated in a timely manner; the overall decision to tolerate the risk and/or the risks alliance to Health Board objectives.

IMs will challenge overall Board decision-making ensuring this is within the Boards risk appetite. In addition, IMs chair Board Committees and in line with the relevant Committee's terms of reference, should gain and provide assurance to the Board that risks within its remit are being managed effectively by the risk owners and report

any areas of concern to the Board. IMs should seek assurance in ensuring a measured risk culture.

Internal Audit

The relationship between risk management and Internal Audit is critical. Risk management is concerned with the assessment of risk and the identification of existing and additional controls, whereas Internal Audit's role is to evaluate these controls and test their efficiency and effectiveness. This is undertaken through the Internal Audit programme of work. Accordingly, the Head of Internal Audit will:

- a. Provide an overall opinion each year to the Accountable Officer of the organisation's risk management, control and governance; to support the preparation of the Annual Governance Statement;
- b. Focus the internal audit work on the significant risks as identified by management, and audit the risk management processes across the organisation;
- c. Audit the organisation's risk management, control and governance through operational audit plans, in a way that affords suitable priority to the organisation's objectives and risks;
- d. Provide assurance on the management of risk and improvement of the organisation's risk management, control and governance; by providing line management with recommendations arising from audit work.

Local Counter Fraud Services

The Health Board's nominated Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The Health Board's Annual Counter Fraud Work Plan, as agreed by the Audit, Risk and Assurance Committee, identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS, and then reported to the Audit Committee as appropriate. The LCFS works with the Chief Executive, Executive Directors and Board Secretary to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned, and are then escalated through the Health Board's escalation process.

Senior Information Risk Officer

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

8. Monitoring the Effectiveness of the Risk Management Framework

Compliance with this Framework is monitored by the Executive Committee and the Audit, Risk & Assurance Committee. The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report. The Corporate Risk Team and RMG will take a lead on seeking assurances and providing Committees and Board with an overview of the Health Board's effectiveness and compliance. The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year.

The Health Board's risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process. The risk management framework draws from best practice standards ISO31000, policy, and legislative instruction such as the National Health Service (Wales) Act 2006, the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. The Health Board understands that risk is inherent in every business and is committed to ensuring full compliance.

Appendix 1

Risk Appetite

The Board set their risk appetite in a developmental session on the 24 August 2023 and is subject to annual review. The appetite session referenced the Good Governance Institute Appetite Risk Matrix (2018) for risk types in order to score appetite.

The output of the session detailed appetite across five risk types:

Financial Risk: There was an agreed consensus on an **'open'** appetite to accept some financial risk with controls, balancing value for money with price not the overriding factor. There was recognition that past caution has not yielded desired results.

Regulatory Risk: There was an agreed consensus supporting an **'open'** risk appetite to accept some regulatory scrutiny, provided there is confidence the organisation can successfully respond to any challenges.

Quality Risk: There was willingness to be **'open'** and accept some short-term quality impacts for long-term gains, signalling an open appetite for innovation and improvement.

Reputational Risk: There was an agreed consensus to **'seek'** some reputational risks if there is potential for stakeholder outcomes to improve.

People Risk: There was an agreed consensus to **'seek'** and accept some workforce risks in the hope to be innovation, provided there are staff recruitment, retention, and development opportunities.

Equality Impact Assessment

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

References

WHC(2000)13 – Corporate Governance in the NHS in Wales: risk management and organisational controls.

AS/NZS ISO 31000:2018 (2018) Risk Management Guidelines. BSI Publication.

HM Treasury (2020) The Orange Book: Risk Management – Principles and Concepts.

NHS Leadership Academy (2013) The Healthy NHS Board 2013 – Principles for Good Governance. Available at: www.leadershipacademy.nhs.uk

IRM (2011) Risk Appetite & Tolerance Guidance Paper.

Deloitte (2015) Enterprise Risk Management – A 'risk-intelligent' approach. Deloitte Advisory Publication.

Committee of Sponsoring Organizations of Treadway Commission (2017) Guidance on Enterprise Risk Management – Integrating with Strategy and Performance. Available at: <https://www.coso.org/enterprise-risk-management>

Included a desktop review of Welsh Health Boards Risk Frameworks



PARTS A (Screening – Forms 1-4) and
B (Key Findings and Actions – Form 5)

<u>For:</u>	RM01 – Risk Management Framework
<u>Date form completed:</u>	Originally completed 02/09/2021 Reviewed and minor amendments Sept 2023



KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "...all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A

Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	RM01 – Risk Management Framework
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The Health Board aims to provide a structured, comprehensive, and coherent framework to support staff in identifying, assessing and managing risks arising from its business activities, as the effective management of risks is an inherent part of its approach to continuous learning, improvement and good governance. RM01 – Risk Management Framework provides guidance for the consistent management of both operational and strategic risks, as drivers for better decision-making and the provision of high quality, personalised, patient-centred care, and enhanced experience.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Interim Board Secretary
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Board Assurance Framework Risk Management Procedures (RM02) Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Information Governance Policy Health and Safety Policy Board Assurance Framework SOP Corporate Risk Register SOP

Part A

Form 1: Preparation

Please answer all questions

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	All employees including Board members.
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	The Corporate Risk Team is launching mandatory risk training which will be updated and reflective of the new framework however there is a risk of delays as the risk module is being produced by the ESR national team. The Board (Executives and Independent Members) will receive updated risk training which is reflective of the new framework, work will be ongoing to ensure all directors and senior managers have strategic risk management training. Training and embedding will take time to ensure all staff have received the updated risk training however this will be tracked and monitored through ESR.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The framework describes the Health Board's approach to risk management as positive, integrated, enterprise-wide and informed by an open and transparent culture in which staff feel empowered and confident to raise and discuss risks without fear, to engage staff across the entire organisation in exploring risk management as a tool for better decision-making and in achieving the Health Board's strategic objectives.

Part A

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

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A

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

Please answer all questions

Protected characteristic or group	<p>Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p>Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?"</p> <p>You can also visit their website here</p>	<p>How will you reduce or remove any negative Impacts that you have identified?</p>
<p><i>Guidance for Completion</i></p> <p><i>In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered ‘Yes’, you need to indicate if the potential impact will be positive or negative. Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.</i></p> <p><i>The information that helps to inform the assessment should be listed in this column. Please provide evidence for all answers.</i></p> <p>Hint/tip: do not say: “not applicable”, “no impact” or “regardless of...”. If you have identified ‘no impact’ please explain clearly how you came to this decision.</p>			

Part A

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

Please answer all questions

<p>NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.</p> <p>For the definitions of each characteristic please click here</p>						
	Yes	No	(+ve)	(-ve)		
Age		No	+ve		The framework does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Disability		No	+ve		Whilst the framework does not discriminate, the assessment has highlighted the need for, along with all other Health Board documentation, availability in a format to address any visual impairment disabilities, including colour blindness, and also, potentially, dyslexia.	This assessment highlighted that for those with visual impairment disabilities, additional support may be required – i.e. document transcription and additional support. With colour blindness identified as a potential difficulty in understanding any RAG ratings, e.g. within Datix where risk registers are documented and the corporate risk register. In terms of dyslexia, a number of Health Board resources

Part A

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

Please answer all questions

						are available to support staff as a mitigating action.
Gender Reassignment		No	+ve		The framework does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Pregnancy and maternity		No	+ve		The framework does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Race		No	+ve		The framework does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Religion, belief and non-belief		No	+ve		The framework does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Sex		No	+ve		The framework does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Sexual orientation		No	+ve		The framework does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Marriage and civil Partnership (Marital status)		No	+ve		The framework does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	

Part A

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

Please answer all questions

Socio Economic Disadvantage		No	+ve		The framework does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
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Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: <http://howis.wales.nhs.uk/sitesplus/861/page/42166> and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker <https://humanrightstracker.com>.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2* *Right to life*
- *Article 3* *Prohibition of inhuman or degrading treatment*
- *Article 5* *Right to liberty and security*
- *Article 8* *Right to respect for family & private life*
- *Article 9* *Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

[UN Convention on the Rights of the Child](#)

[UN Convention on the rights of people with disabilities.](#)

[UN Convention on the Elimination of All Forms of Discrimination against Women](#)

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

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
	No				The framework does not impact upon people's Human Rights – it sets out an inclusive, enterprise-wide approach to risk management.	

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

Please answer all questions

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		No	+ve		Whilst the framework does not discriminate, as with all Health Board documentation, the assessment has highlighted the need for availability in a Welsh language format.	The Health Board's Translation Service is freely available to those who would like a Welsh language version of the framework.
Treating the Welsh language no less favourably than the English language		No	+ve		Whilst the framework does not discriminate, as with all Health Board documentation, the assessment has highlighted the need for availability in a Welsh language format.	The Health Board's Translation Service is freely available to those who would like a Welsh language version of the framework.

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

<p>What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p>The framework underwent Health Board consultation, approval and ratification, involving those responsible for Equality Impact Assessment.</p>
<p>Have any themes emerged? Describe them here.</p>	<p>A previous EqIA noted where risk registers have RAG ratings this may be difficult for those that are colour blind or dyslexic, and it is recognised that these people may need additional support to review these relevant papers.</p>
<p>If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?</p>	<p>This assessment highlighted that for those with visual impairment disabilities, additional support may be required – i.e. document transcription and additional support. With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column in working documents. In terms of dyslexia, a number of Health Board resources are available to support staff as a mitigating action.</p>

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- <http://howis.wales.nhs.uk/sitesplus/861/page/44085>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1)
for further direction on how to complete this section please click [here training vid p13-18](#)

RM01 – Risk Management Framework

2. Brief Aims and Objectives:
(Copy from Form 1)

The Health Board aims to provide a structured, comprehensive, and coherent framework to support staff in identifying, assessing and managing risks arising from its business activities, as the effective management of risks is an inherent part of its approach to continuous learning, improvement and good governance. RM01 – Risk Management Framework provides guidance for the consistent management of both operational and strategic risks, as drivers for better decision-making and the provision of high quality, personalised, patient-centred care, and enhanced experience.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**

Yes

No

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer ‘No’ to this question.</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p>3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?</p> <p>High significance may mean:</p> <ul style="list-style-type: none"> - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine ‘day to day’ decisions. <p>GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p>5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p>6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p>How is it being monitored?</p>	<p>The Health Board will undertake regular Risk Management Self-Assessments via the Risk Management Group, to measure the effectiveness of risk management arrangements across its services.</p>	
<p>Who is responsible?</p>	<p>The Risk Management Team and the Risk Management Group.</p>	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	What information is being used?	Annual internal audits, Snapshot Audits and/or an annual health check of risk management culture, using agreed Key Performance Indicators (KPIs).
	When will the EqIA be reviewed?	In line with the Strategy review cycle of business.

7. Where will your policy or proposal be forwarded for approval?	Audit Committee.
--	------------------

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity</p> <p>Senior sign off prior to committee approval:</p>	Name	Title/Role
	Nesta Collingridge	Head of Risk Management and Assurance
	Phil Meakin	Interim Board Secretary
	Nesta Collingridge	Head of Risk Management and Assurance
	Phil Meakin	Interim Board Secretary
<p>Please Note: The Action Plan below forms an integral part of this Outcome Report</p>		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	<p>Proposed Actions</p> <p>Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.</p>	<p>Who is responsible for this action?</p>	<p>When will this be done by?</p>
<p>1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:</p>	<p>No potential negative impacts identified, therefore no further actions required.</p>		
<p>2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?</p>	<p>No changes required.</p>		
<p>3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?</p>	<p>Already in place. The framework states that for those with visual impairment disabilities, document transcription and support are available. In terms of dyslexia, a number of Health Board resources are available to support staff as a mitigating action. The Health Board's Translation Service is freely available to those who would like a Welsh language version of the framework.</p>		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.	Who is responsible for this action?	When will this be done by?
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column for all associated risk management materials as these are updated, going forward.	Head of Risk Management and Assurance.	As associated documents are updated.
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column for all associated risk management materials as these are updated, going forward.	Head of Risk Management and Assurance.	As associated documents are updated.



Teitl adroddiad: <i>Report title:</i>	Review of Health Board Standing Orders			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Friday, 15 September 2023			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>Welsh Government have amended and updated the Model Standing Orders for the NHS bodies in Wales. The main changes relate to reflecting the provisions of the Health and Social Care (Quality and Engagement) Act 2020 including:</p> <p>a) Introduction of the duty of quality and duty of candour; b) Changes linked to the establishment of Llais and the dissolution of the Community Health Councils and the Board of Community Health Councils; c) Changes to the provisions with regard to a Vice-Chair of Trusts and changes to numbers of board members. d) Narrative update under the Standing Financial Instructions related to Contract/Procurement</p> <p>The Health Board are being asked to incorporate and adopt this latest review into the BCUHB Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions (which form part of the Standing Orders) as appropriate.</p> <p>The Audit Committee is asked to receive and consider the paper and to note the related work that is progressing in parallel in order to make sure that BCUHB has effective Standing Orders in place.</p>			
Argymhellion: <i>Recommendations:</i>	<p>The Audit Committee is asked to take assurance from the report and support the incorporation and adoption of the Standing Orders for consideration and approval by the Board on 28 September 2023.</p> <p>To note the work progressing in parallel to inform some of the Schedules of the Standing Orders.</p>			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Phil Meakin, Interim Board Secretary and Associate Director of Governance			
Awdur yr Adroddiad: <i>Report Author:</i>	Phil Meakin, Interim Board Secretary and Associate Director of Governance Catrin Rhys-Williams – Head of Corporate Office			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input checked="" type="checkbox"/> <small>Lefel uchel o hyder/tystiolaeth o ran</small>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> <small>Lefel gyffredinol o hyder/tystiolaeth o ran</small>	Rhannol <i>Partial</i> <input type="checkbox"/> <small>Rhywfaint o hyder/tystiolaeth o ran</small>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> <small>Dim hyder/tystiolaeth o ran y ddarpariaeth</small>

	darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<i>No confidence / evidence in delivery</i>
<p>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:</p> <p><i>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:</i></p> <p><i>This is been classed as partial assurance because an automated declaration system has only recently been implemented. The Interim Board Secretary is seeking additional assurance from internal teams that effective training and introductions on this system are rolled out and communicated effectively.</i></p>				
<p>Cyswllt ag Amcan/Amcanion Strategol:</p> <p><i>Link to Strategic Objective(s):</i></p>	<p>This report is purely administrative. There are no associated strategy implications.</p>			
<p>Goblygiadau rheoleiddio a lleol:</p> <p><i>Regulatory and legal implications:</i></p>	<p>This annual update is provided in order to comply with Standing Orders 8.1 – 8.7.</p>			
<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	<p>Do/Naddo Y/N</p> <p>Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn berthnasol</p> <p><i>If no please provide an explanation as to why the duty does not apply</i></p> <p><u>Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7</u></p> <p><u>WP7 Procedure for Equality Impact Assessments</u></p>			
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>Do/Naddo Y/N</p> <p>Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn berthnasol</p> <p><i>If no please provide an explanation as to why the duty does not apply</i></p> <p><u>Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.</u></p> <p><u>WP68 Procedure for Socio-economic Impact Assessment.</u></p>			

<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>(crynodedb o'r risgiau a rhagor o fanylion yma)</p> <p>This report is purely administrative. There are no associated risks.</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>Scrutiny of this annual return (undertaken by Counter Fraud, Office of the Board Secretary and the Audit Committee) supports the mitigation of governance/financial risks associated with conflicts of interest and enables the Audit Committee to review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Relevant staff are obliged to make declarations of interest and any gifts and hospitality received or declined.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Amherthnasol</p> <p>Not applicable</p>
<p>Camau Nesaf: Gweithredu argymhellion</p> <p><i>Next Steps:</i> <i>To bring Draft Standing Orders and updated Polices/documents to the Committee of the Board on 28 September 2023 for approval</i></p>	
<p>Rhestr o Atodiadau:</p> <p><i>List of Appendices:</i> Appendix 1 Standing Orders Document Appendix 2 Standing Orders Schedule 2.1 Standing Financial Instructions</p>	

Review of Standing Orders

Audit Committee 15 September 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.** 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 NHS staff make decisions and carry out their activities

Model Standing Orders, Reservations and Delegation of Powers (SO's) were last issued by Welsh Government in 2021 for all Welsh NHS organisations. The current BCUHB Standing Orders reflect this 2021 version. The link to the current Standing Orders for BCUHB is linked here [NHS WALES](#).

Welsh Government have now undertaken a further review of the Model Standing Order documents, together with the Model Standing Orders and SFI's for Digital Health and Care Wales (DHCW). This is mainly to reflect the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and incorporate updates to the Model SFI's previously issued in letters from the Director of Finance. A circular from the Minister to all Health Board on 27 July 2023 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”**

2. Considerations for the Audit Committee

There is a requirement to keep Standing Orders updated and documents under review to ensure they remain accurate and current. The Audit Committee has a role to make sure that there are effective arrangements are in place in relation to adopting the Standing Orders. The formal incorporation and adoption of the Standing Orders would be received at the Board for approval on the 28 September 2023.

The report highlights the key changes to the Standing Orders received from Welsh Government and also highlights **the additional development** of BCUHB specific documents that the BCUHB colleagues are undertaking ready for the Board on 28 September and sets out the next steps for completion of this.

Appendix 1 (Standing Orders – Reservation and Delegation of Powers) and Appendix 2 (Standard Financial Instructions for Local Health Boards) of this report contain the amended DRAFT Standing Orders with tracked changes from Welsh Government, reflecting the key changes below in section 3 of this report and some further amendments needed to make it a BCUHB specific document (these additions were made by the BCUHB Team). Due to the size of the documents these are provided separately by email/link

Section A, Point xxiv of the Model Standing Orders –Appendix 1 sets out that:

“LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Betsi Cadwaladr University Health Board and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and

SFIs.

This means in practice that there are policy statements/policies that the Health Board will develop that become part of the Standing Orders. The Audit Committee is asked to note that the Chief Executive Officer is overseeing the development of a number of such policies and documents that will be recommended to the Board in September 2023 and if adopted would become an integral part of the LHB's SOs and SFIs. These are summarised below in section 4.

It should be noted that Betsi Cadwaladr University Health Board is also subject to the Betsi Cadwaladr University Health Board Intervention Order 2023, No. 1 and No.2. and should continue to reflect these alongside their Standing Orders. These were reviewed and adopted by the Health Board at its meeting of May 2023.

3. Key Changes in the Review of Standing Orders

The key changes in the Standing Orders that Welsh Government have made are in relation to the following matters:

- a) Introduction of the duty of quality and duty of candour;
- b) Changes linked to the establishment of Llais and the dissolution of the Community Health Councils and the Board of Community Health Councils;
- c) Changes to the provisions with regard to a Vice-Chair of Trusts and changes to numbers of board members.
- d) Narrative update under the Standing Financial Instructions related to Contract/Procurement

In addition the Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) Standing Orders have been updated and the updated Standing Orders form Schedule 4.1 and 4.2 of the Local Health Board Standing Orders.

4. Additional Work on BCUHB Specific

As outlined above the Board will be required to incorporate and adopt this latest review from Welsh Government into the organisations Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions (which form part of the Standing Orders) as appropriate.

As mentioned in Section 2 below there are some policies and documents that inform the frameworks and schedules that each Health Board develop that would sit within the overall Standing Orders once approved. These policies and documents exist now but for BCUHB we know that there are plans to design, develop and implement policies and documents that are under development. The Audit Committee is asked to note that these are being developed.

This work is being overseen by the Chief Executive and will be developed in time for the Board to receive these on the 28 September 2023. Until these are approved all existing policies remain in place (extant).

Table 1 – Summary of Policies and Documents Under Development

Policy Document and Section	Policy and Documents to be Developed for Consideration at the Board	Comments
------------------------------------	--	-----------------

Schedule 2.1 Standing Financial Instructions	An update scheme of delegations to officers and others;	This will give enhanced clarity over individual responsibilities for Directors and Officers sign off under the Standing Orders
Standing Orders Schedule 3	Board Committee Arrangements	Proposed model Terms of Reference for Board Committee and Advisory Groups will be received by the Health Board on 28 September 2023
Standing Orders Page 64	Additional Areas of Responsibility delegated to Chair, Vice Chair and Independent Members	This work will be developed after consultation with the Chair and CEO. Noting that Vice Chair is not yet appointed and that Independent Member to full capacity is in progress.

5. Recommendations

- The Audit Committee is asked to take assurance from the report and support the incorporation and adoption of the Standing Orders for consideration and approval by the Board on 28 September 2023.
- To note the work progressing in parallel to inform some of the Schedules of the Standing Orders.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

~~Model~~ Standing Orders

Reservation and Delegation of Powers

Betsi Cadwaladr University For Local Health Boards

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. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs LHBs must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

These SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), 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 Standards of Business Conduct Policy - Values and Standards of Behaviour framework [LHB to insert title of relevant policy], 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 Orders and, where appropriate, should be familiar with their detailed content. The Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or 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/>.

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Section A – Introduction

Statutory Framework

- i) The Betsi Cadwaladr University Health Board ~~[insert name] Local Health Board~~ (the Local Health Board - LHBHB) is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778)**, “the Establishment Order”.

FOR POWYS INSERT

- ii) ~~Powys Teaching Local Health Board (the LHB) is a statutory body that was established on 1 April 2003 and became operational on the 1 June 2003 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2003 (S.I. 2003/148)**, “the Establishment Order”.~~

FOR SWANSEA BAY AND CWM TAF MORGANNWG INSERT

- iii) ~~The Abertawe Bro Morgannwg Local Health Board/Cwm Taf Local Health Board (the LHB) was a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778)**, “the Establishment Order”.~~

- iv) ~~On 1 April 2019 following the transfer of the principal local government area of Bridgend from Abertawe Bro Morgannwg University Local Health Board to Cwm Taf University Local Health Board as a result of the **Local Health Boards (Area Change) (Wales) Miscellaneous Amendments) Order 2019** Abertawe Bro Morgannwg University Health Board was renamed Swansea Bay Local Health Board/Cwm Taf University Local Health Board was renamed Cwm Taf Morgannwg University Local Health Board.~~

- iv) The principal place of business of the LHB is – Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW ~~[insert address]~~

- iii) All business shall be conducted in the name of Betsi Cadwaladr University Health Board ~~[insert name] LHB~~, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.

- 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. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales)

Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

- x)ix) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)** (“The Constitution Regulations”) which set out the constitution and membership arrangements of LHBs, which includes a requirement for LHBs to make SOs for the regulation of its proceedings and business including provision for the Boards ~~suspension. Sections~~[suspension. 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 LHB’s statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511)**.
- v) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** 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 for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee (“WHSSC”). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)**, which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.
- vi) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8)** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee (“EASC”). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566)** which make provision for the constitution and membership of the EASC including its procedures and administrative arrangements.
- vii) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.
- viii) As a statutory body, the LHB has specified powers to contract in its own

name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

ix) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014 (2014)**.

~~ix~~) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

~~x~~)**xi)** Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

~~xi~~)**xii)** Further duties and powers placed on health boards in relation to co-operation and partnership with local authorities and other partners in Wales are set out in the **Social Services and Well-being (Wales) Act 2014**. This Act establishes the legal framework for meeting people's needs for care and support and imposes general and strategic duties on local authorities and LHBs in order to effectively plan and provide a sufficient range and level of care and support services. The **Partnership Arrangements (Wales) Regulations 2015 (2015/1989)**, made under Part 9 of the **Social Services and Well-being (Wales) Act 2014** set out the arrangements made and provides for LHBs and local authorities to pool funds for the purpose of providing specified services.

Guidance on the provisions of Part 9 can be found at <https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf>

~~xii~~)**xiii)** **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);
- The creation 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 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 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>

~~xiii~~xiv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving 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.

~~xiv~~xv) The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

~~xv~~xvi) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as otherwise provided by these SOs.

NHS Framework

~~xvi~~~~xvii~~) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them 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 are expected at all levels of the service, locally and nationally.

~~xvii~~~~xviii~~) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

~~xviii~~~~xix~~) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; 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.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/>

~~xix~~~~xx~~) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015**, have 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.

~~xx~~~~xxi~~) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government'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/>. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Local Health Board Framework

~~xxi~~~~xxii~~) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

~~xxii)~~~~xxiii)~~ LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Betsi Cadwaladr University Health Board~~[insert name] LHB~~ and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.

~~xxiii)~~~~xxiv)~~ LHBs shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph ~~xxiii~~ below).

~~xxiv)~~~~xxv)~~ For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

~~xxv)~~~~xxvi)~~ The SOs of the LHB (together with SFIs and the Standards of Business Conduct Policy~~Values and Standards of Behaviour Framework [LHB to insert title of relevant policy]~~), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs and further details on joint-Committees may be found in Schedule 4.*

~~xxvi)~~~~xxvii)~~ Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to 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 Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

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

Variation and amendment of Standing Orders

~~xxviii)~~~~xxix)~~ Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the

Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

~~xxix~~)xxx) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB 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 shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

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

The role of the Board Secretary

~~xxxi~~)xxxii) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within LHBs, and is a key source of advice and support to the LHB Chair and other Board members. Independent of the Board, the Board Secretary acts as the guardian of good governance within the LHB. The Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of LHB business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board 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 Board 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 LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers;

As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

xxxiv Further details on the role of the Board Secretary within [Betsi Cadwaladr University Health Board\[insert name\]-LHB](#), including details on how to contact them, are available at [Health Board Members - Betsi Cadwaladr University Health Board \(nhs.wales\) \[insert signpost to relevant LHB documentation\]](#).

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

- 1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.
- 1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

FOR POWYS INSERT

~~1.0.3 The LHB was established by the Local Health Boards (Establishment and Dissolution) (Wales) Order 2003 (S.I. 2003/148 (W.18), and most of its functions are contained in the Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511 (W.147)). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.~~

- 1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Local Health Board

- 1.1.1 The membership of the LHB shall be no more than 24 members comprising the Chair, Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), Associate Members, the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members (appointed by the Board).
- 1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. Officer and non-officer members shall have full voting rights. Associate Members do not have voting rights.

Officer Members [to be known as Executive Directors]

- 1.1.3 A total of 9 (including the Chief Executive), appointed by the Board, whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health Science. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.

Non Officer Members [to be known as Independent Members]

- 1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.
- 1.1.5 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Associate Members

- 1.1.6 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights.
- 1.1.7 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:
- Director of Social Services (nominated by local authorities in the LHB area)
 - Chair of the Stakeholder Reference Group
 - Chair of the Healthcare Professionals' Forum
- 1.1.8 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

- 1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice Chair
- Non Officer Members

unless otherwise stated.

1.2 Joint Directors

- 1.2.1 Where a post of Executive Director of the LHB 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 Board 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.

1.3 Tenure of Board members

- 1.3.1 Independent Members and Associate Members 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. These members can be reappointed but may not hold office as a member or associate member for the same Board for 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.
- 1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.
- 1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.
- 1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the LHB Board and responsibilities of individual members

Role

- 1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:
- Setting the organisation's strategic direction
 - Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
 - Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity.

Responsibilities

- 1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.
- 1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.
- 1.4.4 LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".
- 1.4.5 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting rights.
- 1.4.6 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB

within the communities it serves.

- 1.4.7 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.
- 1.4.8 The Chair shall work in close harmony with the Chief Executive and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.
- 1.4.9 **The Vice-Chair** – 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.
- 1.4.10 In addition to their corporate role across the breadth of the Board's responsibilities, the Vice-Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.
- 1.4.11 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.
- 1.4.12 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or “champions” as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

- 2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and

conditions upon which any delegation is being made.

2.0.2 The Board'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 Board;
- ii) Scheme of delegation to committees and others; and
- iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 Subject to Standing Order 4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

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

2.2 Delegation of Board functions

2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:

- i) By a committee, sub-Committee or officer of the LHB (or of another LHB or Trust); or
- ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
- iii) Jointly with one or more bodies including local authorities through a joint-Committee, sub-Committee or joint sub-Committee.

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees, sub-Committees, joint-Committees or joint sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 LHB Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the LHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term 'Committee'

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- Joint-Committee
- Sub-Committee
- Joint Sub-Committee

unless otherwise stated. The Board's Advisory Groups are referred to separately.

3.2 Joint Committees

- 3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.
- 3.2.2 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.
- 3.2.3 The Board shall establish, as a minimum, the following joint-Committees:
- The Welsh Health Specialised Services Committee (WHSSC).
 - The Emergency Ambulance Services Committee

Joint Committee Standing Orders, terms of reference and operating arrangements

- 3.2.4 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. 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 (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;
 - Meeting arrangements;
 - Communications;
 - Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);
 - Any budget, financial and accounting responsibility;
 - Secretariat and other support;
 - Training, development and performance; and
 - Reporting and assurance arrangements.
- 3.2.5 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees

established by the Board are set out in Schedule 4.

3.3 Sub-Committees

3.3.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.4 Committees established by the LHB

3.4.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements.

3.4.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g. [equality](#) and human rights across all areas of activity; and
- Maximise cohesion and integration across all aspects of governance and assurance.

3.4.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. 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 (including the Board its Committees and Advisory Groups)
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.4.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.4.5 The membership of any such 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 Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

3.4.6 Executive Directors or other LHB officers shall not be appointed as 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 or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.5 Other Committees

3.5.1 The Board may also establish other Committees to help the LHB in the conduct of its business.

3.6 Confidentiality

3.6.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.7 Reporting activity to the Board

3.7.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee ~~Chairs~~ shall bring to the Boards 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. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

- 4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261) (“the Shared Services Regulations”) require the Velindre NHS Trust to establish a Shared Services Committee which will be responsible for exercising the Trust’s Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.
- 4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.
- 4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.
- 4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

- 5.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.
- 5.0.2 The LHB’s Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals’ Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*
- 5.0.3 The Board’s commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Terms of reference and operating arrangements

5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as other relevant local and national groups);
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.1.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

5.1.3 The Board may determine that the Advisory Group shall be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.2 Support to the Advisory Groups

5.2.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see Schedule 5.3, paragraph 1.7.1);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.3 Confidentiality

5.3.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.4 Advice and feedback

5.4.1 The LHB may specifically request advice and feedback from the Advisory Groups on any aspect of its business, and they may also offer advice and feedback even if not specifically requested by the LHB. The Groups may provide advice to the Board:

- At Board meetings, through the SRG and HPF Chair's participation as Associate Members;
- In written advice;
- In any other form specified by the Board.

5.5 Reporting activity

5.5.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 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.

5.5.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

5.6.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:

- Early engagement and involvement in the determination of the LHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as

- Feedback on the impact of the LHB's operations on the communities it serves.

5.6.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

5.6.3 The SRG's role is distinctive from that of [Llais](#), who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

5.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

5.7.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

5.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

5.7.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

5.8 Relationship between the SRG and others

5.8.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;

- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

5.9 Working with Llais

- 5.9.1 The SRG shall make arrangements to ensure designated Llais members receive the SRG's papers and are invited to attend SRG meetings.
- 5.9.2 The SRG shall work together with Llais within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Refer to Schedule 5.1 for detailed Terms of Reference and Operating Arrangements

5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

Role

- 5.10.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.
- 5.10.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

5.11 Terms of reference and operating arrangements

- 5.11.1 In addition to the provisions in 5.2.1 above the Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

5.12 Relationship with the Board

- 5.12.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.
- 5.12.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.
- 5.12.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

5.12.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

5.13 Rights of Access to the LHB Board for Professional Groups

5.13.1 The LHB Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

- i) Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or
- ii) Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

5.13.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 7.5.7.

5.14 Relationship with the National Professional Advisory Group

5.14.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group.

Refer to Schedule 5.2 for detailed Terms of Reference and Operating Arrangements

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

5.15.1 The LPF's role is to provide a formal mechanism where the LHB, as employer, and trade unions/professional bodies representing LHB employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the LHB - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the LHB's workforce.

5.15.2 It is the forum where the LHB and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.16 Relationship with the Board and others

5.16.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.16.2 The Board may determine that designated Board members or LHB staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

5.16.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.

5.16.4 The Board's Chair shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.16.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 5.3 for detailed Terms of Reference and Operating Arrangements

6. WORKING IN PARTNERSHIP

6.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of population assessments and area plans.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:

- The LHB's own structures and operating arrangements, e.g., Advisory Groups; and
- The involvement (at very local and community wide levels) in partnerships and community groups – such as Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership

Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working—implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 The Citizen Voice Body for Health and Social Care, Wales (to be known as Llais)

6.1.1 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 its operations.

6.1.2 The 2020 Act places a statutory duty on the LHB 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.

6.1.3 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>

6.1.4 The 2020 Act also places a statutory duty on the LHB 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. The LHB must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

6.1.5 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>

6.1.6 In discharging these duties, the Board shall work constructively with Llais to ensure both organisations are able to discharge their duties. They will ensure their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- Engaging, formally consulting and working jointly within the LHB's area on any proposals for substantial development or change of the services it is responsible for, in line with the [Guidance on Changes to Health Services in Wales 2023](#).

The Guidance on Changes to Health Services can be found at <https://www.gov.wales/guidance-changes-health-services>

6.1.7 The Board shall ensure that Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.8 The Board may determine that a designated Llais representative(s) shall be invited to attend Board meetings.

The Board shall ensure arrangements are in place for regular meetings between LHB officers and regional representatives of Llais.

6.1.9 The Board's Chair shall put in place arrangements to meet with the Regional Director and relevant representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, 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 LHB 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 provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011 .

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the communities served by the LHB, including any views expressed formally to the LHB, e.g., through the SRG or **Llais**.

7.2 Annual Plan of Board Business

7.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

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

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisations website.

Annual General Meeting (AGM)

7.2.5 The LHB must hold an AGM in public no later than the 31 July each year **[Note: no later than 30 September 2023 for year 2022/2023]**. At least 10

calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the LHB's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the LHB are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others.

7.2.6 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

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

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must 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 board business.

Notifying and equipping Board members

- 7.4.3 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.
- 7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board 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 Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.
- 7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.
- 7.4.6 In the case of a meeting called by Board 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

- 7.4.7 Except for meetings called in accordance with Standing Order 7.3, at least 10 calendar days before each meeting of the Board 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 the 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 LHB's communication strategy.
- 7.4.8 When providing notification of the forthcoming meeting, the 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.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

- 7.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.
- 7.5.2 The Board and its committees 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. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board 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 in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).*
- 7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.
- 7.5.4 The Board Secretary, on behalf of the 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.
- 7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.
- 7.5.6 Unless the Board 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 Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the LHB, (whether directly or through the activities of bodies such as **Llais** and the LHB's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the LHB will preside at any meeting of the Board 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.

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

Quorum

7.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board 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, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member 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.

Dealing with motions

7.5.13 In the normal course of Board 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 Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board 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 Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion** – Any Board member wishing to propose a motion must notify the 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 Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The 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 Board business.

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

7.5.17 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.

7.5.18 **Motions under discussion** – When a motion is under discussion, any Board 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 Board member may not be heard further;
- The Board 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.

7.5.19 **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.

7.5.20 **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 Chair.

7.5.21 **Motion to rescind a resolution** – The Board 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 Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board 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 Board.

7.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the community and healthcare professionals within the LHB's area. Such views will usually be presented to the Board through the Chairs of the LHB's Advisory Groups and the **Llais** representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

- 7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.
- 7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulation 2018, and the LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

- 7.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB 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 Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the [Standards of Business Conduct Policy](#) ~~Values and Standards of Behaviour framework [LHB to insert title of relevant policy]~~, or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

- 8.0.1 The Board must adopt a set of values and standards of behaviour for the LHB 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 LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board, [the Standards of Business Conduct Policy](#) ~~[LHB to insert title of relevant policy]~~ will form part of these SOs.

8.1 Declaring and recording Board members' interests

- 8.1.1 **Declaration of interests** – It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to

influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Standards of Business Conduct Policy~~Values and Standards of Behaviour Framework [LHB to insert title of relevant policy]~~, and their statutory duties under the Constitution Regulations. Board members must notify the Chair and Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board 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 Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

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

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

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

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

8.2 Dealing with Members' interests during Board meetings

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

in Wales.

- 8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board 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 Board minutes.
- 8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:
- i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;
 - ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;
 - iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;
 - iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.
- 8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.
- 8.2.5 Where the 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 Board.
- 8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.
- 8.2.7 **Members with pecuniary (financial) interests** – Where a Board

member, or any person they are connected with¹ has any direct or indirect pecuniary interest in any matter being considered by the Board, 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 Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Constitution Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

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

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of LHB officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts², hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework [**LHB to insert title of relevant policy**] approved by the Board prohibits Board members and LHB 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.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may

¹ In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

² The term gift refers also to any reward or benefit.

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 Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 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 Board 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 LHB;
- **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 LHB; 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 should always be declined.

8.5.4 A distinction may 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.

8.6 Sponsorship

8.6.1 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.

- 8.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Standards of Business Conduct Policy**~~Values and Standards of Behaviour Framework~~ ~~[LHB to insert title of relevant policy]~~ and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

- 8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.
- 8.7.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.
- 8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:
- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.
 - **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.
- 8.7.4 Board members and LHB 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 LHB;

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.

- 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.

8.7.5 The Board Secretary will arrange for a full report of all offers of [Gifts](#), [Hospitality](#) and Sponsorship recorded by the LHB to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

9.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1. Register of Sealing

9.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the LHB, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the LHB any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the LHB shall be kept securely by the Board

Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's 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.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

10.0.4 Assurances in respect of the functions discharged by WHSSC and EASC shall be achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for each of the Joint Committees.

10.0.5 Arrangements for seeking and providing assurance in respect of any other services provided on behalf of or in association with the LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board 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 other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);

- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 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-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

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

10.3 External Assurance

10.3.1 The Board 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.

10.3.2 The Board 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 Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB 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.

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

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves 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 communities it serves and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their community and other partners.

11.0.3 The Board shall also facilitate effective scrutiny of the LHB's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

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

12. REVIEW OF STANDING ORDERS

12.0.1 *[The Board Secretary shall arrange for an appropriate impact assessment to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.]*

12.0.2 These SOs shall be reviewed annually by the Audit Committee [or equivalent], which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

As set out in Standing Order 2, the Board - 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 LHB may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

- i) A Committee, e.g., Quality and Safety Committee;
- ii) A sub-Committee, e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;
- iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs established to take forward matters relating to specialist services; and
- iv) Officers of the LHB (who may, subject to the Board'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 Board is notified of any matters that may affect the operation and/or reputation of the LHB.

The Board'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 Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

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

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board 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 Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***
- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's **direction, equipping** the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***
- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***
- ***The Board 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 Board 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***
- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***
- ***The Board may delegate authority to act, but retains overall responsibility and accountability***
- ***When delegating powers, the Board 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 Board

The Board 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 Executive

The Chief Executive 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 Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

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

The Board Secretary

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

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

The Audit⁴ Committee

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

Individuals to whom 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 LHB'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 Chief Executive ~~[LHB to insert details]~~ of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

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

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive 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 LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the LHB.

⁴ LHB to insert title for the committee that carries out these functions.

SCHEDULE OF MATTERS RESERVED TO THE BOARD⁵

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	Board may determine any matter for which it has statutory or delegated authority in accordance with SOs (except for those decisions delegated to the Welsh Health Specialised Services Committee (WHSSC) or Emergency Ambulance Services Committee (EASC).
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are: <u>Items listed on the Board's Cycle of Business</u> [LHB to insert details]
3	FULL	GENERAL	Approve the LHB's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: <ul style="list-style-type: none"> ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. <p>In accordance with any directions set by the Welsh Ministers.</p>

⁵ 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.

5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the LHB’s official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the Standards of Business Conduct Policy LHB’s Values and Standards of Behaviour framework [LHB to insert title of relevant policy]
10	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 Board members’ interests, in accordance with advice received, e.g. From Audit Committee or Board Secretary
11	FULL	STRATEGY & PLANNING	Determine the LHB’s strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the LHB’s key strategies and programmes related to: <ul style="list-style-type: none"> ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes

			<ul style="list-style-type: none"> ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
13	FULL	STRATEGY & PLANNING	Approval of Joint Area Plan prepared under the direction of the Regional Partnership Board and in response to the population assessment
14	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
15	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board
16	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
17	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
18	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
19	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
20	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
21	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 LHB, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE)
22	FULL	STRATEGY & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.

23	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 Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment of officer members of the Board (Chief Executive and Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension officer members in accordance with the provisions of the Regulations and in accordance with Ministerial instructions
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board (Chief Executive and Directors)

27	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Board Secretary
28	NO – Remuneration and Terms of Service Committee	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.
29	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the LHB's top level organisation structure and corporate policies
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss LHB Committees, <u>including any</u> joint-Committees directly accountable to the Board
31	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up <u>by the</u> Board
32	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
33	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board
34	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the LHB's responsibility as a bailee for patients' property

35	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or 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
36	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or 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 Executive and officers
37	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the LHB
38	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the LHB's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.

39	FULL	STRATEGY & PLANNING	Approve new contracts for the LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the LHB's population where the value exceeds the delegated limit of the Chief Executive
40	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
41	FULL	PERFORMANCE & ASSURANCE	Approve the LHB's audit and assurance arrangements
42	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Executive on progress and performance in the delivery of the LHB's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate
43	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Committees, groups and other internal sources on the LHB's performance and approve action required, including improvement plans, as appropriate
44	FULL	PERFORMANCE & ASSURANCE	Receive reports on the LHB's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise significant issue or concerns impacting on the LHB's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate)
45	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the LHB's Chief Internal Auditor and approve action required, including improvement plans
46	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
47	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the LHB's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
48	FULL	REPORTING	Approve the LHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required

49	FULL	REPORTING	Receive, approve and ensure the publication of LHB reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued
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ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		This will be developed after consultation with the Chair and CEO [individual LHB to insert details, in accordance with statutory and Assembly Government requirements]
	VICE CHAIR		[individual LHB to insert details, in accordance with statutory and Assembly Government requirements] To be determined when Vice Chair is appointed and in consultation with the Chair
	CHAMPION/ NOMINATED LEAD		To be determined after consultation with the Chair [individual LHB to insert details, in accordance with statutory and Assembly Government requirements]

DELEGATION OF POWERS TO COMMITTEES AND OTHERS⁶

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, including [individual LHBs to insert details]

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

The Board has delegated a range of its powers to the following Committees and others:

- Audit Committee
- Charitable Funds Committee
- Mental Health and Capacity Compliance Committee
- Quality, Safety and Experience Committee
- Partnership, People and Population Health Committee
- Performance, Finance and Information Governance Committee
- Remuneration and Terms of Service Committee

▪ [LHB to insert details]

[LHB to insert details]

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these

⁶ As defined in Standing Orders

Commented [PM(G&C1): Please note that the decision as to what Committees will be in existence after 28 September will be a matter for the Board. These are the current Committees under the current Standing Orders.

documents form the LHB's Scheme of Delegation to Committees.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The LHB SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, set out in **[insert details]**, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the LHB's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[LHB to determine]	[LHB to determine] The existing documents will be developed for the Board to consider on 28 Sept 2023 Existing links to current is below Standing Orders and Financial Instructions - Betsi Cadwaladr University Health Board (nhs.wales)

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive 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.

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

LHB framework

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

- *SFIs (see Schedule 2.1 below)*
- *Values and Standards of Behaviour Framework (Standards of Business Conduct Policy)*
- *Board Risk and Assurance Framework (BAF)*
- *Risk Management Strategy and Policy*
- *Living Healthier, Staying Well (LHSW)*
- *Annual Plan*
- *Key policy documents [LHB to insert details]*

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

These documents may be accessed by:

<https://bcuhb.nhs.wales/about-us/governance-and-assurance/standing-orders-and-financial-instructions/> *[LHB to insert details]*

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

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can be accessed at <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/>. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

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

[\[please see separate Schedule 2.1 for SFIs\]](#)

This work is under development and will be developed
ready for adoption by the Board

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

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

*[LHB to insert details, including detailed Terms of Reference
and Operating Arrangements for each Committee]*

*Terms of Reference for Committees are being developed and will be
presented to the Board on 28 September 2023*

Schedule 4

JOINT COMMITTEE ARRANGEMENTS

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

~~[LHB to insert details, including detailed terms of reference~~

~~and operating arrangements for each Committee]~~

Schedule 4.1 – Welsh Health Services Specialised Services Committee



WHSSC Model
Standing Orders Re:

Schedule 4.2 – Emergency Ambulance Services Committee



EASC Model SOs
Reservation and Del

Schedule 5

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

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

[LHB to insert details, including detailed terms of reference and operating arrangements for each Advisory Group. These must include and take account of the information detailed below in the model SO's]

Schedule 5.1 – Stakeholder Reference Group

Schedule 5.2 – Health Professionals Forum

Schedule 5.3 – Local Partnership Forum

Schedule 5.1

Stakeholder Reference Group

Terms of Reference and Operating Arrangements

THE STAKEHOLDER REFERENCE GROUP (SRG)

1.1 Role

- 1.1.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:
- Early engagement and involvement in the determination of the LHB's overall strategic direction;
 - Provision of advice on specific service proposals prior to formal consultation; as well as
 - Feedback on the impact of the LHB's operations on the communities it serves.
- 1.1.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.
- 1.1.3 The SRG's role is distinctive from that of **Llais**, who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.
- 1.1.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.
- 1.1.5 In addition to the provisions in 1.1.3 above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

1.2 Membership

- 1.2.1 The membership of the SRG, including the approval of nominations to the Group; the appointment of Chair and Vice Chair; definition of member

roles, powers and terms and conditions of appointment (including remuneration and reimbursement) will be determined by the Board, taking account of the views of its stakeholders.

1.2.2 There shall be no minimum or maximum requirement in terms of membership size. In determining the number of members, the Board shall take account of the need to ensure the SRG's size is optimal to ensure focused and inclusive activity.

1.2.3 Membership must be drawn from within the area served by LHB, and shall ensure involvement from a range of bodies and groups operating within the communities serviced by the LHB. Where the Board determines it appropriate, the LHB may extend membership to individuals in order to represent a key stakeholder group where there are not already formal bodies or groups established or operating within the area and who may represent the interests of these stakeholders on the SRG.

1.2.4 In determining the overall size and composition of the SRG, the Board must take account of the:

- Demography of the areas served by the LHB;
- Need to encourage and reflect the diversity of the locality, to incorporate different ages, race, religion and beliefs, sexual orientation, gender, including transgender, disability and socio-economic status. Where appropriate, the LHB shall support positive action to increase representation;
- Balance needed in both the range of difference stakeholders and the geographical areas covered, taking particular care to avoid domination by any particular stakeholder type or geographical area;
- Design and operation of the partnership/stakeholder fora already influencing the work of the LHB at local community levels;
- Need to complement, and not duplicate the work of **Llais**; and
- Need to guard against the over involvement of particular stakeholders through their roles across the range of partnership/stakeholder arrangements in place.

1.2.5 The Board shall keep under review the size and composition of the SRG to ensure it continues to reflect an appropriate balance in stakeholder representation.

1.3 Member Responsibilities and Accountability:

The Chair

1.3.1 The Chair is responsible for the effective operation of the SRG:

- Chairing Group meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating

- arrangements; and
- Developing positive and professional relationships amongst the Group's membership and between the Group and the LHB's Board and its Chair and Chief Executive.

1.3.2 The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Group in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.3 As Chair of the SRG, they may as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

The Vice Chair

1.3.4 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, and this deputisation includes acting in the role of Associate Member of the LHB Board.

1.3.5 The Vice Chair is accountable, through the SRG Chair to the LHB Board, for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the SRG.

Members

1.3.6 The SRG shall function as a coherent Advisory Body, all members being full and equal members and sharing responsibility for the decisions of the SRG.

1.3.7 All members must:

- Be prepared to engage with and contribute fully to the SRG's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the SRG within the communities it represents.

1.3.8 SRG members are accountable, through the SRG Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the SRG.

1.4 Appointment and terms of office

1.4.1 Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder group where it has determined that formal bodies or groups are not already established or operating within the area that may represent the interests of these stakeholders on the SRG.

1.4.2 The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Welsh Ministers. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment;

1.4.3 The Board Secretary, on behalf of the Chair of the LHB, will oversee the process of nomination and appointment to the SRG.

1.4.4 Members shall be appointed for a period specified by the Board, but for no longer than 3 years in any one term. Those members can be reappointed but may not serve a total period of more than 5 years consecutively. The Board may, where it considers it appropriate, make interim or short term appointments to the SRG to fulfil a particular purpose or need.

1.4.5 The **Chair** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the LHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.4.6 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

1.4.7 The **Vice Chair** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to

any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the LHB Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the SRG Chair's absence, the Vice Chair shall also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

- 1.4.8 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.
- 1.4.9 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.
- 1.4.10 The LHB will require SRG members to confirm in writing their continued eligibility on an annual basis.

1.5 Resignation, suspension and removal of members

- 1.5.1 A member of the SRG may resign office at any time during the period of appointment by giving notice in writing to the SRG Chair and the Board.
- 1.5.2 If the Board, having consulted with the SRG Chair and the nominating body or group, considers that:
- It is not in the interests of the health service in the area covered by the SRG that a person should continue to hold office as a member; or
 - It is not conducive to the effective operation of the SRG
- it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.
- 1.5.3 A nominating body or group may request the removal of a member appointed to the SRG to represent their interests by writing to the Board setting out an explanation and full reasons for removal.
- 1.5.4 If an SRG member fails to attend any meeting of the Group for a period of six months or more, the Board may remove that person from office unless they are satisfied that:
- i) The absence was due to a reasonable cause; and

- ii) The person will be able to attend such meetings within such period as the Board considers reasonable.

1.5.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

1.6 Relationship with the Board

1.6.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

1.6.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

1.6.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

1.6.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

1.7 Relationship between the SRG and others

1.7.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

1.8 Working with **Llais**

1.8.1 The SRG shall make arrangements to ensure designated **Llais** members receive the SRG's papers and are invited to attend SRG meetings.

1.8.2 The SRG shall work together with **Llais** within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Schedule 5.2

Health Professionals' Forum

Terms of Reference and Operating Arrangements

THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

1.1 Role

- 1.1.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.
- 1.1.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

1.2 Terms of reference and operating arrangements

- 1.2.1 The Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

1.3 Membership

- 1.3.1 The membership of the HPF reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the HPF shall therefore comprise the following eleven (11) members, as a minimum:

- Welsh Medical Committee
 - Primary and Community Care Medical representative
 - Mental Health Medical representative
 - Specialist and Tertiary Care medical representative
- Welsh Nursing and Midwifery Committee
 - Community Nursing and Midwifery representative
 - Hospital Nursing and Midwifery representative
- Welsh Therapies Advisory Committee
 - Therapies representative
- Welsh Scientific Advisory Committee

- Scientific representative
- Welsh Optometric Committee
 - Optometry representative
- Welsh Dental Committee
 - Dental representative
- Welsh Pharmaceutical Committee
 - Hospital Pharmacists representative
 - Community Pharmacists representative

1.3.2 Where the Board determines it appropriate, the LHB may extend membership to other individuals in order to ensure an appropriate balance in representation amongst healthcare professional groupings and across the range of primary, community and secondary service provision.

1.4 Member Responsibilities and Accountability:

The Chair

1.4.1 The Chair is responsible for the effective operation of the HPF:

- Chairing meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating arrangements; and
- Developing positive and professional relationships amongst the HPF's membership and between the HPF and the LHB's Board, and in particular its Chair, Chief Executive and clinical Directors.

1.4.2 The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the HPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.4.3 As Chair of the HPF, they will be appointed as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

The Vice Chair

1.4.4 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, and this deputisation includes acting in the role of Associate Member of the LHB Board.

- 1.4.5 The Vice Chair is accountable through the HPF Chair to the LHB Board for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the HPF.

Members

- 1.4.6 The HPF shall function as a coherent advisory group, all members being full and equal members and sharing responsibility for the decisions of the HPF.

- 1.4.7 All members must:

- Be prepared to engage with and contribute fully to the HPF's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the HPF within the healthcare professional discipline they represent.

- 1.4.8 Forum members are accountable through the HPF Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the HPF.

1.5 Appointment and terms of office

- 1.5.1 Appointments to the HPF shall be made by the Board, based upon nominations received from the relevant healthcare professional group, and in accordance with any specific requirements or directions made by the Welsh Ministers. Members shall be appointed for a period specified by the Board, but for no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively.

- 1.5.2 The **Chair** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination will be subject to consideration by the Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. Their appointment as Chair will be made by the Minister, but it will not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the

Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

- 1.5.3 The Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Chair has ended.
- 1.5.4 The **Vice Chair** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to the condition that they be appointed from a different healthcare discipline to that of the Chair, along with any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the HPF Chair's absence, the Vice Chair will also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.
- 1.5.5 The Vice Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Vice Chair has ended.
- 1.5.6 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the HPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The HPF Chair will advise the Board in writing of any such cases immediately.
- 1.5.7 The LHB will require Forum members to confirm in writing their continued eligibility on an annual basis.

1.6 Resignation, suspension and removal of members

- 1.6.1 A member of the HPF may resign office at any time during the period of appointment by giving notice in writing to the HPF Chair and the Board.
- 1.6.2 If the Board, having consulted with the HPF Chair and the nominating body or group, considers that:
 - It is not in the interests of the health service in the area covered by the HPF that a person should continue to hold office as a member; or
 - It is not conducive to the effective operation of the HPF

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

- 1.6.3 A nominating body or group may request the removal of a member appointed to the HPF to represent their interests by writing to the Board setting out an explanation and full reasons for removal.
- 1.6.4 If a member fails to attend any meeting of the HPF for a period of six months or more, the Board may remove that person from office unless they are satisfied that:
 - i) The absence was due to a reasonable cause; and
 - ii) The person will be able to attend such meetings within such period as the Board considers reasonable.
- 1.6.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

1.7 Relationship with the Board

- 1.7.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.
- 1.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.
- 1.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.
- 1.7.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

1.8 Rights of Access to the LHB Board for Professional Groups

- 1.8.1 The LHB Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:
 - i) Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or

- ii) Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

1.8.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 6.5.7.

1.9 Relationship with the National Professional Advisory Group

1.9.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group.

Schedule 5.3

Local Partnership Forum Advisory Group Terms of Reference and Operating Arrangements

1.1 Role and Purpose

- 1.1.1 The LHB Local Partnership Forum (LPF) is the formal mechanism where NHS Wales's employers and trade unions/professional bodies (hereafter referred to as staff organisations) work together to improve health services for the people of Wales. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.
- 1.1.2 At the earliest opportunity, the Board will engage with staff organisations in the key discussions at the LHB Board, LPF and Locality/Divisional level.
- 1.1.3 All members are full and equal members of the forum and collectively share responsibility for the decisions made.
- 1.1.4 The LPF will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply. These principles are attached at Appendix 1.
- 1.1.5 The purpose of the LPF will be to:
- Establish a regular and formal dialogue between the Board's Executive and staff organisations on matters relating to workforce and health service issues.
 - Enable employers and staff organisations to put forward issues affecting the workforce.
 - Provide opportunities for staff organisations and managers to input into organisation service development plans at an early stage.
 - Consider the implications on staff of service reviews and identify and seek to agree new ways of working.
 - Consider the implications for staff of NHS reorganisations at a national or local level and to work in partnership to achieve mutually successful implementation.

- Appraise and discuss in partnership the financial performance of the organisation on a regular basis.
- Appraise and discuss in partnership the Board services and activity and its implications.
- Provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff.
- Communicate to the partners the key decisions taken by the Board and senior management.
- Consider national developments in NHS Wales Workforce and Organisational Strategy and the implications for the Board including matters of service re-profiling.
- Negotiate on matters subject to local determination.
- Ensure staff organisation representatives are afforded reasonable paid time off to undertake trade union duties
- To develop in partnership appropriate facilities arrangements using A4C Facilities Agreement as a minimum standard.

1.1.6 In addition the LPF can establish LPF sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas. Where these sub groups are developed they must report to the LHB LPF.

1.2 General Principles

1.2.1 The LHB and LPF accepts that partnerships help the workforce and management work through challenges and to grow and strengthen their organisations. Relationships are built on trust and confidence and demonstrate a real commitment to work together.

1.2.2 The principles of true partnership working between staff organisations and Management are as follows:

- Staff organisations and management show joint commitment to the success of the organisation with a positive and constructive approach
- They recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
- They demonstrate commitment to employment security for workers and flexible ways of working
- They share success – rewards must be felt to be fair
- They practice open and transparent communication – sharing information widely with openness, honesty and transparency

- They must bring effective representation of the views and interests of the workforce
- They must demonstrate a commitment to work with and learn from each other

All members must:

- be prepared to engage with and contribute fully to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- comply with their terms and conditions of appointment;
- equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- promote the work of the LPF within the professional discipline they represent.

1.2.3 A Code of Conduct is attached as Appendix 2.

1.3 Membership

1.3.1 All members of the LPF are full and equal members and share responsibility for the decisions of the LPF. The NHS organisation shall agree the overall size and composition of the LPF in consultation with those staff organisations the LHB recognises for collective bargaining. The Trade Union member of the LHB Board will be expected to attend the LPF in an ex-officio capacity. As a minimum, the membership of the LPF shall comprise:

Management Representatives

1.3.2 Management will normally consist of the following members of management representatives:

- Chief Executive
- Finance Director
- General Managers/Divisional Managers (as locally identified)
- Director of Workforce and OD
- Workforce and OD staff (as locally identified)

1.3.3 Other Executive Directors and others may also be members or may be co-opted dependent upon the agenda.

Staff Representatives

1.3.4 The Board recognises those staff organisations listed in Appendix 3 for the representation of members who are employed by the organisation.

1.3.5 Staff representatives must be employed by the organisation and

accredited by their respective organisations for the purposes of bargaining. If a representative ceases to be employed by the Board or ceases to be a member of a nominating organisation then they will automatically cease to be a member of the LPF. Full time officers of the staff organisations may attend meetings subject to prior notification and agreement.

- 1.3.6 Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF.

1.4 Quorum

- 1.4.1 Every effort will be made by all parties to maintain a stable membership. There should be 50% attendance of both parties for the meeting to be quorate.
- 1.4.2 If the meeting is not quorate no decisions can be made but information may be exchanged. Where joint chairs agree extraordinary meeting may be scheduled within 7 calendar days' notice.
- 1.4.3 Consistent attendance and commitment to participate in discussions is essential. Where a member of the LPF does not attend on 3 consecutive occasions, the Joint Secretaries will write to the member and bring the response to the next meeting for further consideration and possible removal.

1.5 Officers

- 1.5.1 The Staff Organisation Chair, Vice Chair and Secretary will be elected from the LPF annually. Best practice requires these three officers to come from different staff organisations.

1.6 Chairs

- 1.6.1 The Management and Staff Organisation Chair will chair the LPF. This will be done on a rotational basis. In the absence of the Chair(s) the Vice Chair(s) will act as Chair. The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Board's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the LPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.7 Joint Secretaries

- 1.7.1 Each side of the LPF should appoint/elect its own Joint Secretary. The Management and Staff Organisation Secretary will be responsible for the preparation of the agendas and minutes of the meetings held, and for obtaining the agreement of the Management and Staff Organisation Chairs.

1.7.2 The Director of Workforce and OD will act as Management Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

1.8 Sub Committees

1.8.1 When is considered appropriate, the LPF can decide to appoint a subcommittee, to hold detailed discussion on a particular issue(s). Nominated representatives to sub committees will communicate and report regularly to the LPF.

1.9 Management of Meetings

1.9.1 Meetings will be held bi-monthly but this may be changed to reflect the need of either staff organisations or management.

1.9.2 The business of the meeting shall be restricted to matters pertaining to LPF issues and should include local operational issues. Board wide strategic issues and issues that have LHB wide implications shall be referred to the Welsh Partnership Forum via the LHB Board.

1.9.3 The minutes shall normally be distributed 10 days after the meeting and no later than 7 days prior to meeting. Items for the agenda and supporting papers should be notified to the Management Secretary as early as possible, and in the event at least two weeks in advance of the meeting.

1.9.4 The LPF has the capacity to co-opt others onto the LPF or its sub groups as deemed necessary by agreement.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, ~~personalisation~~scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCM)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropractors and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)



Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

~~Model~~ Standing Orders, Reservation and Delegation of Powers for
BCUHLHBs

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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/>

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Schedule 1

Betsi Cadwaladr University [Insert name]

~~Local~~ 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 2.1 of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by Betsi Cadwaladr University [insert name] Health Board LHB (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

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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-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-2012/](https://www.nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-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

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.

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

- 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 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 LHB 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/knowning-who->

- 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

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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:

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- 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 focussed 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

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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:
 - o Corporate Governance Report
 - o Remuneration Report and Staff Report
 - o Accountability and Audit Report
 - The Performance Report, which must include:
 - o An overview
 - o 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.

10.9.1 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

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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;
- 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 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.**

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

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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

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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

~~10.9.4~~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 competition¹	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 Procurement Services must be consulted prior to any such application being submitted for 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.

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:



Grant v
Procurement.doc

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.

13.4.2 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.

13.4.3 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.

13.4.4 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.**

13.4.5 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.

13.4.6 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.

13.4.7 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 himself 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 and DHCW

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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Gwefan • website:
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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:

- Contracts of employment between LHBs and their staff;
- Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
- Out of Hours contracts; and
- All NHS contracts; that is where one health services body contracts with another health service body.

Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning do not require further Ministerial notification or consent.

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



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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.

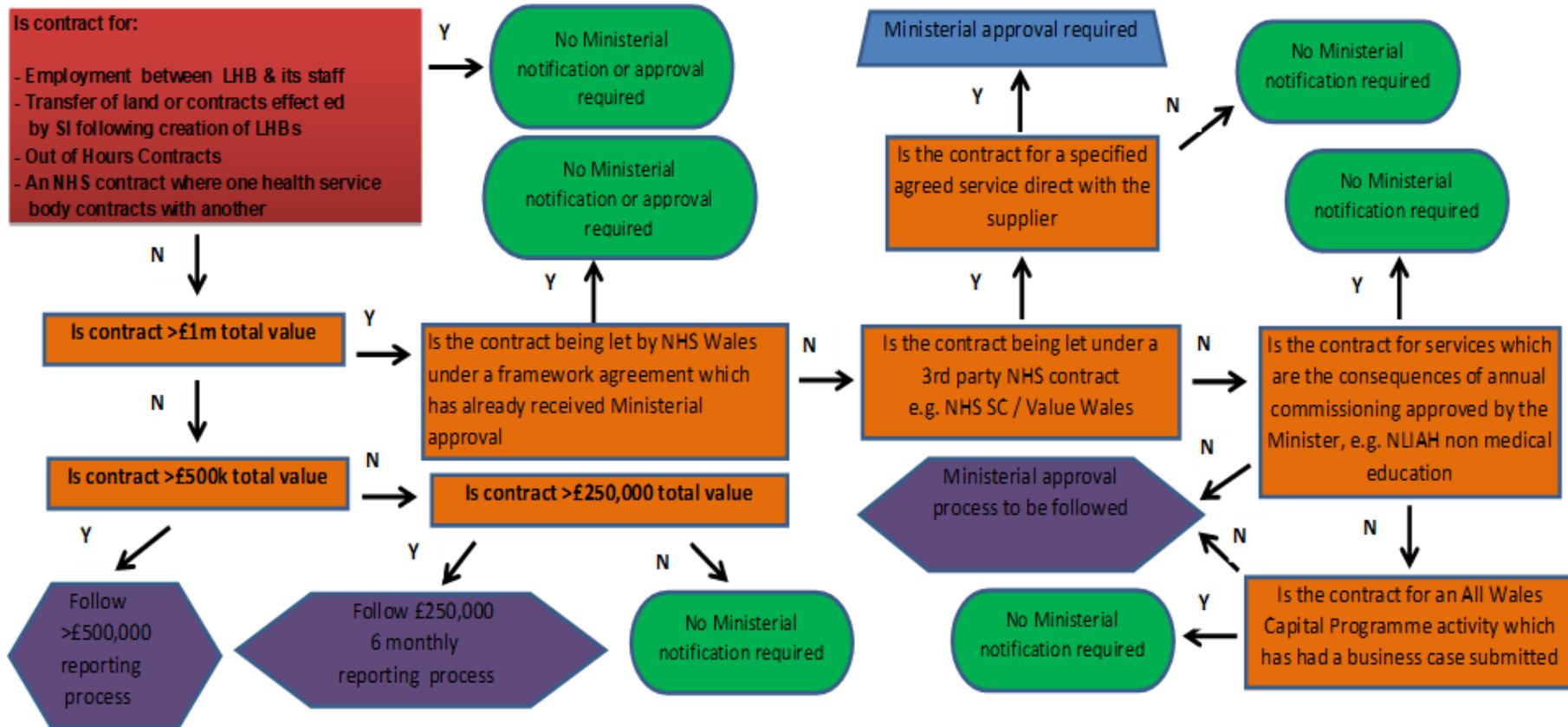
The revision introduced in point v) above will be included formally in the next version of the Standing Financial Instructions.

Yours sincerely



Steve Elliot

Cyfarwyddwr Cyllid dros dro | Interim Director of Finance



Model Standing Orders, Reservation and Delegation of Powers for BCUHBLHBs

Schedule 2.1: Standing Financial Instructions

Status:

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Schedule 2.1: Standing Financial Instructions

Status:

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Teitl adroddiad: <i>Report title:</i>	Annual Declarations of Interests/Gifts and Hospitality			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Friday, 15 September 2023			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>The Board must ensure that the Health Board establishes and maintains a system for the declaration, recording and handling of Health Board officers' interests in accordance with the Values and Standards of Behaviour Framework.</p> <p>The purpose of this paper is to provide assurance and a position statement to the Audit Committee.</p> <p>A new electronic system widely used within the NHS was purchased from Civica called 'Declare' to capture all declarations. This was launched at the end of August 2023 and is available in both English and Welsh. This will be promoted to staff and managers to ensure that annual declarations are made and any gifts and hospitality are appropriately declared and Health Board is compliant.</p>			
Argymhellion: <i>Recommendations:</i>	<p>Gofynnir i'r Bwrdd</p> <p>The Committee is asked to take partial Assurance from the report.</p>			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Phil Meakin, Interim Board Secretary and Associate Director of Governance			
Awdur yr Adroddiad: <i>Report Author:</i>	Richard Coxon, Interim Head of Corporate Governance			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	<p>I'w Nodi <i>For Noting</i></p> <p><input checked="" type="checkbox"/></p>	<p>I Benderfynu arno <i>For Decision</i></p> <p><input type="checkbox"/></p>	<p>Am sicrwydd <i>For Assurance</i></p> <p><input checked="" type="checkbox"/></p>	
Lefel sicrwydd: <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i></p> <p><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i></p> <p><input type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i></p> <p><input checked="" type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i></p> <p><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>
<p>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lie 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:</p>				

<p>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:</p> <p>Partial assurance has been noted above because the system that has previously been invested in by the Health Board has only just been implemented and there needs to be a roll out of Information and engagement with it to ensure it is used effectively.</p>	
<p>Cyswllt ag Amcan/Amcanion Strategol:</p> <p>Link to Strategic Objective(s):</p>	<p>This report is purely administrative. There are no associated strategy implications.</p>
<p>Goblygiadau rheoleiddio a lleol:</p> <p>Regulatory and legal implications:</p>	<p>This annual update is provided in order to comply with Standing Orders 8.1 – 8.7.</p>
<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</p>	<p>Do/Naddo Y/N</p> <p>Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn berthnasol</p> <p><i>If no please provide an explanation as to why the duty does not apply</i></p> <p><u>Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7</u></p> <p><u>WP7 Procedure for Equality Impact Assessments</u></p>
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p>In accordance with WP68, has an SEIA identified as necessary been undertaken?</p>	<p>Do/Naddo Y/N</p> <p>Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn berthnasol</p> <p><i>If no please provide an explanation as to why the duty does not apply</i></p> <p><u>Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.</u></p> <p><u>WP68 Procedure for Socio-economic Impact Assessment.</u></p>
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</p>	<p>(crynodeb o'r risgiau a rhagor o fanylion yma)</p> <p>This report is purely administrative. There are no associated risks.</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p>	<p>Scrutiny of this annual return (undertaken by Counter Fraud, Office of the Board Secretary)</p>

<p>Financial implications as a result of implementing the recommendations</p>	<p>and the Audit Committee) supports the mitigation of governance/financial risks associated with conflicts of interest and enables the Audit Committee to review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p>Workforce implications as a result of implementing the recommendations</p>	<p>Relevant staff are obliged to make declarations of interest and any gifts and hospitality received or declined.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p>Links to BAF risks: (or links to the Corporate Risk Register)</p>	
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p>Reason for submission of report to confidential board (where relevant)</p>	<p>Amherthnasol</p> <p>Not applicable</p>
<p>Camau Nesaf: Gweithredu argymhellion</p> <p>Next Steps: Implementation of recommendations</p>	
<p>Rhestr o Atodiadau:</p> <p>List of Appendices:</p> <p>None</p>	

Annual Declarations of Interests/Gifts and Hospitality

1. The Purpose of this Report:

The Board must adopt a set of values and standards of behaviour for the Health Board (HB) that meets the requirements of the NHS Wales Values and Standards of Behaviour framework.

This report sets out how we will manage two registers:

- Gifts, hospitality and sponsorship for the Health Board
- Declared interests

2. Board Member Responsibilities:

The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of HB officers' interests in accordance with the Values and Standards of Behaviour Framework.

The Standing Orders also sets out that the Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members.

The Board must review these registers at least annually.

3. Previous Arrangements

The previous electronic system was introduced in 2016 to record declarations of interests, gifts and hospitality and rolled out across the Health Board. This was unsuccessfully maintained and manual forms have been used recently to collect declarations.

4. New Arrangements

Declarations made with a value of £25 or below were not included as the policy sets the threshold at any gift with an estimated value over £25.

All declarations have also been reviewed by the Head of Counter Fraud.

A new electronic system, widely used within the NHS was purchased from Civica called 'Declare'. This online portal is easy and quick to use and staff can log on using their NHS email address. Support is available if required but guidance is also provided. This was launched on 31 August 2023 and is available in both English and Welsh.

Following a previous Internal audit, the new electronic forms also contain our counter fraud statement.

Now that the Declare system has been launched there will be a continuous drive to increase the compliance figures for declarations of interests with consistent monitoring.

The Office of Board Secretary team will be working with Civica, Communications team and Local Counter Fraud Services team to ensure staff make their annual declarations of interest and Health Board is compliant.

5. Who do these new arrangements apply to?

These values and standards of behaviour will apply to all those conducting business by or on behalf of the HB, including Board members, HB Officers, Contractors and others, as appropriate. The following groups of people must make an annual declaration of interests:

- All Board Members
- Staff at Band 8C and above (or equivalent pay where staff are not on AfC pay grades)
- All staff who are in a position to influence the purchasing of goods and Services, anyone involved in payroll or payments of invoices or supplier arrangements, as well as fostering relationships with external organisations
- Any member of staff who are offered or takes any gift, hospitality or sponsorship.

6. When do declarations need to be made:

- Annually
- When something changes
- During any procurement activity
- In a meeting when the topic to be discussed is in line with your conflict
- Declarations should cover financial and personal interests and if in doubt, it should always be declared.

When an annual declaration is required, if nothing has changed, or there aren't any declarations to be made, a nil return must be made.

With regard to gifts, hospitality and sponsorship, a declaration must be made whenever it is offered to or by the HB. If it is offered it must be reported even if the offer is declined.

7. Governance arrangements

Every Board member and HB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused.

The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

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

The Audit Committee will review and report to the Board upon the adequacy of the HB arrangements for :

- dealing with offers of gifts, hospitality and sponsorship”.
- declaring, registering and handling interests

8. Where are they published:

The intranet pages have been updated and staff can access the portal via links provided as well as find guidance on declarations: [Declarations of interest, gifts and hospitality \(sharepoint.com\)](#)

In the case of Board Members, submitted declarations of interests are required to be published and documented within the Annual Report in line with the commitment to openness and transparent governance. These are also published on the Health Board website for full transparency which is in line with Standing Orders.

Board Members Declarations of Interest bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-members/register-of-board-members-declarations-of-interest-2023-24-for-the-website-22-august-2023/

Board Members Declarations of Gifts & Hospitality bcuhb.nhs.wales/use-of-site/publication-scheme/class-six-list-and-registers/register-of-interests-and-gifts/board-members-register-of-gifts-hosp-2023-24/

9. Key Priorities for the next Quarter

- As the paper outlines there is a responsibility to capture all those conducting business by or on behalf of the HB, including Board members, HB Officers, Contractors and others, as appropriate.
- To make sure that there is visibility of compliance against our requirements under the Standing Orders by mobilising staff to comply fully with requirements.
- The report proposes that the Audit Committee receive an update on progress from the implementation of the Declare system at the January 2023 Committee and reports on all groups.



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:	15 th September 2023
Crynodeb Gweithredol: Executive Summary:	<p>An important role for the Audit Committee is to monitor the implementation of agreed internal and external audit recommendations.</p> <p>BCUHB has adopted a robust process for monitoring the implementation of agreed audit recommendations and provides regular progress reports to the Audit Committee identifying any recommendations that have not been implemented within the agreed timescales. This 'Tracker' report will be a source of assurance for the Audit Committee that those recommendations are being progressed, monitored, and completed.</p> <p>The following key principles apply:</p> <ul style="list-style-type: none">• The Audit Committee Chair to determine (in the briefing session prior to the meeting) if any additional attendees are required to respond to high risk overdue recommendations where this is concern about the lack of implementation in a particular area.• Appendix 1 to consist of a summary in terms of progress made with the recommendations from internal and external audits.• Appendix 2 of Full Tracker report to focus on high risk recommendations that exceed their original implementation date.• Internal Audit to undertake follow-ups (limited, no assurance reports and others identified as high priority) to provide a level of assurance to the Committee. <p><i>Note: Appendix 2 does not include any overdue recommendations with an intended completion date beyond the 15/09/23 or any reports that were not made 'live tracking' on the system after the report extraction/collation date.</i></p>
Argymhellion: Recommendations:	<p>The Committee is asked;</p> <ul style="list-style-type: none">• To note the progress and implementation of actions as outlined in Appendix 1 and;• Comment on the outstanding high-risk overdue actions as detailed in Appendix 2 and;• Consider where any new reports received may require follow up (to receive assurance on satisfactory implementation).
Arweinydd Gweithredol: Executive Lead:	Interim Board Secretary
Awdur yr Adroddiad: Report Author:	Statutory Compliance, Governance & Policy Manager

Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>		Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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 will be received at the Executive Team. 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			

<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>N/A other than those relating to individual audit reviews / recommendations</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>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.</p> <p>Final Report reviewed by the Interim Board Secretary</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> <i>(or links to the Corporate Risk Register)</i></p>	<p>N/A other than those relating to individual audit reviews / recommendations</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Public</p>
<p>Camau Nesaf: Gweithredu argymhellion</p> <p><i>Next Steps:</i> <i>Implementation of recommendations</i></p> <p>The Tracker is presented to each quarterly meeting of the Audit Committee. The OBS continues to provide support and advice for recommendation owners / leads.</p>	
<p>Rhestr o Atodiadau:</p> <p><i>List of Appendices:</i></p> <ul style="list-style-type: none"> • Appendix 1: Summary of overdue recommendations • Appendix 2: High Risk and Overdue Recommendations 	

Introduction/Background

This report details the status of internal and external audit recommendations over the past five years which are overdue high priority yet still noted as incomplete.

Body of Report

The current position is that 50% of recommendations show a status of progressing or completed. However, the rest of the recommendations show delays or items pending other

actions. The majority of delayed items are concentrated in the 2022-2023 timeframe. Recommendations centred around compliance, reporting, governance and standardisation of processes seem prone to delays.

Progress by Year (Detail reported in Appendix 1)

2017/18 -1 recommendation to implement electronic prescribing systems, status progressing. On track.

2020/21 -2 recommendations, 1 progressing related to developing a Quality Improvement Strategy, 1 delayed related to clinical services strategy. Mixed delays and certain points progressing.

2021/22 -2 recommendations, both progressing related to contract controls and consistency in CHC teams. On track.

2022/23-12 recommendations, 6 progressing, 1 completed, 5 delayed or contingent. Moderate execution issues. Areas of concern include on-call reviews, rotas, CoB/ToR, process design.

2023/24-19 recommendations, 14 progressing, 1 completed, 4 delayed/contingent. Modest execution issues growing. Areas of concern include rota guidance, training, papers, reporting breaches.

No current recommendations require any root cause analysis on stuck initiatives to unblock progress however there are some recommendations awaiting external or National scoping/steer.

Recommendations owned by the Finance department generally tend to show progress (e.g. contract controls, CHC team consistency). Workforce related recommendations around on-call reviews, rotas exhibit consistent delays and dependencies. Multiple recommendations regarding overall governance, and owned by the OBS have dependencies causing delays.

Recommendations

Focus on consistent execution of action plans and ensure an increase in Executive accountability for those in particular which may be delayed. Monthly agenda item at Executive Team to be scheduled.

Bring update to the next Audit Committee with an update and clarity over progress made from this benchmark

Summary

In summary, closing audit recommendations is progressing with over half showing completed or progressing status. However, areas of challenges in relation to execution do exist, specifically around core compliance, reporting, and governance processes.

Tracker: Appendix 1

Executive Summarised version of the Internal and External Audit Recommendations - High Risk and Overdue

ID	Rec Title	Recommendation	Last Status Update	Revised Deadline	Rec State
Year 2017					
<u>243</u>	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.	EMPA Board established. Further programme update planned for January 2024.	31/01/2024	Progressing
Year 2020					
<u>57</u>	Quality Improvement Strategy (QIS)	Publication and launch of a new QIS.	QIS is being developed.	31/03/2024	Progressing
<u>244</u>	R1	Clinical strategy delivered to planned timescales medical staffing, vacancy gaps and on-call rota management.	Further work required to develop the more detailed overarching plan.	01/12/2023	Delayed
<u>245</u>	R5	Reliance on temporary management staffing.	The operating model commenced implementation from 1st August 2023, substantive posts identified and agreed there will continue to be vacancy / interims until substantive posts are recruited to.	01/05/2022	Progressing
Year 2021					
<u>147</u>	Finance and Contracting Arrangements	Verify activity, treatment, and intervention charges, by the Countess of Chester Hospital is fair and reasonable. Contracting to share monthly data with Women's.	Contract information is being received from COCH and distributed.	30/08/2023	Progressing
<u>226</u>	R3	Consistency in the structure of its CHC teams and job descriptions.	Linking with national work on reviewing / agreeing competencies for each role within CHC.	30/09/2023	Progressing

<u>227</u>	R5	Capacity and capability to plan and deliver CHC more effectively and efficiently.	Business Case for Clinical and Business Support Hub is being drafted. Target completion date extended to 30/11/23.	30/11/2023	Progressing
<u>228</u>	R8	CHC leadership currently ad hoc and temporary.	Agreed as complete on local CHC Audit Action Plan 07/03/23.	07/03/2023	Completed
Year 2022					
<u>114</u>	Declarations of Interest Compliance	Review DOIs regularly and escalate non-compliance.	Implementation of the new system.	30/09/2023	Progressing
<u>115</u>	Declarations of Interest Compliance	Review DOIs regularly and escalate non-compliance.	Implementation of the new system.	30/09/2023	Progressing
<u>116</u>	Declarations of Interest System	Confirmation from Finance that this information has been updated and the impact on compliance rates.	Implementation of the new system.	30/09/2023	Progressing
<u>118</u>	Monitoring and Reporting arrangements	Monitoring arrangements of declarations, gifts, regular reporting.	The OBS review to inform new Committee Structure and Audit Committee cycle of business.	30/09/2023	Delayed
<u>119</u>	ISB Governance Arrangements	Alignment with governance and planning frameworks, and is subject to regular review and scrutiny.	Revised Governance and Accountability Framework will be presented to the November Audit Committee.	30/11/2023	Progressing
<u>154</u>	Operational management compliance	Workforce and OD should progress the plans to improve leaver management as a priority, network access is revoked.	Escalated via IT to a national group.	30/12/2023	Delayed
<u>158</u>	Review of on-call arrangements	On-call review should be re-instated as a priority.	Full review underway with support from Workforce. Delays due to interim staff change over. Paper to Execs for the end of October.	31/10/2023	Delayed
<u>159</u>	Rota guidance / sustainability	The following should be documented for on-call rota's: Minimum staff numbers,	The revised timescale is October 2023 to Execs / HBLT for agreement.	31/10/2023	Delayed

		Seniority / experience mix, Timelines for preparation and issuing of rotas, Frequency.			
<u>160</u>	Compensatory rest and payment	Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest.	The policy is in the process of being confirmed.	31/10/2023	Progressing
<u>161</u>	Training	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.	Post implementation of policy, training programme to be implemented.	31/11/2023	Delayed
<u>170</u>	Compliance with Welsh Language Standards (No.7) Regulations 2018 (Standards 39-43)	Comply with Welsh Language Standards.	All underway.	30/09/2023	Progressing
<u>173</u>	Clinical Audit	List of Tier 3 audits should be shared with the East Clinical Effectiveness Group.	Local clinical effectiveness groups underway and EIHC Medical Director now in post.		Progressing
<u>178</u>	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.	The Quality Local Delivery Group across the West IHC has now been established.	31/03/2023	Progressing
<u>183</u>	Request and submission of papers and reports.	Board / Committee Paper Assurance and Publication SOP timescales are met, monitor compliance, publishing meeting calendar.	SOP to be DRAFTED by 30 November. Calendar for 2023/24 has been updated on 5 Sept.	30/09/2023	Delayed
<u>185</u>	Reporting Breaches.	Management to establish controls and monitoring arrangements to ensure that all reporting breaches are captured and reported to the Audit Committee.	Breaches are currently being recorded by the Corporate Governance Manager and propose they are reported to Audit Cttee in November.	31/12/2023	Delayed

<u>230</u>	R1b	Ensure improved focus on financial efficiency of services within finance reports deep dives.	actioned through special measures and the independent planning review that include governance and budget allocation.	31/12/2023	Delayed
<u>235</u>	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.	Snap audit has identified data completeness and application of Welsh Waiting Time rules learning. Interim refresh of SOP to maximise their commitment to care pathway commenced.	31/08/2023	Progressing
<u>240</u>	R7	Accountability for eye care services: Undertake a review of the accountability arrangements for eye care services.	A Continuous Improvement Network Steering Group to be formed within Q2 2023.	30/04/2023	Progressing
<u>241</u>	R8	Eye care strengthen the clinical leadership structure.	Recruitment attempts not successful.	30/04/2023	Delayed
Year 2023					
<u>172</u>	Finance	Management to identify and progress savings schemes as a matter of urgency. ensure financial scrutiny.	East IHC Annual Plan has been signed off at IHC level (including oversight from the Corporate Planning team). IHC F&P Sub-Group established. The Savings Guidance and Templates are due September).	31/10/2023	Progressing
<u>175</u>	Risk Management	IHC Risk Register requires review Management to review consistency of reporting in accordance with the revised Operating Model.	We have fully integrated within the IHC governance framework.		Completed
<u>184</u>	Submitted papers meet the Board / Committee requirements.	Management to ensure that papers and reports submitted to the BCU Board, Committees, or Advisory Groups are of the expected standard.	Update pending the outcome of the OBS review. The Head of Corporate Office will be developing a SOP that is now being drafted.	31/12/2023	Progressing
<u>186</u>	CoB/ToR	4.1 Health Board/Committee Cycles of Business and/or Terms of Reference should be periodically reviewed.	TOR being reviewed following OBS Review.	31/12/2023	Delayed

<u>187</u>	Process Design	The Health Board should adopt a formal process for documenting requests and approval of Chairs actions.	Recommendation has been delayed due to OBS staffing issues and board member changes. There is a monthly slot in the Corporate Governance to report actions.	29/02/2024	Delayed
<u>194</u>	Charitable Funds Committee	Review Membership of the Charitable Funds Committee including the quoracy required for meetings and ToR.	The intention is for the ToR to be signed off at CFC meeting Jan 2024.	31/03/2024	Delayed
<u>195</u>	Strategy	The Charity Strategy should be presented to Board of Trustees for review and approval.	Strategy is due to be submitted to the Charitable Funds Committee for November Board.	30/11/2023	Progressing
<u>202</u>	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.			Delayed
<u>203</u>	Transformational Savings and the establishment of the Transformational Team	Reviews the role of the Transformational Team in driving service change and savings.	Work is progressing through August 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.		Delayed
<u>206</u>	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.	evidence log will be presented to MH&LD Senior Leadership team 05/09/2023 with further actions required agreed.	30/10/2023	Progressing
<u>210</u>	CHC Service Delivery	Executive Management review the delivery of CHC.	Temp Asst. Director of CHC to support the longer term arrangements has been extended & will work with confirmed Exec lead.	30/09/2023	Progressing

<u>211</u>	Governance, accountability and performance	governance and accountability arrangements for CHC.	Notes of all actions completed-Not yet approved.		Complete
<u>238</u>	R5	Eye care service efficiency and productivity.	A Continuous Improvement Network Steering Group to be formed within, Q2 2023	30/04/2024	Delayed
<u>247</u>	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.	Remuneration committee now receives monthly report to identify compliance with SOP.	31/12/2023	Progressing
<u>251</u>	Oversight, scrutiny and challenge of CRR and BAF	COB Board and Audit Committee receive the CRR and BAF for review and scrutiny.	The OBS Independent review is now complete, which included a review of Committee ToRs.	31/09/23	Progressing
<u>252</u>	Board Assurance Framework	The process for reviewing and updating the BAF should be documented and ensure focused actions.	The BAF SOP will be updated following the TOR for all committees however, the BAF has been updated for the November Board, and the format is being revised to allow for more detailed action plans.	31/10/2023	Progressing
<u>253</u>	Escalation and de-escalation of risks	Clarification is required on the Committee approval process for the escalation and de-escalation of risks.	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.	31/10/2023	Progressing
<u>254</u>	Oversight and scrutiny of Divisions / IHCs	Review of all meetings attended across the three areas by the Risk Management Department is required.	The risk team compiled a list of meetings but IHC West processes are currently outstanding and due for review following Oct RMG.	31/10/2023	Progressing
<u>256</u>	Planned Care Recovery & Transformation Group	Planned care programme membership and terms of reference should be reviewed	Inaugural board meeting held. Awaiting confirmation of arrangements for specific clinical lead roles specifically to support GiRFT and the 6 clinical networks.		Delayed

<u>257</u>	Reporting	Planned care programme: Review the mechanisms for reporting, ensure requirements have been clearly established and expectations communicated with the relevant Groups / Committee.	Planned Care Board established with terms of reference approved.		Completed
<u>258</u>	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 within Datix.	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.	31/11/2023	Delayed
<u>261</u>	Process management	Management establishes robust overarching Commissioning Assurance Framework, Policy, or relevant SOP.	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.	31/01/2024	Delayed
<u>262</u>	Contractual obligations	Management establishes 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.	Work is progressing, with input from the CEO, to develop the CAF.	31/01/2024	Delayed

Table Keys	
Final Approved	Responsible Executive has reviewed and confirmed implementation
Marked as Implemented by Owner	Relevant Operational Lead has marked as complete/implemented for Executive review
Pending	No progress recorded
Started:	Progress has been recorded but not yet marked as complete/implemented

1. Overall Summary Position in respect of Overdue Internal/External Recommendations by Year*

Individual Recommendation Risk Level	Year of Review						Grand Total
	2016	2019	2020	2021	2022	2023	
High	1	2	4	2	28	13	50
Medium				3	9	6	18
Grand Total	1	2	4	5	37	19	68

**Totals do not include any recommendations with an implementation date past the 15/09/23 or those 'Final Approved' by the relevant Executive.*

2. Summary Position of External and Internal Audit Recommendations

External Audit Recommendations that exceed their original implementation date

Year	External Audit Title	Final Client approved	Marked as Implemented by Owner	Started	Grand Total	Lead Executive
2016	Managing Medicines in Primary and Secondary Care			1	1	Executive Medical Director
2019	Structured Assessment 2019			2	2	CEO/ Interim Board Secretary
2020	Audit Wales Structured Assessment 2020	1			1	CEO/ Interim Board Secretary

2020	Continuing Healthcare Arrangements		1		2	3	Executive Director Transformation And Strategic Planning
2021	Structured Assessment (Phase 2) 2021				1	1	CEO/ Interim Board Secretary
2022	Review of Eye Care Services				4	4	<ul style="list-style-type: none"> • Interim Executive Director of Operations • Executive Director Transformation And Strategic Planning
Grand Total			1	1	10	12	

Internal Audit Recommendations that exceed their original implementation date

Year	Assurance Level	Internal Audit Title	Final Client approved	Marked as Implemented by Owner	Pending	Started	Grand Total	Lead Executive
2020	Limited	Quality Improvement Strategy				1	1	Executive Director of Nursing and Midwifery
2021	Reasonable	Budgetary Control & Financial Reporting, including COVID-19 financial governance	2				2	Interim Executive Director of Finance
2021	Reasonable	Procurement & Tendering				1	1	Interim Executive Director of Finance
2021	Reasonable	Women's Services Division – Sustainability of services		1		1	2	Interim Executive Director of Operations

Year	Assurance Level	Internal Audit Title	Final Client approved	Marked as Implemented by Owner	Pending	Started	Grand Total	Lead Executive
2021	Reasonable	Performance measure reporting to the Board – Accuracy of information	1			1	2	<ul style="list-style-type: none"> Interim Executive Director of Finance Interim Executive Director of Operations
2022	Reasonable	Impact Assessments	1				1	Deputy Director of People
2022	Limited	Standards of Business Conduct: Declarations				5	5	Interim Board Secretary
2022	Limited	Integrated Service Boards (ISB)				1	1	Interim Executive Director of Operations
2022	Limited	Clinical Audit	1				1	Executive Medical Director
2022	Reasonable	Employment of Medical Locum Doctors	1			1	2	Deputy Director of People
2022	Limited	Roster management	3				3	Deputy Director of People
2022	Limited	Establishment control – Leaver management	1			1	2	Deputy Director of People
2022	Limited	On-Call arrangements			0	4	4	Interim Executive Director of Operations
2022	Reasonable	Waste Management	1				1	Interim Executive Director of Finance
2022	Reasonable	Speak out Safely	1				1	Deputy Director of People
2022	Limited	Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website	1			1	2	Executive Director Of Public Health
2022	Limited	Effective Governance: YWM		1	2		3	Interim Executive Director of Operations
2022	Limited	Effective Governance: YG		1			1	Interim Executive Director of Operations
2022	Limited	Board and committee reporting				4	4	Interim Board Secretary

Year	Assurance Level	Internal Audit Title	Final Client approved	Marked as Implemented by Owner	Pending	Started	Grand Total	Lead Executive
2022	Reasonable	Chairs action				4	4	Interim Board Secretary
2022	Limited	Charitable Funds	2			3	5	Interim Executive Director of Finance
2022	Substantial	Management of Utilities	1				1	Interim Executive Director of Finance
2022	Reasonable	Audit Wales CHC follow-up		2	0	1	3	Executive Director Transformation And Strategic Planning
2022	Reasonable	Audit Wales Follow up - counter fraud	1			1	2	Interim Executive Director of Finance
2022	Reasonable	Risk Management				1	1	Interim Board Secretary
2023	Limited	Delivery of HB Savings			2		2	Interim Executive Director of Finance
2023	Reasonable	MH&LD	2			2	4	Executive Director Of Public Health
2023	Substantial	Recruitment Improvement Review	1			1	2	Deputy Director of People
2023	Reasonable	Accounts Receivable	1				1	Interim Executive Director of Finance
2023	Limited	Clinical Audit – Tier 1 National Audits	1				1	Executive Medical Director
2023	Limited	Contracted Patient Services: Quality and Safety Arrangements			1	1	2	Executive Director of Nursing and Midwifery
2023	Substantial	Cyber Security				1	1	Chief Digital and Information Officer
2023	Limited	Data analysis – Triangulation of data				1	1	Executive Director of Nursing and Midwifery
2023	Reasonable	Digital strategy	1				1	Chief Digital and Information Officer
2023	Reasonable	Financial Control – Receipting of goods and year-end accruals	1				1	Interim Executive Director of Finance

Year	Assurance Level	Internal Audit Title	Final Client approved	Marked as Implemented by Owner	Pending	Started	Grand Total	Lead Executive
2023	Limited	Performance Management – Quality and Performance Reporting and Accountability Arrangements	1				1	Interim Executive Director of Finance
2023	Limited	Planned Care Recovery & Transformation Group			2		2	Interim Executive Director of Operations
2023	Limited	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	1			1	2	Deputy Director of People
2023	Limited	Risk Management & Board Assurance Framework				5	5	Interim Board Secretary
2023	Limited	Unscheduled care (USC): Urgent Primary Care Centres - Business case outcomes achieved		1		1	2	Interim Executive Director of Operations
		Grand Total	26	5	7	44	83	



Teitl adroddiad: Report title:	BCUHB Policy on Policies
Adrodd i: Report to:	Audit Committee
Dyddiad y Cyfarfod: Date of Meeting:	15 September 2023
Crynodeb Gweithredol: Executive Summary:	<p>Betsi Cadwaladr University Health Board (BCUHB) has a duty to ensure that appropriate policies and supporting procedures, protocols or guidelines (referred to collectively as written control documents) are in place to comply with legislation, enabling all employees/workers to fulfil their roles safely and competently.</p> <p>The Health Board's Policy on Policies sets out the various roles, responsibilities and the route to be followed when developing or updating written control documents.</p> <p>The Policy on Policies was originally developed in 2018 and was due for review in 2021. The revised Policy on Policies is appended at appendix 1. The Main changes are as follows:</p> <ul style="list-style-type: none">• A proposed new approvals route. Previously, any pan BCUHB policy required final approval at the relevant Board level Committee. The revised approval route delegates this responsibility to the relevant Executive (noting that some policies, as per the Health Board Standing Orders, are reserved for Board approval) [14].• 'Scope' section strengthened to ensure the policy captures all workers (i.e. interim/agency) [5.1].• Clarity provided as to the definition of a 'local document' [5.3]• 'Document outside the Scope' section added to provide clarity on the management of Patient Group Directions, Pathways and Patient Information [7.3].• 'Impact Assessments' section revised to make reference to the newly developed BCUHB Integrated Assessment Screening Tool [11]. <p>The Policy on Policies was discussed by the Executive Team on the 30/08/2023. The amendments and proposed approval route were agreed in principle, subject to final review at Audit Committee.</p> <p>In conjunction with the review of the Policy on Policies, work is underway to address the number of documents past their review date. In addition, the Office of the Board Secretary will consider future reporting requirements to ensure organisational oversight.</p>
Argymhellion: Recommendations:	<p>The Committee is asked;</p> <ul style="list-style-type: none">• To approve, in principle, the revised approval route and subsequent minor amendments. Once approved, the document will be subject to organisational consultation.• Note the work underway to review the existing library of written control documents and the development of a proposal for reporting documents past their review date.

Arweinydd Gweithredol: <i>Executive Lead:</i>	Interim Board Secretary			
Awdur yr Adroddiad: <i>Report Author:</i>	Statutory Compliance, Governance & Policy Manager			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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: <i>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:</i>				
N/A				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	Up to date and easy to follow written control documents minimise the risk to patients, visitors, employees/workers and the Health Board. They help to ensure that statutory requirements, standards and regulations are understood and provide a framework to monitor compliance. This ensures the Health Board provides a robust and clear governance framework within which service delivery and operational activity can occur.			
Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i>	As per above			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>	An EqIA has been undertaken and is appended at appendix 2			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>	The Socio-Economic duty is not applicable. The associated public sector duties are not engaged (the report does not relate to a strategic decision).			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) <i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i>	Internal controls such as the Policy on Policies are fundamental to compliance. A failure to implement a robust policy for the development and review of written control documents may leave the organisation exposed to the following risks:			

	<ul style="list-style-type: none"> • Failure to provide employees/workers with comprehensive, up to date guidance may result in the application of inappropriate care or care that is not in line with current best practice. This in turn could lead to harm being incurred by patients and subsequently, financial detriment via the redress process. • Failure to provide employees/workers with comprehensive, up to date guidance may result in non-compliance with non-clinical legislative obligations / public sector duties, which could incur financial penalty via fines. • Failure to provide an authoritative repository may result in employees/workers having limited confidence that the document they require is extant or fit for purpose. Employees/workers should be able to efficiently access a single, authoritative source where they can easily navigate to the appropriate guidance and have confidence that the document that they are applying is correct, without fear of legal or professional repercussions. • Failure to provide adequate guidance may result in complications during disciplinary proceedings. Written control documents enable BCUHB to set out the standards required. If employees/workers do not comply with the relevant written control document, then this may be justification for invoking the relevant disciplinary and/or capability procedure. • Failure to provide an authoritative Policy on Policies may result in written control documents being developed without the appropriate oversight, consultation or approval which may lead to variances in care across the BCUHB sites. • When incidents/concerns do occur or arise, professional regulators or members of the public may request the document in force at the time. BCUHB risk further reputational damage or regulatory enforcement action wherein the document cannot be found, is out of date or not fit for purpose
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	None
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	None
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p>	To be actioned post discussion at Audit Committee

Feedback, response, and follow up summary following consultation	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) Links to BAF risks: (or links to the Corporate Risk Register)	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) Reason for submission of report to confidential board (where relevant)	Public
Camau Nesaf: Gweithredu argymhellion Next Steps: Implementation of recommendations <ul style="list-style-type: none"> • The Policy on Policies to be subject to organisational consultation • A summary report of documents past their review date to be monitored by the Executive Team • Relevant Executives to progress the review of Written Control Documents within their area of responsibility. • Organisational reporting requirements to be defined. 	
Rhestr o Atodiadau: List of Appendices: <ul style="list-style-type: none"> • Appendix 1: Policy on Policies • Appendix 2: EqIA 	

Version:

OBS1 – V01.01



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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents

Author & Title	Statutory Compliance, Governance & Policy Manager
Responsible dept / director:	Board Secretary
Approved by:	Executive Team: 30.08.2023 Audit Committee: 00.00.00
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Changes made yes/no:	Yes	Yes	Yes	Yes	yes

N.B. Employees/workers should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document being used. The Intranet should be referred to for the current version of the document.

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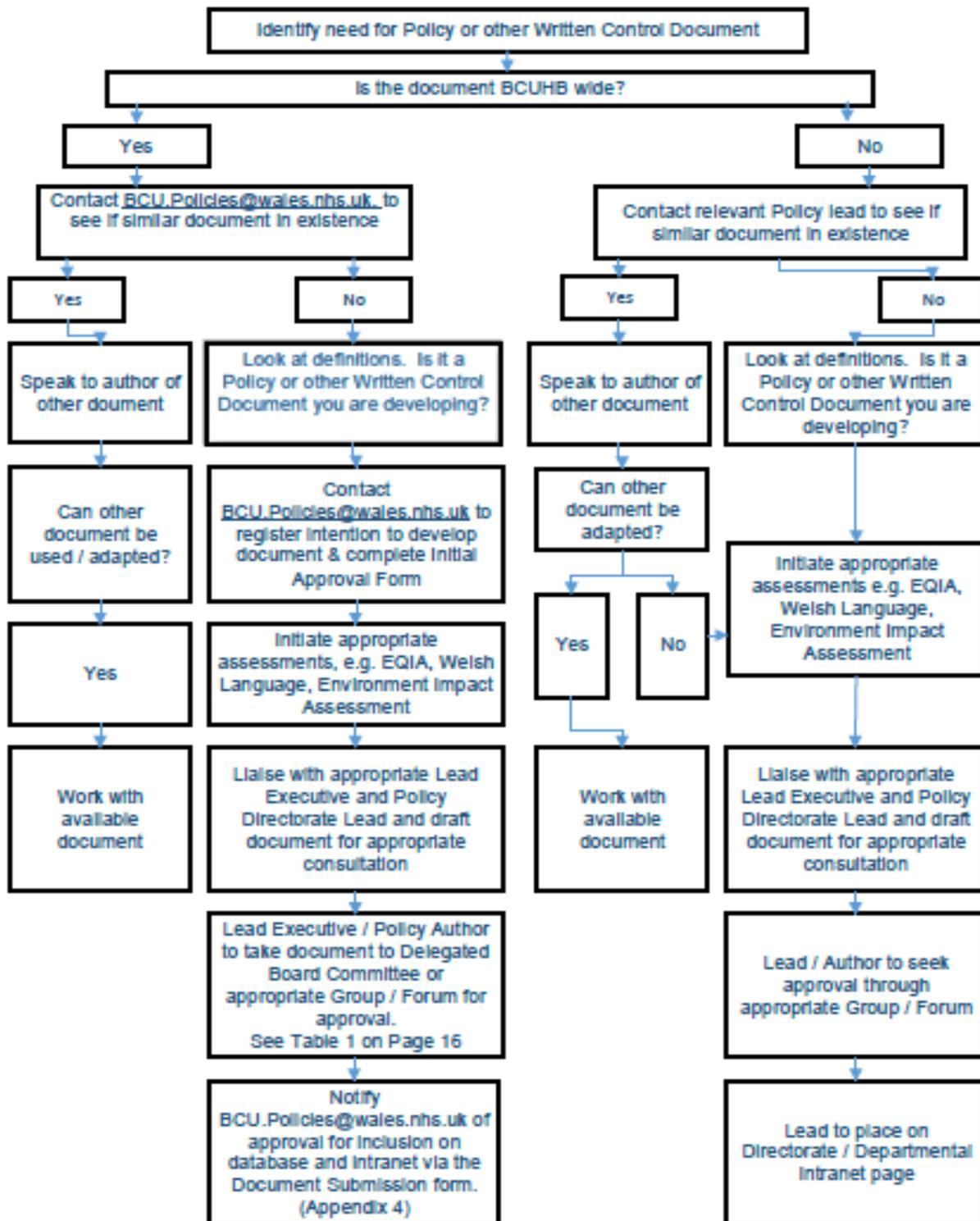
1. INTRODUCTION

1.1 BCUHB, subsequently referred to as the 'Health Board', has a statutory duty to ensure that appropriate policies and supporting procedures, protocols or guidelines (referred to collectively as written control documents) are in place to comply with legislative obligations, enabling employee/workers to fulfil their roles safely and competently.

1.2 Up to date and easy to follow policies and written control documents minimise risk to patients, visitors, employees/workers and the Health Board. They help to ensure that statutory requirements, standards and regulations are understood, and provide a framework to monitor compliance. This ensures the Health Board provides a robust and clear governance framework within which service delivery and operational activity can occur.

1.3 Through this policy, the Health Board ensures that there is a process whereby all Health Board wide policy documentation is consistent in format, compilation and dissemination. In addition, there is an effective process for managing and reviewing policies and any associated written control documents on a regular basis, to ensure that documentation remains legally compliant and actions are undertaken in a safe and efficient manner. This policy will ensure that the Health Board meets its legal responsibilities and provides a clear approach to policy and written control documentation, implementation and monitoring of compliance.

2. QUICK REFERENCE/HOW TO GUIDE/FLOWCHART



3. POLICY STATEMENT

The Health Board has a framework for the development, approval and dissemination of policies and other written control documents. This includes:

- Ensuring that employee/workers have access to the most recent copies of Health Board-wide documents – employee/workers should not print copies of policies/procedures and hold them locally – the intranet page will hold the definitive documentation;
- Having a control procedure for all Health Board policies and other written control documents to ensure that those in use are current and relevant and that duplication is avoided;
- Mandating that the equality impact assessment (EqIA) process is completed on all Health Board wide policies and other Written control Documents to ensure that decisions do not discriminate against people based on any protected characteristic, these are: race/ethnicity, sex, gender reassignment, disability, sexual orientation, religion or belief, age, marriage and civil partnership and pregnancy and maternity. Ensuring that policy makers are aware of the Health Board's legal duties around equality and human rights and that policy makers are aware of their responsibility to undertake EqIA necessary to inform evidenced based policy development and inclusive decision making.
- Having a corporate style and promoting the use of templates, to ensure a standard approach to the associated documentation;
- Ensuring systems exist and are used to monitor the use of, and compliance with, associated Health Board wide written control documents;
- Actively managing and maintaining a central database of Health Board wide policies, procedures and written control documents;
- Maintaining an archive of past documentation, for reference and to meet legal requirements.
- The Quality, Safety and Experience Committee and relevant corporate Patient Safety & Quality Group are key approval bodies in respect of all clinical policies and written control documents. Policy and working control documents involving medicines are considered clinical documents and will follow this approval route.

4. PURPOSE

The purpose of this policy is to provide a framework and pathway for the continued development, approval and management of all Health Board wide policies and other written control documents across the Health Board and where required in partnership with external agencies.

5. SCOPE

5.1 This Policy applies to all Betsi Cadwaladr University Health Board (BCUHB), employees and workers as defined by section 230 of the Employment Rights Act 1996. The scope includes, but is not limited to agency; board members; consultants, contractors; locums; office holders; students; vendors and volunteers, unless otherwise specified or a specific exemption applies in law or policy.

5.2 This policy sets out the route to be followed when developing or updating Health Board wide policies and other written control documents, and distributing them as appropriate within the Health Board. Policies and other written control documents that are not Health Board wide will be the responsibility of the relevant policy lead (see paragraph 8.7). The templates attached to this document may be used at a local level. However, the coordination of local procedures will be provided by the relevant policy lead.

5.3 A 'local' document refers to a departmental internal document. It does not include Service wide documents. For example, a local document could be an individual Ward or Team informal 'how to' guide that is deployed within an isolated area and is unlikely to be relevant to, or requested for, investigative purposes (i.e. as part of a concern or disciplinary proceedings). Any queries on whether a document is 'local' will be determined by the relevant Executive / Office of the Board Secretary.

Authors of 'local' documents are further reminded that all Health Board records are subject to relevant legal obligations, including the Freedom of Information Act 2000, the Inquiries Act 2005, the Inquiry Rules 2006 etc., whether local or otherwise.

6. OBJECTIVES

6.1 The objectives of this policy are to enable Health Board wide consistency in the format, compilation and dissemination of such policies and other written control documents, ensuring that these are:

- Developed/reviewed in line with legal requirements;
- Considered and approved at the appropriate level, and within the Health Board by the appropriate Group, sub group, Committee or forum (with delegated powers and authority for approval);

- Implemented and cascaded to Health Board employee/workers with supportive information as appropriate;
- Supported by appropriate development and training throughout the Health Board;
- Available to the public in accordance with the requirements of the Freedom of Information Act 2000.

7. DEFINITIONS

7.1 Policies and supporting written control documents are essential in the delivery of high quality and safe health services and to ensure the Health Board operates within the law. They form an integral element of the governance and assurance framework by which the Health Board regulates its activities to achieve its goals, and are used as reference points to assist employees/workers in their day-to-day working.

7.2 Terminology across the range of documentation can often be confusing for both those that develop the documents and to those that use them. Clear definitions for these terms, highlighting the differences and similarities and the appropriate use of each is provided below:-

Strategy - A long-term plan designed to achieve particular goals or objectives that can be supported by policies and procedures.

Policy – A written statement of intent, describing the broad approach or course of action that the Health Board is taking with a particular issue. Policies define the commitment of the Health Board and the obligations of individual employees/workers. A Policy describes the ‘what’ and the ‘why’.

Protocol - a written code of practice, including recommendations, roles and standards to be followed, which can also include details of competencies and delegation of authority. A protocol specifies the procedures to be followed in defined situations. Protocols are different from policies as they lack the ‘mandatory’ element by allowing for professional judgment and individual cases and competency to play a role.

Procedure - A standard method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. Procedures must be formulated using evidence based knowledge and best practice.

Guidelines - give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by

giving options of how something might be carried out. They are used in conjunction with knowledge and expertise of the individual using them.

Standards - provide a record of service or representation of care which people are entitled to experience, either as a basic minimum or for use as a measure of excellence.

7.3 Documents Outside the Scope of this Policy

Patient Group Directions (PGDs) - provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). PGDs are managed in accordance with the Human Medicines Regulations 2012 and NICE Guidelines by the Pharmacy & Medicines Management Department (see MMPGD-01 Patient Group Directions, Procedure and Guidance for Authors and Users).

Pathways – Pathway development uses process management methodologies to review and re-design the patients journey to align with recognised best practice e.g. NICE, GIRFT or the National Optimal Pathway for cancer patients. Pathway redesign will incorporate scoping work and feedback from external reviews to ensure BCUHB develop an organised, efficient and effective patient journey to enhance quality, standardise equity, reduce variability and optimise outcomes.

Patient Information / Leaflets – are managed in accordance with ISU02 Patient, Service User & Carer Procedure for the Production of Written Information. The procedure defines health information and provides the minimum standards required to ensure that information is produced in an easy to read, accessible, bilingual, Welsh and English format.

8. ROLES AND RESPONSIBILITIES

8.1 **Accountable Officer** - the Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Health Board has appropriate policies and other written control documents in place to ensure the Health Board works to best practice and complies with all relevant legislation.

8.2 **Board Secretary** - is responsible for the effective management of, and compliance with this policy. This includes ensuring that:

- A database of Health Board wide policies and procedures is maintained;
- Policies and procedures are approved as part of the Governance and Assurance Framework at the appropriate level in the Health Board;

- The documents are accessible to all relevant employees/workers;
- Documents are implemented and cascaded across the Health Board and the awareness is raised appropriately across the organisation;
- All Health Board wide policies and other written control documents are reviewed in a timely manner.

8.3 Executive Directors - are responsible for ensuring that all policies and other written control documents within their remit are maintained and updated by liaising with the appropriate policy author(s). They are responsible for ensuring that the appropriate advice and assistance is provided to authors and that consideration is given to any training and resources implications that are identified.

8.4 Statutory Compliance, Governance & Policy Manager – will act as the Health Board policy gatekeeper with the responsibility for providing guidance, training and support for the process. The Statutory Compliance, Governance & Policy Manager will:

- Manage the development and maintenance of the Health Board policy database;
- Manage the approval process in line with this policy;
- Cascade approved/amended policies and other written control documents in line with the Health Board communications system;
- Ensure Health Board wide policies and other written control documents are accessible via the Health Board's internet/intranet sites as appropriate;
- Maintain an archive of the previous versions of any revised or reviewed policy documents;
- Provide advice and assistance as required;

8.5 Authors of Policies, Procedures and other Health Board wide Written Control documents - are responsible for ensuring that the guidance provided in this policy is followed.

This will include:

- Liaising with Executive Leads to ensure that policies and other written control documents are implemented appropriately and, where necessary, compliance with those documents is formally audited;

- Ensuring that there is an appropriate review of policies and other written control documents, either in line with the review timescale set at the time of approval or as a result of changes to practice, management structure or legislation;
- Ensuring that appropriate consultation has taken place with the relevant individuals and groups;
- Ensuring that training needs and resources required for implementation are clearly identified;
- Ensuring the necessary impact assessments have been carried out prior to the document entering the approval process (see Section 11);

8.6 Authors are responsible for their policy documents. If an author leaves the Health Board, the responsibility for their policy document is taken on by their role replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager or Director. This should be made clear in any handover arrangements. Notification should also be made to the Policy Leads.

8.7 **Policy Leads** - Policy Leads have been nominated by each Directorate/Division/Specialty/Corporate Function as appropriate. These Leads will:-

- In respect of BCU wide documentation act as the function gatekeeper for their respective areas of responsibility.
- Be responsible for acting as a gatekeeper and coordinator for all local written control documents (not BCU wide). They will be responsible for advising authors of their document's impending review, coordinating the production, version control (including archiving), local approval and dissemination of the documents. They will also be responsible for uploading the documents onto their area of the Intranet and updating their departmental database including maintaining an archive of historic local documentation.
- Ensure that any new employees/workers joining the Health Board are made aware of the policy control system at local induction, and how to access Health Board-wide and local policy documents specific to their area;
- Allocate an appropriate lead manager to take overall responsibility for the development and management of their respective policy documents in accordance with the Health Board policy process;

- Understand the policy process and their role in supporting best practice including the relevant impact assessment of all new or revised policies at the appropriate stage;
- Work with employees/workers without access to the intranet to ensure they have access to relevant documentation;
- Ensure that local arrangements are established to monitor the receipt and understanding of all relevant Health Board documents; thus reducing the risk of misuse or misinterpretation.

8.8 Line Managers - at all levels managers are responsible for ensuring that employees/workers for whom they are responsible are aware of and adhere to this policy. This includes ensuring that:

- The Health Board policies and other written control documents are readily available and accessible to all employees/workers;
- Information is disseminated on a regular basis, to ensure employees/workers have read and understood the relevant documents and are aware of any new guidance or revisions;
- The identification of specific employee/worker training needs on the implementation of new or updated documents are addressed and linking with the relevant Executive Director where this might be a Health Board-wide need;
- Local systems exist to enable the review, audit and compliance testing of all relevant departmental policies, and other written control documents as required.

8.9 All employees/workers – are responsible for ensuring that:

- Their practice is in line with policies and other written control documents in use across the Health Board and specific to their area of work;
- Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their Line Manager and that the incident reporting system (i.e. DATIX) is used where appropriate;
- Information regarding any changes in practice, management structure or legislation that would require an urgent review of documents is immediately reported to their Line Manager;

- Compliance with this policy and where requested, can demonstrate such compliance. Failure to comply will be dealt with under the Health Board's Disciplinary Policies as appropriate.

9. HEALTH BOARD WIDE POLICY ORGANISATION

9.1 The diverse nature of health care means there will be a large number of policies and procedures in place. This policy specifically relates to the management of Health Board wide policies/documentation.

9.2 For ease of reference, all Health Board wide policy documentation will be listed and numbered under a series of headings. An index of policies and other written control documents will be maintained as part of the on-line database that is in place and maintained to manage the review process. The database will become the central register for all Health Board wide policies and other written control documents which apply across the Health Board.

10. POLICY DEVELOPMENT

10.1 Each Health Board-wide policy will be sponsored by a lead Executive Director. At Directorate/Divisional/Departmental/site level, policies and other written control documents will be sponsored by the appropriate Director or Divisional Director who will ensure that appropriate arrangements are in place for the creation, consultation and training and dissemination/storage/ accessibility of local procedures.

10.2 The development of new Health Board wide policies and other written control documents, or the amendment of existing documentation, will be overseen by the appropriate Executive/Divisional Director supported by the relevant governance lead. They will be responsible for ensuring that content and scope are fit for purpose before being presented for approval.

10.3 When the need for a new policy or written control document arises, the Office of the Board Secretary should be informed before preparation commences to ensure there is not a policy already in existence on the same or similar subject thus avoiding duplication of effort. Authors should complete Initial Approval Form (IAF) attached as Appendix 1.

10.4 Once the need and type of written control document is identified, the process for production and approval must follow that contained within this policy.

10.5 The language used should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes (refer to Appendix 3). In

accordance with the requirements of the Data Protection Act 2018 / GDPR, the names of individuals will not be contained within policies and other written control documents. Individuals with particular responsibilities will be identified by their job title only (In practice the name of the author is recorded in the Policy Management System as this proves useful when the procedure is going out of date and needs review).

10.6 All policy and written control document development should be undertaken in line with current legislation, national and professional guidance. Documentation should also be based on sound evidence and be appropriately referenced.

11. IMPACT ASSESSMENTS

11.1 As a public sector organisation, the BCUHB is bound by various legal obligations/duties that must be observed during the execution of its business. Impact Assessments are practical tools or mechanisms used to meet these duties in that they:

- measure the impact (both positive and negative) of a proposed action
- remove or mitigate negative impacts and maximise positive impacts
- facilitate and evidence 'due regard'

To have 'due regard' means that in carrying out all of its functions and day to day activities, a public authority subject to the duty, must consciously consider the needs of the general equality duty: eliminate discrimination; advance equality of opportunity and foster good relations.

Undertaking these assessments supports good decision-making based on evidence and consideration of how our decisions will affect our stakeholders (patients, employees/workers, carers, partner organisations). Failure to comply with these obligations could lead to legal challenge.

11.2 **The Integrated Assessment Screening Tool (IAST)** should be completed BEFORE commencing or reviewing and written control document. The IAST is a useful screening tool that summaries the various types of assessments / considerations that should be undertaken and signposts authors to the relevant documentation and/or Corporate Leads for further information. Certain impact assessments are **mandatory** for all documents:

- **Equality Impact Assessment (EqIA):** this provides a structured process set out in statute, which enables the organisation to consider the effects of its decisions, policies or services on different communities, individuals or groups. Please see WP7 - Procedure for Equality Impact Assessment for more information.

- **Welsh Language:** The Welsh Language standards are a set of statutory requirements and state clearly the Health Board's responsibilities to provide bilingual services to patients and the public. Under the standards, the Health Board must not treat the Welsh language less favourably than the English language. Further guidance is available via the Health Board's Guidance on applying the Welsh Language Standards Regulations 2018 under the Welsh Language (Wales) Measure 2011

Others relevant impact assessments will be dependent on the type of document being developed / reviewed:

- **Socio-Economic Impact Assessment (SEIA):** this assessment is required for strategic decisions and includes strategic decisions which are subject to review. In general, strategic decisions will be those which effect how Health Board fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions.
- **Data Protection:** Data protection impact assessments (DPIAs) are tools that will assist organisations in identifying the most effective way to comply with their data protection obligations and meet individuals' expectations of privacy. Carrying out a data protection impact screening assessment is a systematic way of doing this to establish if a full Data Protection Impact Assessment (DPIA) is required.
- **Rights of Children and Young People:** Children have needs and rights that are separate and different to adults. Authors should carefully consider whether the proposed written control document will have any impact on children and whether it will effectively protect and implement the rights expressed in the United Nations Convention on the Rights of the Child (UNCRC). The Social Services and Wellbeing (Wales) Act 2014 implements a duty that decision makers must have regard to the convention.
- **Older Person and/or People living with Dementia (including young onset dementia):** The Health Board has a duty to ensure older people have their rights respected and are involved in decisions. All documents should be developed using a person-centered approach and ensure an evidence based approach in relation to the older adult and/or those with dementia (who may be under the age of 50 years). Due regard should be given to the United Nations Principles for Older Persons.
- **Carers:** The Social Services and Well-being (Wales) Act 2014 places a responsibility on the Health Board to identify unpaid carers, acknowledge their importance as an equal partner in care and provide them with information, advice and assistance.
- **Environment:** An Environmental Impact Assessment (EIA) is an assessment of the possible positive or negative impact that a proposed project may have on the environment, together consisting of the natural, social and economic aspects. The purpose of the assessment is to ensure that decision makers consider the ensuing environmental impacts when deciding whether to proceed with a course of action.

11.3 The outcomes of the IAST should then be used to inform the written control document development, promote a positive impact, mitigate any negative impact where possible and/or identify where further or specialist impact assessment may be necessary.

As part of any document development or decision, you should also consider how the document:

- Contributes to the social, environmental, economic and cultural well-being of Wales under the Well-being of Future Generations (Wales) Act 2015
- Impacts on Wales and the people who live and work here
- Supports the delivery of BCUHB objectives

12. DOCUMENT FORMAT

12.1 A document template together with supplementary guidance has been developed to provide clarification on what information should be included. It also contains the standard front cover that is to be applied to all Health Board wide policies and other written control documents, together with some specific points regarding formatting. See Appendices 2 and 3.

13. CONSULTATION

13.1 Policy and written control documents must not be written in isolation. All policies and other written control documents should be developed in consultation with their target audience involving managerial, clinical, employee/worker and patient involvement as appropriate. All new, or significantly revised, policies should be the subject of consultation within the directorate / structure and with relevant professional groups and/or individuals. Policies or written control documents that include medicines must include a specialist lead pharmacist from that clinical area in the document development team.

13.2 For consultation, all Health Board-wide policy documents must be shared with:

- Relevant Executive Director / Senior Management.
- Employees/workers affected by the policy (including Trade Unions where relevant).
- Relevant clinical leads (medical, nursing, therapies, MH&LD, children's and older person etc.)
- Consideration should also be given to uploading to the Health Boards 'Draft Policies & Written Control Documents for Consultation' page with

an accompanying notification in the Health Board's Corporate Bulletin to all employees/workers. This will be managed by the Office of the Board Secretary Policies Team.

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14. APPROVAL PROCESS

14.1 The Health Board will be responsible for the approval of all Health Board wide policy documents. This responsibility can be delegated to an appropriate Committee, Executive, Group, Sub Group or Forum in the Health Board in accordance with the overarching Health Boards Governance arrangements i.e:

- Approval retained by the Health Board
- Delegated to Health Board Committee
- Delegated to Health Board Executive
- Delegated to other Group or Partnership

14.2 All Wales Policy documents will also be approved for implementation and adoption in the organisation, via the route and should be accompanied by an Equality Impact Assessment completed by the sponsoring Executive Director.

A simplified approval route planner is detailed below in Table 1. Table 2 specifically relates to those policies that include medicines management:-

Table 1: Simplified Approval Route Planner

Document Type/Scope	Approval route in sequence order		
	1	2	3
Policies reserved as a matter for the board i.e. Health & Safety Policy, Standards of Business Conduct Policy, Counter Fraud Policy	Please refer to the Health Board Standing Orders, Scheme of Reservation & Delegation and the Office of the Board Secretary to confirm approval route.		
Clinical Policy BCU Wide	Relevant Local Governance Groups	Relevant BCUHB Corporate Quality & Safety Group	Exec Team (subject to approval of the Clinical Executives) and noted at QSE Committee.
Clinical Other written control document BCU wide	Relevant Local Governance Groups	Relevant BCUHB Corporate Quality & Safety Group	
Non-Clinical Policy BCU Wide	Relevant Local Governance Groups	HBLT/Exec Team and noted at relevant Committee	
Non-Clinical other written control document BCU wide	Relevant Local Governance Groups	Relevant BCUHB Corporate Group or Senior Management Team	
Clinical - Local Written Control document (i.e. below policy level)	Local Q&S Group	Relevant Senior Management Team	
Non-Clinical – Local Written Control document (i.e. below policy level)	Relevant Senior Management Team		

Table 2: Documents that include Medicines Management

Document Type/Scope	Approval route in sequence order			
	1	2	3	4
Any BCU Wide Policy which includes Medicines Management	Medicines Policy, Procedures and Patient Group Direction Sub Group	Drug and Therapeutics Group	Relevant BCUHB Corporate Quality & Safety Group	Exec Team (subject to approval of the Clinical Executive) and noted at QSE.
Any BCU Wide written control document (below policy level) which includes Medicines Management	Medicines Policy, Procedures and Patient Group Direction Sub Group	Drug and Therapeutics Group	Relevant BCUHB Corporate Quality & Safety Group	
Patient Group Directives (PGDs)	Medicines Policy, Procedures and Patient Group Direction Sub Group	Drug and Therapeutics Group		

14.3 All Policies and written control documents involving medicines management are BCU wide, i.e. are applicable to patients pan BCU. In the event of a clinically urgent situation to meet a public health need, the Chief Pharmacist will be given delegated authority to approve any specific documentation that will then be endorsed at the next meeting of the Drug and Therapeutics Group.

14.4 Where Policies relate to Specialised and Tertiary Services, the Board will delegate approval to the Joint Welsh Health Specialised Services Committee (WHSSC). In relation to NHS Wales Shared Services the approval of policies relating to the business activities delivered by the Shared Services body on behalf of the Health Board will be delegated accordingly.

Clinical Policies and Procedures

14.5 In the case of Health Board wide policies for clinical practice, the Relevant Corporate Quality & Safety Group will receive and approve all clinical policies with Health Board-wide implications, prior to their ratification by the relevant Exec (or Committee/Board for matters that are reserved).

14.6 The relevant Corporate Quality & Safety Group will also discuss and identify the need for Health Board-wide policies for clinical practice arising from recommendations from audit, NICE, external reports etc. and issues arising from changes in evidence-based practice and take action as appropriate. All new policies must be evidence based and aligned to best practice and where relevant have input from service users and carers.

14.7 All Clinical Policies should be developed using a person-centered approach. Existing Policies should be reviewed to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified and if necessary separate clinical policies and procedures should be developed with input from experts.

Within the policy development process it is important to consider both physical health and mental health conditions that may require a particular attention or focus, this may be related to short and long term needs and conditions, i.e.: acute medical or surgical conditions, injuries, mental health, neurological conditions, dementia and learning disability.

All people, at some stage in their life maybe in a vulnerable circumstance or require additional care and support when accessing healthcare services, therefore, in the development and/or renewal of all BCUHB polices this must be realised by giving consideration to the broad range of issues which may impact upon an individual (and their families or carers) in how they understand, consent, and receive healthcare.

The vulnerability should be considered in any of the associated health interventions required and the related polices applied. The policy developer should address pertinent aspects identified within the policy that may relate to a person with specialist needs.

It is important for all policy developers to ensure they have considered the above elements in the development and renewal processes of all polices. The policy owners and developers should consider engaging the appropriate specialist medical/nursing/AHP practitioners when further expertise is required in a particular aspect of the policy. All policy developments must reflect the consideration in given in context of the individual circumstance, biopsychosocial needs and the legal guidance framework under the Mental Capacity Act.

14.8 Policies and written control documents that include medicines are to be approved by the Health Board's Medicines Policy, Procedures and PGD Sub

Group and should be submitted to the chair of that group for review and approval. Decisions taken at the above Sub Group will then be ratified by the Health Board's Drug and Therapeutics Group at its subsequent meeting. Policies and written control documents that include medicines must not be uploaded onto the Health Board's intranet until formal approval and endorsement has been given by the Health Board's Drug and Therapeutics Group.

14.9 The approval of policy documents will be retained by the Board or delegated to Health Board Committees in line with their individual remits and responsibilities. This will be reflected in the Health Board's overarching governance arrangements.

14.10 The Office of the Board Secretary will ensure that all Health Board wide approved policies and other written control documents are recorded in the Health Board Policy Register and published on the intranet site and that there is clear revision control applied to policies.

14.11 A submission checklist must be completed for each document to be uploaded to the intranet and submitted to the Office of the Board Secretary. The checklist is attached as Appendix 3.

14.12 All policies, procedures, protocols and guidelines must be produced by using corporate templates. The Board or relevant Committee will not ratify documents that do not comply with this policy.

15. REVIEW PROCESS

15.1 Good governance requires that certain policies must be reviewed annually. These are:

- Risk Management Strategy and Policy
- Major Incident Plan

15.2 All other policy documents must be reviewed no later than three years after initial approval and regularly reviewed on the same basis thereafter. Documents will be reviewed more frequently if changes in legislation or the service requires it. Until a document is reviewed, it will remain the extant policy document of the Health Board until replaced. It is the responsibility of the policy or written control document author to ensure that documents are reviewed in line with their review dates.

15.3 Where a review forms part of a document periodic review as per the review cycle (i.e. minimum of three years), the full approval process as detailed

in Table 1 must be observed, even if there are no changes. This is to ensure the Health Board maintains a periodic overview of its library.

15.4 Where a periodic review necessitates considerable change to the previous document, the process will be treated as though it is a new document, for dissemination and training. Minor amendments can be notified by distributing copies of the document to appropriate recipients, with a cover sheet annotating where and what the changes are and their implications. This sheet should be kept with the original but copies cascaded to appropriate members of employees/workers. Policy Leads/Authors must ensure that a copy of the revised document is sent into the Office of the Board Secretary with a note of the revisions.

15.5 In all cases, the review should include a review of the original Equality Impact Assessment (where one exists) or the drafting of a new Assessment where this has not previously been undertaken (or cannot be located).

16. PUBLICATION, DISSEMINATION AND DISTRIBUTION

16.1 All policies and other written control documents that have been ratified appropriately must be forwarded to the Office of the Board Secretary within ten working days of approval. They will then ensure that the document is:

- Added/updated on the BCUHB Policy database;
- Cascaded in line with the Health Board communications system and included in the weekly Corporate Bulletin.
- Uploaded onto the BCUHB Policies, Procedures and other Written Control Documents Intranet page.

16.2 The intranet site will be the primary location for all Health Board wide policies and other written control documents to ensure that employees/workers can access the most up to date versions. Employees/workers should not print copies and hold them locally. Where a hard copy is required e.g. for team briefing/reference purposes etc. these should be downloaded from the intranet site by the appropriate Line Manager who will be responsible for ensuring their destruction following the briefing.

16.3 All documents will be subject to the BCU version control standard operating procedure and archived in line with legal requirements. Once revised policies and other written control documents are approved, the Office of the Board Secretary will e-mail the author/policy lead to inform them in order that they can ensure appropriate dissemination to their teams.

16.4 Once issued, Policy Leads together with individual line managers will be responsible for ensuring that all employees/workers are aware of the revisions and that any out of date versions are taken out of local circulation. Each

Directorate or Division will put in place a robust controlled records management system.

16.5 This policy and any associated written control documents will be distributed in accordance with this policy and made available on the Health Board intranet site.

16.6 Policies and written control documents that are non BCU wide should be forwarded to the relevant Directorate Policy Lead for appropriate publication, dissemination and distribution.

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17. RESOURCES

17.1 A policy management database has been established and will be further developed in support of this policy. Resources will be utilised as within current structures.

17.2 Resources in terms of time will be required to educate employees/workers on both the requirements of this policy and the development of documents across the Health Board. This will need to be identified within each Directorate.

18. TRAINING

18.1 All Executive Directors will work with the Executive Director of Workforce and Organisational Development to ensure that there is an ongoing training programme for all employees/workers that incorporates the implementation of policies and other written control documents. Key subject areas will be included at local induction and as part of employees/workers development processes.

18.2 Line Managers must ensure that new starters are aware of this policy, induction arrangements and of their individual departmental processes.

18.3 It is the responsibility of individual Line Managers to inform the Executive Director of Workforce and Organisational Development of the requirement where specific employees/workers training needs are identified, particularly in relation to the implementation of new or updated documents.

18.4 Executive Directors will ensure that responsibilities for policy development are clearly outlined in relevant Job Descriptions, in accordance with roles.

19. IMPLEMENTATION

19.1 It is the responsibility of the author to identify how any policy or written control document will be implemented. This will include liaising with Workforce and Organisational Development in order to ensure that employee/worker training requirements have been highlighted in time for the policy document to go live. This will avoid any confusion in changes of practice or resources required of the new or updated policy document.

19.2 Executive Directors and Policy Leads have key implementation roles in this policy and should ensure that information is cascaded appropriately to the employees/workers within their divisions and localities.

20. REVIEW

20.1 This policy will be reviewed every three years, or sooner should the author or legal requirements deem it relevant or required. This policy has been subject to Equality Impact Assessment screening.

DRAFT

Reference number (to be allocated by Office of Board Secretary)

21. Appendix 1: Initial Approval Form



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

BCUHB-wide Policy Initial Approval Form

This form should be completed and approval obtained before you start producing your policy document. The Equality Impact Assessment should also have been started and any Welsh Language requirements considered. **To be completed by document author(s)/group.**

For any help or guidance please contact: BCU.Policies@wales.nhs.uk

Document title: <i>Insert Title</i>	
Please indicate what type of document e.g. Policy, Procedure, Guideline etc:	
Is this a new document or replacement:	
Brief Summary:	
Reason for the review:	Tick to indicate
Aligning services/changing service (i.e. re-organisation):	
Amendments to documentation needed:	
New/amended legislation:	
Review date approaching:	
Supporting National guidelines, policies, legislation, standards:	
Other:	
Document(s) this will replace:	
Previous organisation policy/procedures – Name/number : Please also provide a link to existing location	
Responsible Directorate: Area that is responsible for creating, updating, monitoring the document/elements the document specifies:	
Responsible Executive Director/Director:	

NB. Your Executive Director is ultimately responsible for this document, so it is important that they are aware of the document's production.

Has the responsible Executive Director/Director approved the instigation of this document?

Yes: No:

If no, please state why

Will they be informed?

Yes: No:

If no, please state why:

Responsible Author: (ie nominated by the Executive Director/Director)

Working Group: (please detail who is involved – include job titles)

Engagement to take place with relevant stakeholders (please ensure you detail exactly who you are engaging with):

Method of engagement (for the draft document)

Meeting:

Email:

Union representative must be consulted for all Workforce/HR related Policies

Yes: No:

If no, please state why

Local Counter Fraud

Certain policy documents require input from your Local Counter Fraud Specialists. If your document content involves patient or employees/workers claim forms or other financial records please ensure your draft document is sent to Karl.Woodward@wales.nhs.uk as part of the consultation process. Please tick here if this is the case:

Yes: No:

If no, please state why

Welsh Language

If your document will impact on patient /user experience please ensure you send your draft document to: Eleri.Hughes-Jones@wales.nhs.uk (Welsh Language Services Manager). Please tick here if this is the case:

Yes: No:

If no, please state why

Resource implications associated with implementing this Policy:	
Financial:	
Training / employees/workers time:	
Have these been discussed/resolved within your Division/Directorate/Corporate Department?	
Yes: <input type="checkbox"/> No: <input type="checkbox"/>	
Details:	
Timescales envisaged – please give details. An action plan can be submitted for further clarification:	
Equality Impact Assessment screening and produce final draft version: The Equality Impact Assessment	
Approval and endorsement:	
Implementation:	
Training:	
Monitoring arrangements. Please detail here how the document / process within the document will be monitored: Through designated Lead	
Is this an All Wales document? tick if applicable: <input type="checkbox"/>	
What are the legislative or statutory elements of this document?	
N/A	
Approval: where do you envisage this Policy will be approved?	Patient Safety & Quality Group <input type="checkbox"/> Executive Team <input type="checkbox"/> Committee <input type="checkbox"/>
Please state which Board Committee (if applicable): Professional Advisory Group	
Any additional comments regarding the Policy:	

Please return this form to: BCU.Policies@wales.nhs.uk

22. **Appendix 2: Policy, Procedures and other Written Control Documents Template**

Version & Reference Number:



Insert Title Here

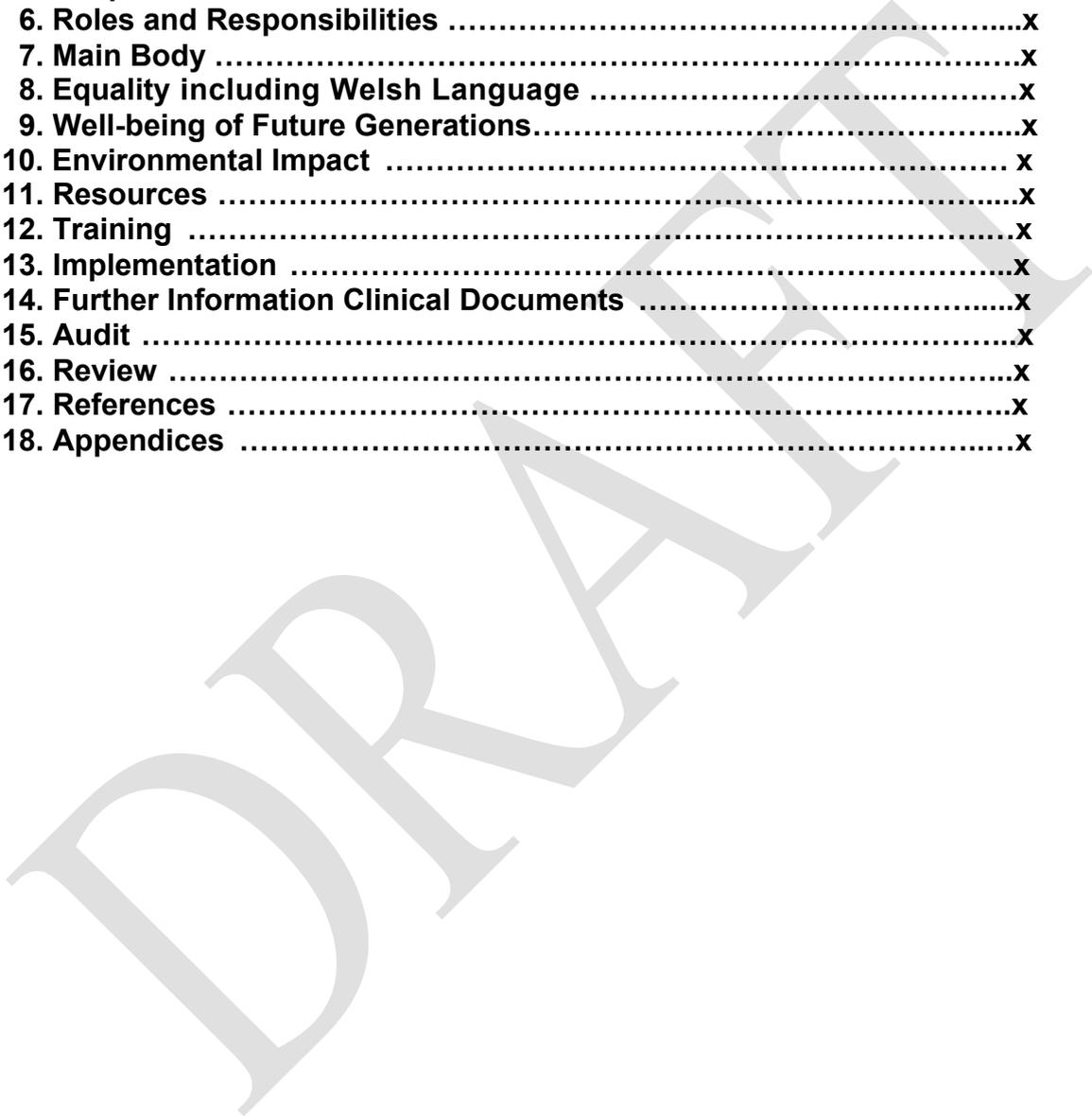
Author & Title	
Responsible dept / director:	
Approved by:	
Date approved:	
Date activated (live):	
Documents to be read alongside this document:	
Date of next review:	
Date EqIA completed:	

First operational:					
Previously reviewed:					
Changes made yes/no:					

N.B. Employees/workers should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Contents:

- 1. Introduction/Overview.....X**
- 2. Policy StatementX**
- 3. Aims/PurposeX**
- 4. ObjectivesX**
- 5. ScopeX**
- 6. Roles and ResponsibilitiesX**
- 7. Main BodyX**
- 8. Equality including Welsh LanguageX**
- 9. Well-being of Future Generations.....X**
- 10. Environmental Impact X**
- 11. ResourcesX**
- 12. Training X**
- 13. ImplementationX**
- 14. Further Information Clinical DocumentsX**
- 15. AuditX**
- 16. ReviewX**
- 17. ReferencesX**
- 18. Appendices X**



1. Introduction/Overview

What is it about? Why is it needed?

This may require information relating to audit, risk management, quality and safety.

2. Policy Statement

What is the commitment of the Health Board? What is the statement of intent?

3. Aims/Purpose

What is the purpose of the document?

4. Objectives

What will the document achieve?

5. Scope

Who does the document relate to:

- All Staff?
- Directorate/Division/Site/Clinical/Department specific?

6. Roles and Responsibilities

Who is responsible for implementation?

- Which groups of staff are able to carry out the procedures required?
- What action points does the document raise?
- Who is responsible for ensuring action points are undertaken?
- Who is accountable if the responsibilities are not followed?

7. Main Body

Show how the document statement will be achieved. Reference evidence appropriately.

8. Impact Assessments

Detail what impact assessments have been undertaken and any relevant findings

11. Resources

Are there any resource issues in order for the document to be implemented?

Financial/Time/Training – these must be identified as if there are no resources the document will not be achievable.

12. Training

Are there any training issues and if so who is responsible for the training programme?

- Who will keep a record of those members of staff who have been trained?
- Will there be update training? How often?
- If the document compliance is not carried out for any length of time at what stage will the person cease to be authorised to carry out that policy?
- Where appropriate, specify the grade and required education and training of staff implementing the document.

13. Implementation

How will the document be implemented?

- Action Plan?
- Time scales?
- What level of training should they have?

14. Further Information - Clinical Documents

The evidence base provided for the document. Name any recognised relevant professional body, for example the source of your evidence base. Where appropriate, specify what is required to be documented in patients' notes. Clinical policies should also include a review of the evidence used and a reference list of that evidence.

All clinical policies should be reviewed with the specific needs of the older adult in mind. Policies should be written to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified in detail, or separate clinical policies and procedures should be developed for this particular patient cohort. This work should be conducted with expert multidisciplinary inputs.

15. Audit

This is required to ensure that the document is appropriate and achievable and that there is compliance with the document by staff. A suitable audit mechanism should therefore be described within the policy document.

16. Review

Generally 3 years unless legislation requires differently – check with the Office of the Board Secretary.

17. References

All reference material should be listed in full at the end of every document in Harvard style

18. Appendices

To include any procedures, protocols or guidance applicable to the policy.

The above headings are key to good implementation and essential to clinical policy development, they are not exhaustive and other headings will apply to individual documents.

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23. Appendix 3: Supplementary Guidance for Completing the Policy Template

The template and control sheet should be used by anyone wishing to formulate any written control system. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Microsoft Word - PDF Read only
Front cover	Corporate template
Audit trail	Use Policy process
Body text	Arial 12
Headings	Arial 12 (UPPER CASE)
Tables and charts	Arial (size as appropriate)
Use of bold	Headings only
Alignment	Left aligned
Line spacing	Body text single
Paragraph spacing	One line between paragraphs. Two lines between main sections.
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily.
Staff Names	Use titles rather than names.
Logo	Use Health Board logo.
Headers and footers	Aerial 9
Margins	Top and bottom of page 2.5cm, sides 2.5cm.
Document Title	To be included in the header on every page
Page numbering	To be included in the footer (e.g. page x of x)
Bullets	• Use standard bullets only, as they do not always format across different systems.
Abbreviations	State in full in first usage with abbreviation in brackets.
Printing	A4/double sided.
Referencing	All reference material should be listed in full at the end of every document in Harvard style.

Glossary of terms	As all policy documents are subject to the Freedom of Information Act, they need to be user friendly as they are documents that can be held up to public scrutiny. Therefore all abbreviations, jargon and specific wording must be clearly explained to the reader.
Version Control	Reference Number provided by the Office of the Board Secretary. Documents to state 'Draft' whilst in development.

All Policies must include the following headings as a minimum.

Introduction/Overview	What is it about? Why is it needed? This may require information relating to audit, risk management, quality and safety.
Statement	What is the commitment of the Health Board? What is the statement of intent?
Aims/Purpose	What is the purpose of the document?
Objectives	What will the document achieve?
Scope/Area of Application	Who does the document relate to: - All staff? - Directorate/Clinical Department/Corporate Department specific?
Roles and Responsibilities	- Who is responsible for implementation? - Which groups of staff are able to carry out the procedures required? - What action points does the document raise? - Who is responsible for ensuring action points are undertaken? - Who is accountable if the responsibilities are not followed?
Main Body	Show how the document statement will be achieved. Reference evidence appropriately.

<p>Equality, Well-being and the Environment (including Welsh Language Requirements)</p>	<p>- Has an equality impact assessment been carried out? If 'yes' append it. If 'no' explain why not.</p> <p>- Has any adverse impact been identified? If so, is it justified and lawful? Describe any measures taken to mitigate or remove the adverse impact.</p> <p>Explain how the document eliminates unlawful discrimination, harassment and victimization, promotes equality of opportunity and/or good relations between different groups.</p> <p>Welsh Language Standards should be maintained – when a policy is formulated or reviewed/revised the effects of the policy decision (whether positive or adverse) need to be considered in terms of the opportunities for people to use the Welsh Language and treating the Welsh Language no less favorably than the English Language.</p> <p>Indicate how the provisions of the WFG Act are being address and demonstrate that all key goals have been considered in the development of the document.</p> <p>Does an Environmental Impact Assessment need to be carried out? For further information contact:-</p> <ul style="list-style-type: none"> • BCUHB East – Environment Officer 01978 727500 • BCUHB Central – Environment Officer 01745 445979 • BCUHB West – Environment Officer 01248 385324
<p>Resources</p>	<p>Are there any resource issues in order for the document to be implemented? Financial/Time/Training – these must be identified as if there are no resources the document will not be achievable.</p>

Training	<ul style="list-style-type: none"> • Are there any training issues and if so who is responsible for the • training programme? • Who will keep a record of those members of staff who have been trained? • Will there be update training? How often? • If the document compliance is not carried out for any length of time at • what stage will the person cease to be authorised to carry out that • policy? • Where appropriate, specify the grade and required education and training of staff implementing the document.
Implementation	<p>How will the document be implemented?</p> <ul style="list-style-type: none"> - Action Plan? - Time scales? - What level of training should they have?
Further Information Clinical Documents:	<p>The evidence base provided for the document. Name any recognised relevant professional body, for example the source of your evidence base.</p> <p>Where appropriate, specify what is required to be documented in patients' notes. Clinical policies should also include a review of the evidence used and a reference list of that evidence.</p> <p>If medicines are referred to within the document it must have had prior approval by the BCUHB Medicines Policy, Procedures and Patient Group Direction Sub-Group and Drug and Therapeutics Group.</p>
Audit	<p>This is required to ensure that the document is appropriate and achievable and that there is compliance with the document by staff. An audit tool must therefore be built into the policy document.</p>
Review	<p>Generally 3 years unless legislation requires differently – check with the Office of the.</p>

24. Appendix 4: Document Submission form for Uploading to the BCU Intranet Policies page

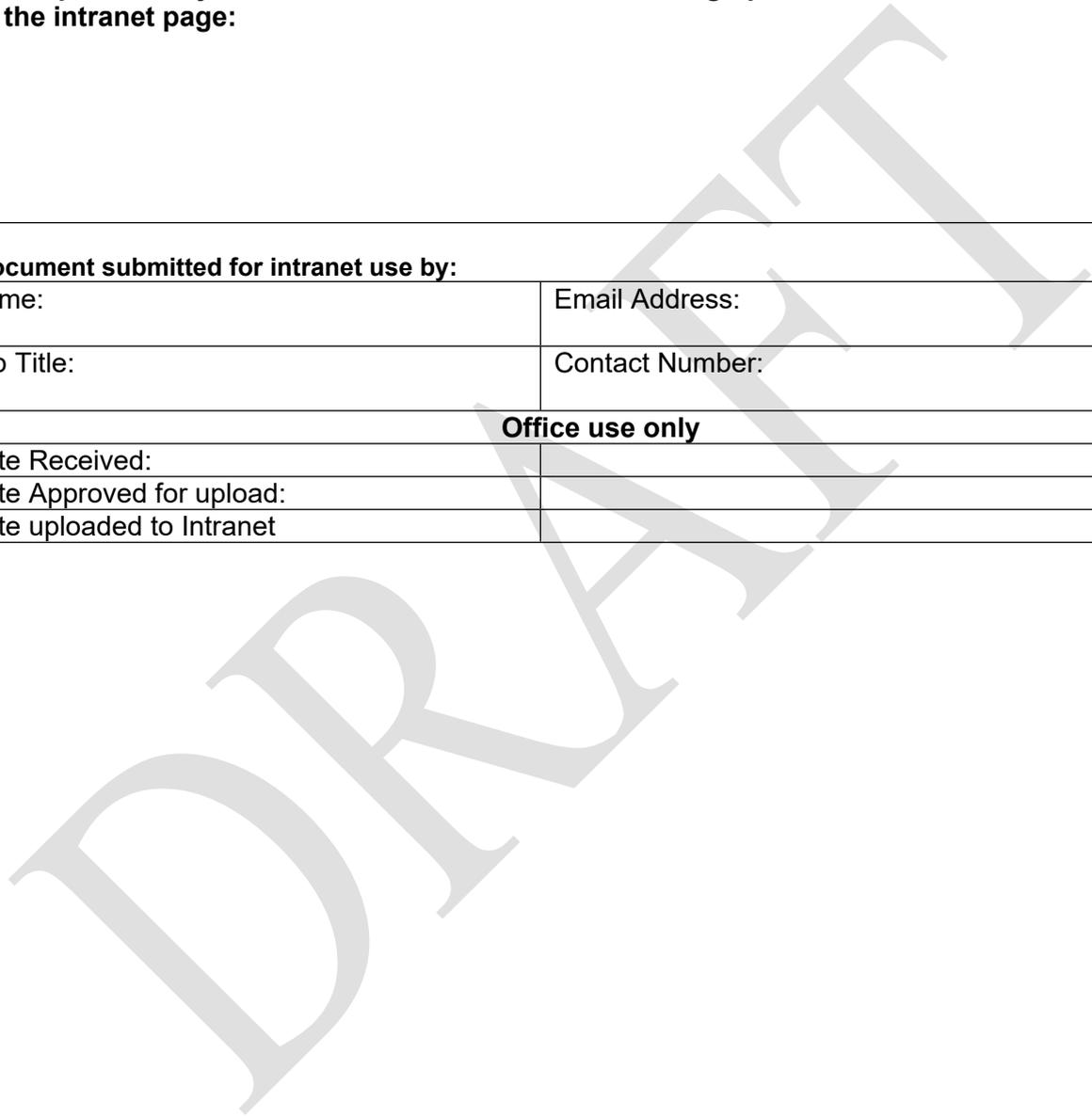
Document Title:	
Document Type: (PLEASE TICK/SELECT) Target Audience	
BCUHB Wide	<input type="checkbox"/>
Directorate/Department Specific	<input type="checkbox"/>
Strategy	<input type="checkbox"/>
Policy	<input type="checkbox"/>
Procedure	<input type="checkbox"/>
Guideline	<input type="checkbox"/>
Standard	<input type="checkbox"/>
Protocol	<input type="checkbox"/>
Document Lead:	
Name:	Email Address:
Job Title:	Contact Number:
Is this document new or does it replace an existing document(s):	
New	<input type="checkbox"/>
Replacement	<input type="checkbox"/>
If replacement please provide the links below to the document which are to be removed:-	
Please select the section on the intranet policy and procedure page that you require this to be placed on (please tick): <i>(Please note: This document will automatically be entered on the A-Z section of the main Intranet Page for Policies etc.)</i>	
Cancer, Palliative & Clinical Haematology	<input type="checkbox"/>
Communications	<input type="checkbox"/>
Concerns and Patient Experience	<input type="checkbox"/>
Emergency Planning and Business Continuity	<input type="checkbox"/>
Estates	<input type="checkbox"/>
Falls (Prevention & Management of)	<input type="checkbox"/>
Finance	<input type="checkbox"/>
Health & Safety	<input type="checkbox"/>
Health Records	<input type="checkbox"/>
Immunisation	<input type="checkbox"/>
Infection Prevention	<input type="checkbox"/>
Medical Devices	<input type="checkbox"/>
Governance	<input type="checkbox"/>
Mental Health & Learning Disabilities	<input type="checkbox"/>
Nursing	<input type="checkbox"/>
Office of the Medical Director	<input type="checkbox"/>
Pathology	<input type="checkbox"/>
Pharmacy & Medicines Management	<input type="checkbox"/>
Radiation Protection	<input type="checkbox"/>
Radiology	<input type="checkbox"/>
Risk Management	<input type="checkbox"/>
Safeguarding	<input type="checkbox"/>
Therapies	<input type="checkbox"/>
Tissue Viability	<input type="checkbox"/>

I.T	<input type="checkbox"/>	Women and Children	<input type="checkbox"/>
Information Governance	<input type="checkbox"/>	Workforce & Organisational Development	<input type="checkbox"/>
Other <i>(Please specify new category below)</i>	<input type="checkbox"/>		

Please provide keywords which will be used when setting up the search criteria for the document on the intranet page:

Document submitted for intranet use by:

Name:	Email Address:
Job Title:	Contact Number:
Office use only	
Date Received:	
Date Approved for upload:	
Date uploaded to Intranet	





PARTS A (Screening – Forms 1-4) and
B (Key Findings and Actions – Form 5)

<u>For:</u>	BCUHB Policy on Policies (periodic review).
<u>Date form completed:</u>	Original – June 2018 Transferred to new EqIA template and reviewed August 2023



KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "...all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A

Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	BCUHB Policy on Policies (PoP).
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>BCUHB has both a common law and a statutory duty to ensure that appropriate policies and supporting procedures, protocols or guidelines etc. (referred to collectively as written control documents (WCDs)) are in place to ensure compliance with relevant legislation and enable employees to fulfil their roles safely and competently.</p> <p>The Health Board's Policy on Policies (PoP) sets out the various roles, responsibilities and the route to be followed when developing or reviewing Health Board wide WCDs.</p> <p>WCDs that are not Health Board wide will be the responsibility of the relevant Directorate/Area/Specialty policy lead. The templates attached to the PoP are encouraged to be used at a local level but the co-ordination of local procedures will be provided by the relevant policy lead.</p>
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	<p>Board Secretary as lead director</p> <p>Audit Committee as final approving body.</p>
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	<p>BCUHB Governance Review (approved by Board 2021).</p> <p>WP7 - Procedure for Equality Impact Assessment.</p> <p>OBs06 BCUHB Integrated Assessment Screening Tool (IAST)</p> <p>Welsh Language (Wales) Measure 2011 / Welsh Language Standards.</p>

Part A

Form 1: Preparation

Please answer all questions

		Well-being of Future Generations (Wales) Act 2015
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	<ul style="list-style-type: none"> All BCUHB employees/workers, volunteers etc. All BCUHB patients, carers and members of the public. <p>Organisational consultation will take place with specific, targeted comms for key governance leads and groups.</p> <p>BCUHB strives to operate in accordance with good governance principles – transparency and openness. Some BCUHB WCDs are available publically via the public organisational website, others are currently stored internally and available on request via the generic policies email or via the Information Governance team under the Freedom of Information Act 2000.</p>
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	<ul style="list-style-type: none"> Communication: It is important that all BCUHB employees/workers are familiar with, and develop and manage WCDs in accordance with the PoP. PoP will be available to all employees/workers via the staff intranet. Signposting to the PoP intranet page is clearly visible on the intranet home page (top banner). Additional comms will be required to ensure awareness of the updated version and any amendments. Training: As per the last review of PoP, once final approved, a number of awareness and training sessions will be available for governance leads/authors.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	An EqIA remains a mandatory requirement for the development and review of all WCDs (also mandated by the BCUHB Integrated Assessment Tool (IAST)). This ensures that negative impacts are identified and mitigated as well as promoting and advancing equality. In addition, PoP will continue to advocate the ‘five ways of working’ (Long term, Prevention, Integration, Collaboration and Involvement) as per the Well-being of Future Generations (Wales) Act 2015 (WBFG) when developing all WCDs.

Part A

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

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A

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

Please answer all questions

Protected characteristic or group	<p>Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p>Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?"</p> <p>You can also visit their website here</p>	<p>How will you reduce or remove any negative Impacts that you have identified?</p>
<p><i>Guidance for Completion</i></p> <p><i>In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered ‘Yes’, you need to indicate if the potential impact will be positive or negative. Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.</i></p> <p><i>The information that helps to inform the assessment should be listed in this column. Please provide evidence for all answers.</i></p> <p>Hint/tip: do not say: “not applicable”, “no impact” or “regardless of...”. If you have identified ‘no impact’ please explain clearly how you came to this decision.</p>			

Part A

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

Please answer all questions

<p>NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.</p> <p>For the definitions of each characteristic please click here</p>						
	Yes	No	(+ve)	(-ve)		
Age	x		x		<p>As part of the HASCAS/Ockenden work, Consultant Dementia Nurses have provided an additional paragraph for inclusion in the revised PoP. This ensures BCUHB maintains an inclusive approach to policy development with consideration for vulnerable groups and in particular, that the needs of older adults are specifically considered within all relevant policies.</p> <p>The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqlA for the development and review of all WCDs (covers all protected characteristics).</p>	No negative impacts identified. Amendments to be added as detailed to improve equality advancement and mitigate negative impacts.
Disability	x		x		<p>The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqlA for the development and review of all WCDs (covers all protected characteristics).</p>	No negative impacts identified. Amendments to be added as detailed to improve equality advancement and mitigate negative impacts.
Gender Reassignment	x		x		<p>The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqlA for the development and review of all WCDs (covers all protected characteristics).</p>	No negative impacts identified. Amendments to be added as detailed to improve equality

Part A

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

Please answer all questions

						advancement and mitigate negative impacts.
Pregnancy and maternity	x		x		The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqIA for the development and review of all WCDs (covers all protected characteristics).	No negative impacts identified. Amendments to be added as detailed to improve equality advancement and mitigate negative impacts.
Race	x		x		The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqIA for the development and review of all WCDs (covers all protected characteristics).	No negative impacts identified. Amendments to be added as detailed to improve equality advancement and mitigate negative impacts.
Religion, belief and non-belief	x		x		The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqIA for the development and review of all WCDs (covers all protected characteristics).	No negative impacts identified. Amendments to be added as detailed to improve equality advancement and mitigate negative impacts.
Sex	x		x		The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqIA for the development and review of all WCDs (covers all protected characteristics).	No negative impacts identified. Amendments to be added as detailed to improve equality advancement and mitigate negative impacts.

Part A

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

Please answer all questions

Sexual orientation	x		x		The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqlA for the development and review of all WCDs (covers all protected characteristics).	No negative impacts identified. Amendments to be added as detailed to improve equality advancement and mitigate negative impacts
Marriage and civil Partnership (Marital status)	x		x		The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqlA for the development and review of all WCDs (covers all protected characteristics).	No negative impacts identified. Amendments to be added as detailed to improve equality advancement and mitigate negative impacts
Socio Economic Disadvantage	x		x		The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqlA for the development and review of all WCDs (covers all protected characteristics).	No negative impacts identified. Amendments to be added as detailed to improve equality advancement and mitigate negative impacts

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

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: <http://howis.wales.nhs.uk/sitesplus/861/page/42166> and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker <https://humanrightstracker.com>.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2* *Right to life*
- *Article 3* *Prohibition of inhuman or degrading treatment*
- *Article 5* *Right to liberty and security*
- *Article 8* *Right to respect for family & private life*
- *Article 9* *Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

[UN Convention on the Rights of the Child](#)

[UN Convention on the rights of people with disabilities.](#)

[UN Convention on the Elimination of All Forms of Discrimination against Women](#)

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

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
x		x		Potentially numerous depending on the nature of the document being developed	The PoP will make reference to the newly developed 'Integrated Assessment Screening tool (IAST)'. This includes the mandatory requirement of an EqIA for the development and review of all WCDs (covers all protected characteristics). Impact on Human Rights will form part of that assessment.	No negative impacts identified. EqIA to be listed as a mandatory assessment.

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

Please answer all questions

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	x		x		Document will be translated once finalised and approved. The IAST also has a Welsh Language section that has been developed in conjunction with the WL Team. The IAST notes the case of <i>Swansea Council v Welsh Language Commissioner</i> (TyG/WLT/21/01) and the requirement that any ‘policy’ decision must consider the impact on the Welsh Language.	None identified.
Treating the Welsh language no less favourably than the	x		x		Document will be translated once finalised and approved. The IAST also has a Welsh Language section that has been developed in conjunction with the WL Team. The IAST notes the case of <i>Swansea Council v Welsh Language Commissioner</i>	None identified.

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

Please answer all questions

English language					(TyG/WLT/21/01) and the requirement that any 'policy' decision must consider the impact on the Welsh Language.	
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Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

<p>What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p>The document will be uploaded to the 'draft documents for consultation page' with a notification placed in the corporate bulletin.</p>
<p>Have any themes emerged? Describe them here.</p>	<p>To be confirmed / updated post consultation</p>
<p>If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?</p>	<p>As per above</p>

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- <http://howis.wales.nhs.uk/sitesplus/861/page/44085>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) <i>for further direction on how to complete this section please click here training vid p13-18</i>	As per above
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2. Brief Aims and Objectives: (Copy from Form 1)	As per above
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From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? Guidance: This is as indicated on form 2 and 3	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?</p> <p>High significance may mean:</p> <ul style="list-style-type: none"> - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. <p>GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
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Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p>5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?</p>	<p>Yes <input type="checkbox"/></p>	<p><input checked="" type="checkbox"/></p>
<p>6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>How is it being monitored?</p>	<p></p>	<p>The Equality team undertake various adhoc reviews/audits and are in the process of developing a new EqIA repository (the policy team will ensure any EqIAs received are forwarded for inclusion).</p> <p>The effectiveness of the document in ensuring EqIA are undertaken robustly and appropriately will be reflected in the governance reviews as part of the Equality Accountability Framework. OBS quality checks include the requirement to conduct an EqIA or IAST for all WCDs</p>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Who is responsible?	The Office of the Board Secretary
	What information is being used?	Policy Management System / Library
	When will the EqIA be reviewed?	Alongside the document review cycle or sooner if required.

7. Where will your policy or proposal be forwarded for approval?	Executive Team / Audit Committee
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8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity	Title/Role
	Statutory Compliance & Policy Manager
	Equality Leads
Senior sign off prior to committee approval:	Executive team 30/08/23

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

Please Note: The Action Plan below forms an integral part of this Outcome Report

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
	Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.		
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	Updating of PoP to include reference to the IAST, in addition to the existing mandatory requirement to complete an EqIA for all WCDs		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	<p>Proposed Actions</p> <p>Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.</p>	<p>Who is responsible for this action?</p>	<p>When will this be done by?</p>
<p>3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?</p>	<p>N/A</p>		
<p>3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.</p>	<p>N/A</p>		
<p>4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.</p>	<p>Inclusion of IAST requirement</p>		

Teitl adroddiad: <i>Report title:</i>	Financial Reporting Single Tender Waivers & Losses payments 2023/24			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Friday, 15 September 2023			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>The purpose of this report is to provide an update for 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.</p> <p>Updates have already been provided for the Fourth quarter in 2022/23 and were reported to Committee on 24th August 2023.</p>			
Argymhellion: <i>Recommendations:</i>	<p>The Audit Committee is asked to:</p> <p>Review:</p> <ul style="list-style-type: none"> • Single Tender Waivers & Single Quote Waivers implemented by the Health Board. • Approve the Losses and Special Payments. 			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Russel Coldicott, Interim Executive Director of Finance			
Awdur yr Adroddiad: <i>Report Author:</i>	Finance Director – Operational Finance			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i> <input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i> <input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>
<p>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:</p> <p><i>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:</i></p>				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	This paper aligns to the strategic aim 1: Improving physical, emotional and mental health and wellbeing for all/improving the safety and quality of all services			

	BCUHB's SOs and financial requirements included are designed to ensure that expenditure is incurred for the purposes intended and aligned.
Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i>	Areas of identified non-conformance highlight risk of failing to meet regulatory and legal requirements, and expected good practice. Mitigating actions are designed to manage highlighted risks effectively.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>	None identified as necessary
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>	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) <i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i>	BAF: 2.3 – Plan to reduce BCUHB's Financial deficit, secure WG funding and retain WG's strategic support
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith <i>Financial implications as a result of implementing the recommendations</i>	Unquantified lower financial risk
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith <i>Workforce implications as a result of implementing the recommendations</i>	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori <i>Feedback, response, and follow up summary following consultation</i>	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <i>Links to BAF risks:</i> (or links to the Corporate Risk Register)	See above
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) <i>Reason for submission of report to confidential board (where relevant)</i>	Not applicable
Camau Nesaf: Gweithredu argymhellion <i>Next Steps:</i> <i>The report is for noting.</i>	
Rhestr o Atodiadau: None	

Single Tender Waivers (for items of expenditure above £25,000)

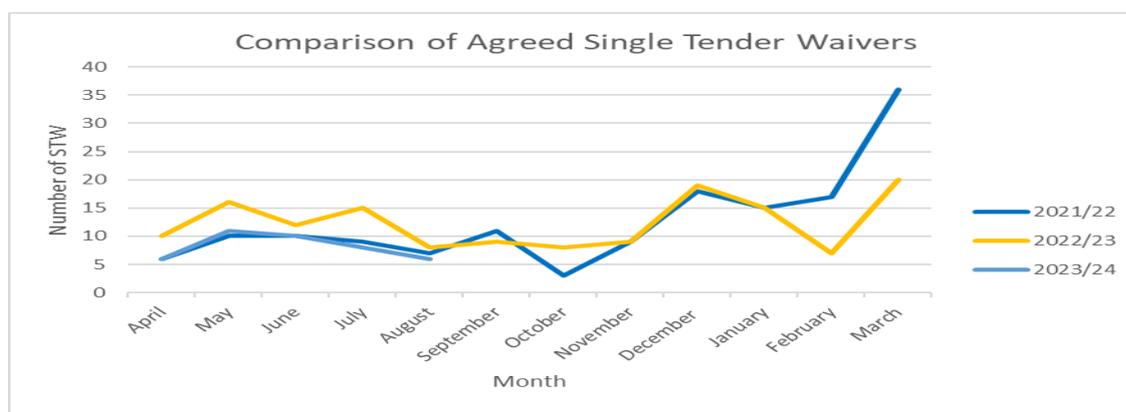
It is normal practice to request bids from multiple suppliers. Where this is not possible, a single tender waiver should be obtained and approved ahead of expenditure being committed, providing assurance of scrutiny for value for money and contract awards complying with procurement legislation. Allowable 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 April 2023 - 31st August 2023:

Single Tender Waivers	2023/24 Q1	2023/24 Jul - Aug	2022/23 YTD	2023/24 YTD
Waivers Issued	36	19	55	55
Waivers Approved	27	5	61	32
Value of Approved Waivers	£2.3m	£0.24m	£3.9m	£2.54m
Waivers approval above EU Threshold	7	0	5	7
Cancelled Waivers	5	2	6	7

The chart below provides a summary of the approvals to waive tender requirements, which were received by Procurement for 2023/24 (Apr – Aug), compared with 2021/22 and 2022/23. There has been a slight decrease in approvals compared to previous financial years. 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 April – 31st August 2023

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Breached OJEU	Supported By Procurement
						£000s		
2022/2023-1135	03/04/2023	SecCare - North Wales Cancer Services	Paxman	Chemotherapy Machine for treatment to receive scalp cooling which helps prevent hair loss	Genuinely one provider	£104,748.00	No	Accept
2022/2023-1143	05/06/2023	Corporate - WOD	BMJ	Advertising of medical vacancies - professional journal for Doctors	Genuinely one provider	£143,854.00	Yes	Accept
2022/2023-1166	02/05/2023	Estates and Facilities	FAAC Entrance Solutions	Maintenance contract for all the Automatic doors West sites of BCUHB.	This STW complies with strict manufacturers recommendations & Third party contracts would pose a risk to BCUHB. Part of this contract requires additional spares to be purchased.	£40,000.00	No	Accept
2022/2023-1181	17/04/2023	Secure - Managed Clinical Support	Nanosonics	Maintenance of 19 Trophon II ultrasound decontamination units across Radiology	Maintenance	£80,569.50	No	Accept
2022/2023-1199	02/05/2023	Corporate	3M	Encoding software All Wales	Follow on from previous waiver	£38,327.74	No	Reject
2022/2023-1204	05/04/2023	Corporate	Gwynedd Council - Ysgol Gynradd Bethel	Support to cover Maternity leave from April 1st 2023 to March 31st 2024 within Gwynedd Healthy Schools Team.	Follow on from previous waiver	£29,299.00	No	Accept

2023/2024-1212	24/04/2023	Estates and Facilities	static systems	Fire Alarm Maintenance	Genuinely one provider	£60,250.32	No	Accept
2023/2024-1215	11/04/2023	IHC West (Area Team - West)	Pathway Software	ResuTherapy Manager licence extension 1yr 23/24 - patient administration system and digital patient record system used across Therapy Services BCU	Genuinely one provider	£176,176.00	Yes	Accept
2023/2024-1216	06/04/2023	IHC East (Sec care)	Daybreak Medical	Ellex Tango Reflex Yag/SLT Laser	Genuinely one provider	£35,940.00	No	Accept
2023/2024-1217	09/05/2023	Corporate - WOD	Page Tiger	Software company creating handbooks, training material etc to support our staff in areas such as Leaving & Joining, Leadership training, Recruitment.	Other (please specify) - Supplier is used by other Welsh & English NHS Boards / Trusts	£73,700.00	No	Accept
2023/2024-1223	09/05/2023	Mental Health & LD	CMECIC	Skills Audit for CAMHS staff (circa 275 clinical staff across all CAMHS services). The skills audit will provide us with a comprehensive view of the training needs and gaps of the service and form part of the CAMHS Strategic	Genuinely one provider, Workforce Plan to support short term and long term recruitment and retention as a key enabler of the CAMHS TI Programme.	£70,000.00	No	Accept
2023/2024-1226	02/05/2023	IHC East (Area East)	Supply Point Systems	Service/maintenance contract for automated cabinets	Maintenance	£31,695.00	No	Accept
2023/2024-1228	02/05/2023	IHC West (Sec Care -	Cinos Limited	3yr Switchboard ARC Licencing and support & maintenance (premium support), To be invoiced annually.	Genuinely one provider	£42,908.62	No	Accept
2023/2024-1231	16/05/2023	Corporate	Age Connects North Wales Central	The social prescribing service will work closely with General Practices - Conwy West cluster community.	This is a continuation of a Social Prescribing service which was previously managed through Area Central.	£38,768.00	No	Accept

2023/2024-1232	09/05/2023	IHC Centre (Area Team - Central)	Barnardos	Extension of measured pilot of a commissioned in the West CAMHS provision specifically highlights intervention for those; who do not meet core criteria for CAMHS intervention, brief intervention following crisis admission to hospital.	Follow on from previous waiver	£77,505.00	No	Accept
2023/2024-1245	18/05/2023	Estates and Facilities	Vertiv Infrastructure Ltd	Maintenance Contract/Technical Support for 2 UPS installations (4 UPS units) at Ysbyty Gwynedd which provide uninterruptible power supplies to the IPS systems supplying the critical care areas e.g. Operating Theatres, SCBU at Ysbyty Gwynedd. This contract is part of the electrical infrastructure costs.	Genuinely one provider	£30,000.00	No	Accept
2023/2024-1247	22/05/2023	IHC Centre (Secondary Care - YGC)	Cwtch Consulting	Cwtch Consulting is a UK based company to provide appropriate training for schools, focusing on supporting professionals to understand and embed a whole school approach to good mental health and emotional wellbeing. The curriculum covers interventions designed specifically to address teacher stress, teacher absence and poor staff retention.	School In Reach - new service funding for educational programmes to support North Wales Schools, i.e. in all areas Trauma Informed Schools training encompasses a whole-school approach to enhancing self-esteem and building positive relationships in school communities. The admission criteria: working with young people on a regular basis or in a strategic role supporting staff who are working with young people.	£66,000.00	No	Accept

2023/2024-1252	22/06/2023	IHC Centre (Sec Care -	Royal National Institute for the Blind	Provision of an Eye Clinical Liaison Officer full time for 3 years fixed to support the Ophthalmic patients with sight loss.	Genuinely one provider, Crucial to service and within the recommendations of the Royal College of Ophthalmologist guidelines for AMD	£84,271.00	No	Reject
2023/2024-1254	30/05/2023	SecCare - North Wales Cancer Services	Clatterbridge PPJV	Clinical service for the treatment of colorectal (anal/rectum) cancers that require radiotherapy treatment	Genuinely one provider	£324,000.00	Yes	Accept
2023/2024-1258	07/06/2023	Sec Care - Managed Clinical Support	JFHunt Power & Fuels Ltd	High power electrical generator to power the Mobile PET-CT Scanner (attends 3 days per week) - outsourced to AML Ltd. The unit is temporarily displaced from Radiology mobile PAD - agreed extension to reduce COVID backlog. The HB have agreed to fund the mobile MRI a further 12 months - requiring the PET scanner to stay at ALAC using the generator.	Follow on from previous waiver	£115,000.00	Yes	Accept

2023/2024-1264	20/06/2023	Estates and Facilities	Applied Integration	Highly complex SCADA system that controls all of the Low Voltage circuit breakers for all the Main Switchboards and all the Sub Switchboards throughout the whole of the electrical infrastructure at Ysbyty Gwynedd. The system also controls a majority of the High Voltage circuit breakers and integrates into the Comap control system, which controls the emergency standby generators and all the associated High Voltage circuit breakers. Comap is a separate system (and company now Applied Power Engineering Ltd) and as previously mentioned integrates into the SCADA system.	Compatibility Issue (eg. warranty cover clause or specific equipment)	£40,000.00	No	Accept
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2023/2024-1265	15/06/2023	Estates and Facilities	Static Systems	<p>Statutory testing for the fire alarm system installed at Ysbyty Gwynedd. The contract supports 24/7 in accordance with BS5839-1, 2002 & A2:2008 statutory testing. This request also covers additional costs for call outs and spares for the system where and if available. The system software is supplier specific and closed protocol, therefore cannot be maintained or serviced by a third party contractor.</p>	Genuinely one provider	£110,000.00	No	Accept
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2023/2024-1268	20/06/2023	Estates and Facilities	ABB Electrification	Maintenance and repairs of all the Low Voltage and High Voltage switchgear of the electrical infrastructure. The switchgear is out of warranty so is very important to ensure that it is maintained in accordance with manufacturer's instructions. Integrated basis between The amalgamations of specialities between these highly specialist companies is what makes this system so complex and integrated. If the switchgear were just standard, then another company could probably maintain them; however, the switchgear is not standard due to the way all the systems integrate with each other. It's not just the switchgear that is maintained by ABB, as system designers and manufacturers they also ensure that not only the switchgear (Vacuum Circuit Breakers VCB's) are maintained but all of the protection relays, auxiliary contacts and interfacing controls to both the SCADA and Comap systems.	Compatibility Issue (eg. warranty cover clause or specific equipment)	£234,200.00	Yes	Accept
2023/2024-1272	26/06/2023	Estates and Facilities	Honeywell		Genuinely one provider	£160,909.00	Yes	Accept

2023/2024-1273	26/06/2023	Estates and Facilities	Static Systems Ltd	Upgrade of obsolete wireless nurse call system on Ffrancon and Tudno wards at YG and the nurse call system in the Hergest Unit on the YG site These systems are now failing and causing issues and risk to the patients. These systems are closed protocol to Static Systems and would need to integrate to existing parts of adjacent wards; therefore, the option of using an alternative supplier would not be feasible on this occasion as the systems are closed protocol.	Genuinely one provider	£140,000.00	Yes	Accept
2023/2024-1274	30/06/2023	Estates and Facilities	Static Systems Ltd	Upgrade of the fire alarm system for the whole of the YG site, which is closed protocol. This is the second year of a multi-year program.	Genuinely one provider	£100,000.00	No	Accept
2023/2024-1278	27/06/2023	IHC West (Area Team - West)	JIWSI	Relationship and Sex Education Training Programme for Sexual Health Service pan BCU for a 6 month period	Interim arrangement pending tender	£39,234.00	No	Accept
2023/2024-1282	04/07/2023	Corporate	Rotherham Respiratory	Training courses for primary care workforce - Foundation and Advanced level chronic disease covers 5 topics i.e. asthma, COPD, at both levels of learning.	Interim arrangement pending tender	£28,800.00	No	Accept
2023/2024-1288	09/08/2023	IHC East (Area Team - East)	Rainbow Foundation	Active Futures (see attached)	Genuinely one provider	£100,000.00	No	Accept
2023/2024-1289	12/07/2023	SecCare - Managed Clinical Support	Steris	Maintenance contract for Dental Drills across all 3 sites	Maintenance	£40,350.00	No	Accept

2023/2024-1296	29/08/2023	IHC West (Sec Care -	Maintel Europe Limited	Ongoing Support and maintenance of legacy telephone systems in BCU	Genuinely one provider	£41,011.68	No	Accept
2023/2024-1297	10/08/2023	Sec Care - Managed Clinical Support	Vitalograph Ltd	Maintenance contract for Spirometers for the period of 01/10/23 -1/10/26. Located throughout the health board. Vital graph Ltd are the OEM with access to parts, no other supplier can maintain the equipment	Genuinely one provider	£26,660.00	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 April – 31st August 2023

Single Quote Waiver	2023/24 Q1	2023/24 Jul - Aug	2022/23 YTD	2023/24 YTD
Waivers Issued	35	22	72	57
Waivers Approved	22	14	30	36
Value of Approved Waivers	£0.31m	0.14m	£0.42m	£0.45m
Cancelled Waivers	2	3	1	5

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 April – 31st August 2023

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement
						£000s	
2022/2023-1151	04/04/2023	IHC East (Area East)	Ecolab Bioquell Service	Contracts for PM of Clarus L SN: 2008019552 sterility suite Clarus L SN: 200819498 (Aseptics 2 visits per annum) and Port SN: 2008019499 (Aseptics 2 visits per annum).	Genuinely one provider	£15,620.25	Accept
2022/2023-1156	03/05/2023	Mental Health & LD	Dr Cathy Wood	Specialist Trauma Counselling	Genuinely one provider	£5,800.00	Accept
2022/2023-1184	06/06/2023	Research & Development	Marie-Claire Howorth	Provision of MIT sessions as per her last contract. The evaluation of MIT be undertaken by BCU funded/approved researchers	Follow-up work from previous open competition procurement	£20,840.00	Accept
2022/2023-1189	28/04/2023	Sec Care - Managed Clinical Support	Hologic	Maintenance contract for 2.5 years for T2000 processor. Service for this device to stop at end October 2025 due to age.	Genuinely one provider	£9,095.90	Accept
2022/2023-1205	24/05/2023	Finance	AFD Software Ltd	12 months Postcoding licence renewal (x30) that supports Postcode lookup functionality from within the BCU local Symphony system pan-BCU.	Maintenance	£6,900.00	Accept
2023/2024-1210	11/04/2023	Sec Care - Managed Clinical Support	MELYD SURGICAL LTD	SERVICE OF THEATRE TABLES ON ALL 3 SITES	Maintenance	£11,880.00	Accept
2023/2024-1214	24/04/2023	Estates and Facilities	Courtney thorne	Fully inclusive service contract on our closed protocol nurse call system with free equipment repair or replacement if required for all handsets, screens call points ,full software updates as required and 24/7 expert help line with manufacture technical help.	Genuinely one provider	£11,164.70	Accept
2023/2024-1222	13/04/2023	SecCare - North Wales Cancer Services	MDSAS	Haemophilia clinical information system Access database	Genuinely one provider	£6,672.73	Accept

2023/2024-1229	22/05/2023	Mental Health & LD	HD Labs	Project extension will enable continued support to the Digital Health Place project and deliver the outcomes set out in the initial proposal until its completion in March 2023. The deliverables set out are reliant on engagement from BCUHB, DPIA signoff, and youth code sign group identification. This extension will ensure the Digital Health Place project delivers value with a sustainable long-term plan.	Follow on from previous waiver	£5,000.00	Accept
2023/2024-1230	07/06/2023	Mental Health & LD	Health Place	The extension phase work plan will focus on completing existing work plan priorities and through matched investment will deepen our collective ability to test, learn, improve and embed within this existing scope.	Follow on from previous waiver	£19,764.00	Accept
2023/2024-1236	09/05/2023	IHC Centre (SecCare -	NANOG Dental Implant Team	to provide diagnostic Cone Beam CT Scan	Interim arrangement pending tender	£7,140.00	Accept
2023/2024-1239	09/05/2023	Sec Care - Managed Clinical Support	Leica Bio Systems	Maintenance of Aperio AT2	Maintenance	£19,860.40	Accept
2023/2024-1240	09/05/2023	SecCare - Managed Clinical Support	Sakura Finetek	Platinum Maintenance and cover of VIP6 AI x2 + Auto section. Gold service cover for DRS2000 Stainer	Maintenance	£11,482.33	Accept
2023/2024-1246	22/05/2023	IHC East (Area Team - East)	THE PRISON OPTICIANS COMPANY LTD	Extension of Optometry Service to patients resident at HMP Berwyn to ensure no break in service prior to completion of tender exercise.	Interim arrangement pending tender	£22,150.00	Accept

2023/2024-1248	19/05/2023	Estates and Facilities	PB Design	Installers/commissioners of all the battery backup systems installed as part of the electrical infrastructure at YG. These systems again integrate into the main system and provide critical battery backup power and operating power for all of the Low Voltage and High Voltage switchgear overall system. If these units were to fail then in the event of a power outage from Scottish Power to site and the whole site is off (black site), then the system would not operate, as it should i.e. emergency standby generators may not start, switchgear around the site may not switch/operate to reinstate supplies.	Maintenance	£20,000.00	Accept
2023/2024-1250	19/05/2023	Estates and Facilities	Applied Power Engineering Ltd (COMAP)	Applied Power Engineering Ltd (APE) (Comap) are the original system designers who have the full, complete and detailed knowledge, and hold and control all the project files for the control systems software and their experience and knowledge of the system is also unparalleled. Again, without this in depth detailed knowledge of the software configuration could cause catastrophic consequences to the electrical supplies of the whole site, emergency generators included, if it is not fully and completely understood. The advantage of the Comap controllers is that each of them have an on board "virtual PLC", this PLC functionality is used to tailor the system to give the bespoke "non-standard" functionality that the YG site requires, it is this detail that would not be known by a third party contractor.	Maintenance	£20,000.00	Accept
2023/2024-1251	22/05/2023	Mental Health & LD	POBL TECH	maintaining service websites, call logging system, database. Further design & development,pobl tech have already started work with us and host all websites, crms and databases. Some of the work from last year has not been completed due to complex issues. pobl tech still need to complete work on the database and complete work for admin access. if new provider comes in at this point, progress will be lost, work is likely not going to be completed with agreed deadlines, and it will cause delay and come with a greater cost to the department.	Maintenance	£21,500.00	Accept

2023/2024-1256	02/06/2023	Sec Care - Managed Clinical Support	Agilent Technologies	Maintenance for the Agilent DAKO Diagnostic Coverstainer System	Maintenance	£6,609.81	Accept
2023/2024-1257	12/06/2023	Sec Care - Managed Clinical Support	Vyair Medical	Single Tender Waiver for 4 year maintenance cover of 11 x CPAPs to ensure equipment is safe to use. They are the OEM with access to parts; no other supplier can maintain the equipment.	Genuinely one provider	£21,531.82	Accept
2023/2024-1269	30/06/2023	Corporate	Arana	SAS doctors away days and training workshops. Background to applying for a waiver is that the first 3 "away days" were under £5,000 and therefore did not need to go through that process. The later workshops when uploaded to Oracle then as the cumulatively had gone over £25,000 – procurement raised why not gone out to tender. I contacted Deborah Evans in Procurement who explained the process, and the options that we could follow with regard to tender for future workshops. I contacted David Williams in Finance who felt feasible to put in a waiver for the first three as arranged and under the limit, and as enough time to put tender in for later workshops	Other (please specify) - 3 dates have been arranged and promoted, will tender for future ones.	£13,500.00	Accept
2023/2024-1271	29/06/2023	Charitable Funds	Zip World	264 Velocity Zip World flights for staff for the 75th anniversary of the NHS	Genuinely one provider	£17,600.00	Accept
2023/2024-1277	29/06/2023	Estates and Facilities	Intastop Ltd	Annual Maintenance and Repair PPM contract on 243 off Anti-Ligature door top alarm units (in various BCUHB Mental Health locations) for a contract period of 12 months Intastop Ltd are the sole supplier of this equipment. The alarm units were manufactured, supplied, installed and commissioned by Intastop Ltd This is a fully inclusive PPM contract.	Maintenance	£16,852.05	Accept
2023/2024-1242	11/08/2023	IHC Centre (Area Team - Central)	EMDR: Advanced Child & Adolescent	CPD Training Level 2	Genuinely one provider	£6,600.00	Accept

2023/2024-1263	09/07/2023	Mental Health & LD	Dr Cathy Wood	Specialist Trauma Counselling	Genuinely one provider	£11,600.00	Accept
2023/2024-1275	15/08/2023	IHC Centre (Area Team - Central)	Conwy Education Services	Joint funding for the post of the Health and Wellbeing Development Officer recruited by Conwy CBC to work in partnership with NW CAMH School In-Reach Service (BCUHB) to keep focus on Mental Health wellbeing in schools and to provide strategies to promote the prevention of Mental Health illnesses and early intervention consultations.	Genuinely one provider	£22,500.00	Accept
2023/2024-1280	04/07/2023	Corporate	M&K Update Ltd	Training courses for primary care workforce - 11 different courses for both clinical and non-clinical staff, bespoke to GP Practices.	Interim arrangement pending tender	£14,168.00	Accept
2023/2024-1281	04/07/2023	Corporate	Thornfield	Training courses for primary care workforce - 11 different courses for non-clinical staff, bespoke to GP Practices.	Interim arrangement pending tender	£7,856.15	Accept
2023/2024-1284	18/07/2023	Mental Health & LD	Bild Association of Certified Training	Accreditation	Genuinely one provider	£6,996.00	Accept
2023/2024-1285	11/07/2023	Corporate	Vivid Resourcing	IPC Specialist covering senior backfill for an 8B supporting other work for 1 day per week	Follow on from previous waiver	£10,710.00	Accept
2023/2024-1286	13/07/2023	Corporate	M&K Ltd	Training Courses	Interim arrangement pending tender	£5,500.00	Accept
2023/2024-1287	13/07/2023	Corporate	Thornfield	Training courses	Interim arrangement pending tender	£1,500.00	Accept
2023/2024-1291	31/07/2023	Corporate	North Wales Police	Partnership Analyst post -This is a continuation of provision of contribution to a multi-agency agreement to support a post at North Wales Police.	Recent pay awards, exceeded £5000, requiring a waiver to be completed.	£5,739.00	Accept

2023/2024-1312	21/08/2023	Sec Care - Managed Clinical Support	Medtronic	Service contract for Manoscan A120 Module	Genuinely one provider	£9,585.00	Accept
2023/2024-1313	21/08/2023	Sec Care - Managed Clinical Support	A. Menarini Diagnostics Ltd (Menarini)	The lease of 2 Seal-safe bagging systems for theatres and laboratory on a 2-year contract. Currently have the 2 units on reagent rental at a cost of £30,000+ per annum.	Genuinely one provider	£19,824.00	Accept
2023/2024-1333	29/08/2023	Corporate	ASH Wales	Campaign highlighting the emerging threat posed by illegal tobacco and e-cigarette distributors in North Wales. Also supports Wales' Tobacco Control Strategy and Welsh Government's target of addressing the illegal tobacco and vaping market in Wales. The aim of the Campaign is to further provoke a community response through signposting to the dedicated, anonymous, reporting portal, which supports the work of Trading Standards and Operation CeCe.	Genuinely one provider	£10,000.00	Accept
2023/2024-1336	24/08/2023	Sec Care - Managed Clinical Support	Carl Zeiss	Maintenance Cover for Zeiss units in Abergele and Wrexham to ensure they are safe for use. 7.5% Discount - quote attached.	Genuinely one provider	£6,093.90	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 to August 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 285 active claims at the end of August 23. Of these 143 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £140m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

59% of the caseload (167 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
2023/24 (YTD)	18
2022/23	40
2021/22	48
2020/21	59
2019/20	60
2018/19	27
2017/18	9
2016/17	6
2015/16	6
2014/15	3
2013/14	1
2011/12	4
2010/11	1
2009/10	2
2008/09	1
Total claims	285

Losses and Special Payments

	Q3 22/23 £	Q4 22/23 £	Q1 23/24 £	July & Aug 23/24 £	Latest quarter analysis and further action
Medical Negligence					
Gross cost	7,576,269	2,378,506	6,304,445	2,344,112	Payments were made on 159 cases, of which 7 came under the Redress Scheme.
WRPS Reclaim	(7,077,023)	(1,983,851)	(5,823,370)	(2,103,182)	
Net Cost	499,246	394,655	481,055	240,930	
Personal Injury					
Gross cost	189,117	69,411	97,010	46,439	Payments were made on 23 cases.
WRPS Reclaim	(95,872)	(21,122)	(25,608)	(0)	
Net cost	93,245	48,289	74,402	46,439	
Loss of cash	450	200	1,000	0	No loss of cash has been reported in July & August 2023.
Debtors written off	14,927	11,275	376	7,442	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	77,245	233,213	33,989	50,048	Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. 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	8,055	179,027	19,154	6,202	Relates to 9 payments for loss/damage of patient's property and 3 ombudsman payments for delayed and unsatisfactory treatment.
VERS Payments	181,083	72,809	0	0	All payments are approved by the RATS Committee.
Total	874,251	939,468	609,976	351,061	

* The Welsh Risk Pool Service administers the risk pooling arrangement for negligence claims and reimburses amounts over £25,000.



Teitl adroddiad: Report title:	Internal Audit Plan 2023/24 – October 2023 to March 2024 Internal Audit Progress Report 1st May to 31st August 2023
Adrodd i: Report to:	Audit Committee
Dyddiad y Cyfarfod: Date of Meeting:	15 September 2023
Crynodeb Gweithredol: Executive Summary:	<p>The audit plan for 2023/24 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan.</p> <p>The internal audit plan for October 2023 to March 2024 details the risk based planned reviews for the second six months of the financial year following review of Board and Committee papers; Board Assurance Framework; Corporate Risk Register; risk based meetings with the Audit Committee Chair, Chief Executive and Board Secretary; Special Measures Action Plan; and reviews deferred from 2022/23.</p> <p>The six-month plan format was agreed by the Audit Committee and Interim Chief Executive (Accountable Officer) to ensure internal audit focus on areas of emerging risks facing the Health Board.</p> <p>The progress report is produced in accordance with:</p> <ul style="list-style-type: none">• 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. <p>The progress report summarises fourteen assurance reviews finalised since the last Committee meeting in May 2023, with the recorded assurance as follows:</p> <ul style="list-style-type: none">• Substantial assurance (green) – two;• Reasonable assurance (yellow) – three;• Limited assurance (amber) – seven;• No assurance (red) – one; and• Advisory (grey) – one. <p>The report also details the reviews with reports issued as draft and work in progress.</p>
Argymhellion: Recommendations:	<p>The Committee is asked:</p> <p>Plan</p> <ul style="list-style-type: none">• To approve the six-month Internal Audit Plan for October 2023 to March 2024.• To note the Audit Universe/Rolling plan and the risks identified for consideration for 2024/25. <p>Progress report</p> <ul style="list-style-type: none">• To receive the progress report.• To approve the recommendation to defer one review from the plan.
Arweinydd Gweithredol:	Interim Board Secretary

Executive Lead:				
Awdur yr Adroddiad:	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit			
Report Author:				
Pwrpas yr adroddiad: Purpose of report:	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: Assurance level:	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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: <i>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:</i>				
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:	N/A other than those relating to individual audit reviews / recommendations.			
Link to Strategic Objective(s):				
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 EqIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>	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? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>	The Socio-Economic duty is not applicable. The audit plan for 2023/24 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan. 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).			

<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>N/A other than those relating to individual audit reviews / recommendations.</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>N/A other than those relating to individual audit reviews / recommendations.</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>The draft plan has been agreed with the Chief Executive (Accountable Officer).</p> <p>The progress report is produced independently of management.</p> <p>The progress report has been shared with the Interim Board Secretary.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	<p>N/A other than those relating to individual audit reviews.</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>N/A</p>
<p>Camau Nesaf: Gweithredu argymhellion</p> <p><i>Next Steps:</i> <i>Implementation of recommendations</i></p> <p>The six month internal audit plan and 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.</p>	
<p>Rhestr o Atodiadau:</p> <p><i>List of Appendices:</i></p> <ul style="list-style-type: none"> • Appendix 1: Internal Audit Plan 2023/24 – October 2023 to March 2024 • Appendix 2: Progress report • Appendix 3: Contracted patient activity – Quality & Safety arrangements • Appendix 4: Recruitment of Substantive and Interim Executive and Senior Posts (ESP) • Appendix 5: Planned Care Recovery and Transformation Group • Appendix 6: Data analysis – Triangulation of data • Appendix 7: Performance management and accountability arrangements • Appendix 8: Board Assurance Framework (BAF) & Risk Management • Appendix 9: Hergest Unit Notice of Contravention (NoC) Action Plan 	

- Appendix 10: Clinical Audit – Tier 1 National Audits

Betsi Cadwaladr University Local Health Board

Audit Committee Internal Audit Progress Report

1st May to 31st August 2023

NWSSP Audit and Assurance Services

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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.

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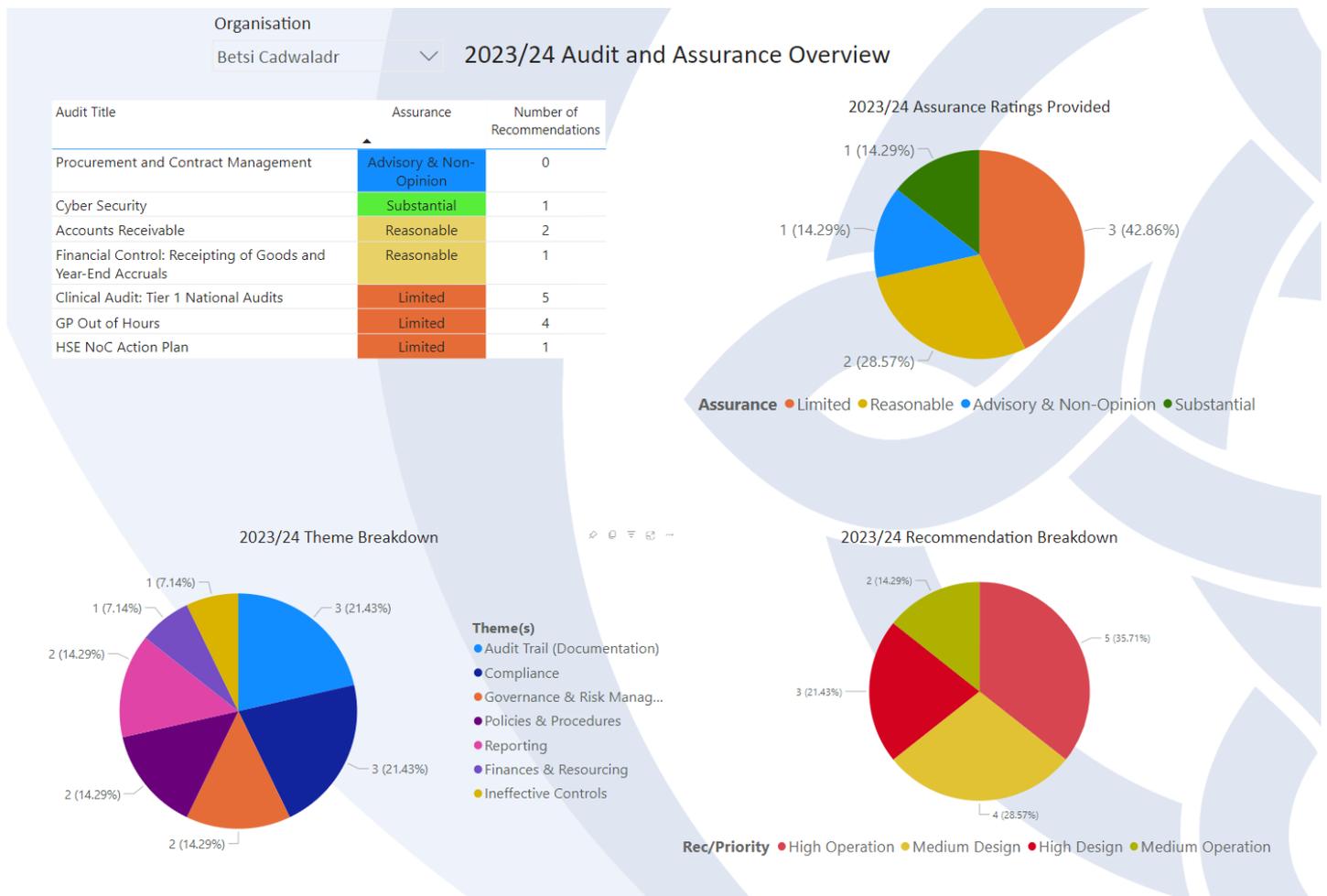
Introduction

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 and 2022-23 which have been finalised since the last Committee meeting. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Office of the Board Secretary.

Reports Issued

2. Since the last progress report, fourteen reviews (nine relating to 2022-23) have been finalised in conjunction with Health Board management and one issued as draft. A summary of the finalised reviews is provided in Table 1.
3. In reviewing the 2023/24 draft and final reports issued to date (seven in total, 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 August 2023



- Theme definition is included at Table 6.

Table 1 – Summary of assurance reviews issued as final

Title	Assurance Level	High	Medium	Low	Key Messages
2023-24					
Financial Control – Receipting of goods and year-end accruals	Reasonable	1	-	-	<p>The purpose of the review was to ensure the internal financial controls for purchase order accruals was robust and the Health Board's own Standard Operating Procedure was complied with.</p> <p>We found good practice taken by Finance to prepare detailed guidance and provide training to colleagues on year-end processes.</p> <p>The one matter requiring management attention concerns the process for ensuring all staff involved in procurement receive mandatory training in line with the requirements stipulated by the Chief Executive of NHS Wales. In doing so, this will bring into focus responsibilities to receipt correctly, including at year-end.</p>
Accounts Receivable	Reasonable	1	1	-	<p>The purpose of the audit was to review key controls for the receipt, banking and debt management in accordance with standard operating procedures and Standing Financial Instructions.</p> <p>There were two matters requiring management attention:</p> <ul style="list-style-type: none"> On occasions we were unable to establish a formal and robust process to capture reasons for cash deficit / surplus, or action taken to escalate the issue further and prevent future occurrence. This is non-compliant with Standing Financial Instructions. Some financial procedures were out of date and need review and updating to prevent poor working practices.
Clinical Audit – Tier 1 National Audits	Limited	3	2	-	<p>The purpose of the audit was to review the Health Board's participation in Tier 1 audits, including submission of data and resulting actions.</p> <p>There were several matters requiring management attention:</p>

Title	Assurance Level	High	Medium	Low	Key Messages
					<ul style="list-style-type: none"> The 2023/24 Clinical Audit plan has not been formally approved by an appropriate committee. The Health Board has participated in the majority of Tier 1 audits (32 out of 38); however, we are advised a lack of resources and insufficient clinical and administrative capacity have restricted achieving full completion of the Tier 1 plan. There is no clear reporting through governance structures on progress and any issues with Tier 1 audits. The Clinical Effectiveness Department does not have oversight of validation checks for the data collated for national audits. The Clinical Effectiveness department do not receive assurance that local Clinical Effectiveness meetings are taking place and are therefore unsighted on areas being discussed. Clinical Audit reports covering quarters 3 and 4, and the annual plan, have not been presented to the Quality, Safety and Experience Committee. We recognise this is due to Committees not taking place for a period.
Cyber Security	Substantial	-	1	-	<p>The purpose of the audit was to ensure that the organisation is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.</p> <p>There is a cyber improvement plan in place, with actions being progressed; an appropriate governance and reporting framework and a process for backups.</p> <p>There was one matter requiring management attention:</p> <ul style="list-style-type: none"> Reporting does not currently use KPIs which show the security posture of the organisation.
Hergest Unit Notice of Contravention (NoC) Action Plan	Limited	1	-	-	<p>The purpose of the audit was to ensure the Health Board could demonstrate it has the evidence to support completion of the action plan developed to address the three Material</p>

Title	Assurance Level	High	Medium	Low	Key Messages
					<p>Breaches identified by the Health and Safety Executive.</p> <p>Whilst evidence was provided for the actions identified by the Service, for the majority of the action plan, the evidence did not support completion of the actions, or provide assurance that actions are embedded as part of day to day processes across the Division. We believe the action plan should be revisited with urgency to ensure the Health Board can demonstrate the actions it set out are embedded.</p>
2022-23					
Transformation and Improvement – Progress reporting	Advisory	-	-	-	<p>No recommendations were made, however a review of the information provided highlighted some areas of potential risk, which will be considered in the review of the internal audit annual plan:</p> <ul style="list-style-type: none"> • Transformation and Improvement prioritisation matrix; this has been developed and is currently being trialed. There is a risk that work undertaken does not support the priorities of the Health Board. • Benefits realisation of changes; as a number of developments are recent and ongoing, the resulting outcomes / benefits have not been assessed to determine whether changes have made a difference i.e. have the revised pathways improved the patient experience and waiting lists. • Progress of projects / programmes; the review of project /programme information highlights some delays in projects.
Recruitment Improvement Review – Pre-Employment verification and appointment process	Substantial	-	2	-	<p>The review considered whether there were robust processes and controls in place within the Health Board and the relevant teams in NWSSP recruitment to support the implementation of the Recruitment Improvement Plan and monitor performance against the revised Key Performance Indicators (KPIs).</p> <p>Recognising implementation is ongoing, the matters which require management attention include:</p>

Title	Assurance Level	High	Medium	Low	Key Messages
					<ul style="list-style-type: none"> • Online published supporting documents / guidance notes have not been updated to reflect current practice. • Performance data and / implementation progress is not routinely reported to Executive committees.
Wrexham Maelor Continuity – Phase 1 (Integrated Assurance and Approval Plan)	Reasonable	1	7	-	<p>We focused on the initial stages of the Phase 1 of the continuity work planned at Wrexham Maelor Hospital. This element of the works has been identified as a priority and fast-tracked ahead of the rest of the infrastructure programme.</p> <p>The key priorities for management attention identified were:</p> <ul style="list-style-type: none"> • That forward looking governance arrangements are adequately considered and key documents such as terms of reference, Project Execution Plan are updated to ensure adequate coverage. • Appoint a Senior Responsible Officer (SRO) for the Project and formalise handover arrangements for the new Project Director. • Formally agree/ complete the Cost Adviser's contract as a matter of priority.
Board Assurance Framework (BAF) & Risk Management	Limited	4	1	-	<p>The purpose of the audit was to consider the corporate risk management arrangements, including development of the BAF, and the oversight of Divisions, IHCs and Services risk processes.</p> <p>The significant matters requiring management attention include:</p> <ul style="list-style-type: none"> • There is no description of duties for the corporate risk management department within the Risk Management strategy 2022-2025 (version 10.0 RM01). • There is a lack of scrutiny and challenge to the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) due to the cancellations of the Risk Management Group meetings and the Quality, Safety and Experience Committee meetings. • A number of risks in the BAF do not have action plans noted, and detail varies, limiting

Title	Assurance Level	High	Medium	Low	Key Messages
					<p>the assurance provided on whether actions taken will address the risks identified.</p> <ul style="list-style-type: none"> • The Committee approval process pertaining to escalation/de-escalation of risks is not clear. • There is limited oversight of risk management arrangements within the Divisions/IHCs due to numerous meetings being stood down. • The Health Board and Audit Committee meetings are not provided with the CRR and BAF in line with the frequency stated within the Risk Management strategy 2022- 2025 (version 10.0 RM01), limiting effective scrutiny and challenge of risks.
Performance management and accountability arrangements	Limited	2	1	-	<p>The purpose of the review was to consider the process in place to ensure the Health Board is provided with information on appropriate performance measures in line with the NHS Performance Framework, and that delivery of performance is adequately scrutinised at accountability meetings. The significant matters requiring management attention include:</p> <ul style="list-style-type: none"> • Performance information provided to the Health Board and its Committees has been subject to recent review, with enhanced reporting provided in May 2023. Consideration needs to be given to the information provided at Committees and subsequent assurance arrangements to the Board, to ensure the Board are focused on significant matters. • There is a process in place for collation of data and narratives to support the information in the performance report, however there is no documentation setting out the process, including roles and responsibilities, data standards, systems used etc. • Improvement actions stated in performance reports are not subject to review to confirm whether actions are completed and have positively impacted performance. Further development of performance assurance is required.

Title	Assurance Level	High	Medium	Low	Key Messages
					<ul style="list-style-type: none"> Accountability meetings are taking place, however these have not been consistent over a period of time and the process for recording and updating actions requires review and improvement.
Data analysis – Triangulation of data	Limited	3	-	-	<p>The purpose of the review considered how information/data within the Health Board was triangulated to ensure possible areas of risks are identified and are subject to scrutiny. We recognised the appetite to develop greater use and reporting of data quality across the different data systems; this must be developed at pace to ensure the Health Board can identify outliers/opportunities to share best practice from the data it already has. The following areas of significance were identified:</p> <ul style="list-style-type: none"> There are issues concerning data quality in Datix which will have a direct, negative impact on the Health Board's ability to rely on the output. The evidence we received from operational services shows a range of data being reported to their Patient Safety related meetings. There are opportunities for all to build on this base to enhance the use of all data sets to support delivery of safe, quality patient care. There is no standard reporting template in use across the Health Board that stipulates the minimum quality and safety metrics/information that should be reported for operational scrutiny. Quality, Safety and Experience Committee Members should determine the data they require to discharge their delegated responsibilities by the Board for assurance.
Planned Care Recovery and Transformation Group	Limited	2	-	-	<p>We reviewed whether the Planned Care Recovery and Transformation Group is operating in line with the requirements set out in the Terms of Reference. The review was limited to the operation of the Group and has not validated the data reported.</p> <p>The following issues were identified in the review:</p> <ul style="list-style-type: none"> The Group has not met since December 2022, we are therefore unable to confirm that it is

Title	Assurance Level	High	Medium	Low	Key Messages
					<p>fulfilling its responsibility to provide assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented. We are advised there are resource issues affecting this.</p> <ul style="list-style-type: none"> • The Group is required to receive regular reports from groups / meetings taking forward planned care, however there is no consistency or standard template for the reporting. • From the meetings that took place, there is no evidence of issues for escalation being discussed and escalated. • There is no regular reporting to the Performance, Finance and Information Governance Committee, and the Transformation Executive Delivery Group.
Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	Limited	3	-	-	<p>The audit considered if the controls in the engagement of Executive/Very Senior Managers (including Interim) comply with the requirements issued by Welsh Government; and if Interim appointments comply with the requirements of the Health Board Standing Orders and associated governing documents. The significant matters which require management attention include:</p> <ul style="list-style-type: none"> • Non-compliance with the Reservation of Powers to the Full Board in the appointment of Officer Members of the Board (Executives) or approval of the appointment of other Board level/senior employees – We believe the Model Standing Orders may require review as the Full Board includes Executive Directors; in our view, only the Chief Executive should be involved in their appointment along with Independent Members of the Board. • Expected controls outlined by the WG Director General/Chief Executive NHS Wales and Director of Workforce & OD NHS Wales have not been complied with. The Health Board has acted outside its powers in agreeing a salary for one officer in our sample (having sought and received retrospective approval from Welsh Government during this

Title	Assurance Level	High	Medium	Low	Key Messages
					<p>review).</p> <ul style="list-style-type: none"> • Repeated non-compliance with controls governing the engagement of interims/agency appointments; it appears the norm for an initial appointment to be extended more than once without seeking further competition or approval. We are unable to provide any assurance of value for money in some engagements where individuals move posts. • The R&TS Committee is not receiving assurance that expected controls around Welsh Government instructions/Health Board's own governing documents/first line of assurance are complied with.
Contracted patient activity – Quality & Safety arrangements	No assurance	4	-	-	<p>The review considered whether there were effective quality and safety contract monitoring arrangements in place where the Health Board has contracted services outside of NHS Wales. The review focussed solely on services commissioned from English NHS providers. We found that:</p> <ul style="list-style-type: none"> • There is no Commissioning Assurance Framework, Policy, or Standard Operating Procedure (SOP) in place to support the Health Board healthcare commissioning / contracting process. • Lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are not clearly defined. • The majority of providers are not meeting their contractual obligations to provide required quality information. • Where quality data is received, it is not subject to review or scrutiny. • The Health Board is not provided with assurance that the quality of providers care is adequate. • There is an inconsistent approach to data sharing / distribution and engagement with providers. • The role and remit of the Quality Team in the

Title	Assurance Level	High	Medium	Low	Key Messages
					review and scrutiny of quality aspects of provider performance is not defined.

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
GP Out of Hours	Draft report – awaiting management response	31 August 2023	28 September 2023

Fieldwork

5. The following 2023/24 reviews are currently in progress:

- Falls Management.
- Digital Operating Model.
- Lessons learnt.
- Adult and Older Persons IAAP.
- Follow up – Welsh Language Commissioner – Documents on the website.
- Special Measures - Contract Procurement review.
- Decarbonisation.
- Corporate Legislative Compliance – water safety.

Contingency/Organisational Support/Advice

6. Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.
7. 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

8. The additional support provided to the Health Board with focused reviews is channelled through contingency.
9. As new risks are identified in year, the Board Secretary and internal audit consider the planned reviews against the emerging high-level risks. Following a risk-based assessment of the current plan with the interim Board Secretary in January 2023, the following reviews were recommended to the Executive Team for deferment / removal from the plan:

Table 3: Audit reviews recommended for deferral or removal from the 2023-24 plan

Audit Title	Reason for requesting deferral / removal from plan
Workforce Strategy: Operational implementation (Deferred from 22/23)	Welsh Government commissioned a review following Special Measures focusing on the People & OD Strategy with a report being issued. Undertaking a review now would add no value to the Health Board as management are aware of the gaps/issues, with actions from Special Measures to be factored into a refreshed strategy. It is recommended this review is deferred to Quarter 1 2024/25 to enable a Board approved Strategy refresh.

10. 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.
11. Table 4 is reporting a positive status across all indicators. Figures are based on five 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%

12. Following completion of audits we issue a Post Audit Questionnaire to key staff involved in the review. A total of three responses have been received since March 2023. The illustration below summarises the key words used to describe our service and how it is viewed by staff.



Table 5 – Core Plan 2023-24 (April to September 2023)

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Contract award and management	September	Review in progress.	
Financial Control: Receipting of goods and year-end accruals	April	Final report issued.	Reasonable
Accounts Receivable	June	Final report issued.	Reasonable
Clinical Audit: Tier 1 National Audits	June	Final report issued.	Limited
Falls management	June	Review in progress.	
Lessons learned	July	Review in progress.	
Cyber security	April	Final report issued.	Substantial
Digital Operating Model	June	Review in progress.	
GP Out of Hours (Deferred from 22/23)	June	Draft report issued.	Limited
Workforce Strategy: Operational implementation (Deferred from 22/23)	June	Deferred.	
Decarbonisation	September	Brief agreed	
Adult and Older Persons Mental Health Unit (IAAP)	April - September	Review in progress.	
Corporate Legislative Compliance: Water Safety	June	Brief agreed	
Hergest Unit Notice of Contravention (NoC) Action Plan	June	Final report issued.	Limited
Follow up - Delivery of HB Savings	October	Deferred to October to accommodate Contract Procurement review	
Follow up - Welsh Language Commissioner - Documents on the Website	August	In progress	

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.
	No 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.

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.

Contracted Patient Services: Quality and Safety Arrangements

Final Internal Audit Report

June 2023

Betsi Cadwaladr University Health Board



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Review reference:	BCU-2223-19
Report status:	Final
Fieldwork commencement:	20 March 2023
Fieldwork completion:	22 May 2023
Debrief correspondence sent:	23 May 2023
Draft report issued:	24 May 2023
Management response received:	21 June 2023
Final report issued:	22 June 2023
Auditors:	Rhys Jones, 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:	Steve Webster, Interim Executive Director of Finance Mandy Jones, Deputy Executive Director of Nursing Christine Lynes, Deputy Director of Nursing Matthew Joyes, Deputy Director of Quality Adrian Tompkins, Associate Director of Healthcare Contracting Tracy Pope, Head of Healthcare Contracts Gillian Milne, Head of Healthcare Contracting, Finance Dylan Jones, Senior Contracts Manager, Finance 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 Institute of Internal Auditors

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.

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Executive Summary

Purpose

The review has considered whether there are effective quality and safety contract monitoring arrangements in place where the Health Board has contracted services outside of NHS Wales. The review focussed solely on services commissioned from English NHS providers.

Overview

We have issued no assurance on this area. The significant matters which require management attention include:

- There is no Commissioning Assurance Framework, Policy, or Standard Operating Procedure (SOP) in place to support the Health Board healthcare commissioning / contracting process.
- Lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are not clearly defined.
- The majority of providers are not meeting their contractual obligations to provide required quality information.
- Where quality data is received, it is not subject to review or scrutiny.
- The Health Board is not provided with assurance that the quality of providers care is adequate.
- There is an inconsistent approach to data sharing / distribution and engagement with providers.
- The role and remit of the Quality Team in the review and scrutiny of quality aspects of provider performance is not defined.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

No assurance



Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.

Trend

n/a

Assurance summary¹

Objectives	Assurance
1 There is a process in place where the Health Board receives regular information from providers on the quality of service its patients receive and meet with providers as required and in line with contract requirements.	No
2 Where issues of concern are identified there is a process in place to ensure sufficient monitoring of the provider, including assurance on improvement actions.	No
3 There are appropriate reporting arrangements in place and assurance is provided to a Health Board Committee.	No

¹The 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 robust controls in place to manage and monitor the quality of services commissioned from English NHS providers, and roles and responsibilities are not clearly defined.	1	Design	High
2	English NHS providers are not meeting contractually agreed reporting requirements, and there are no formal mechanisms in place to ensure adherence to these requirements, monitor provider performance, and manage/escalate issues of concern.	1 and 2	Design	High
3	Standard quality measures are in place however there is no process to identify service specific quality risks and measures.	2	Operation	High
4	The Health Board or its Committees are not provided with any assurance regarding service quality, with reporting limited to financial performance only.	3	Design	High

1. Introduction

1.1 The Health Board is responsible for planning and securing the delivery of primary, community and secondary care services alongside specialist services for the population of North Wales. Whilst it delivers most services itself, there is often a need to contract with other health providers which offer specialist services which it cannot or does not have the capacity to do so e.g. major trauma.

The Health Board remains accountable for the quality of care its contractors deliver on its behalf and must have adequate arrangements in place to monitor the quality and safety its patients receive through effective contract and performance monitoring.

The purpose of this audit was to ensure there are effective quality and safety contract monitoring arrangements in place where the Health Board has contracted services outside of NHS Wales. Objectives of the review were:

- There is a process in place where the Health Board receive regular information from providers on the quality of service its patients receive and meet with providers as required and in line with contract requirements.
- Where issues of concern are identified there is a process in place to ensure sufficient monitoring of the provider, including assurance on improvement actions.
- There are appropriate reporting arrangements in place and assurance is provided to a Health Board Committee.

1.2 The following risks were identified at the outset of the review:

- Patients are exposed to risk of poor care which is not subject to scrutiny.
- Reputational damage to the Health Board.

1.3 This report is based upon the information provided by the Deputy Executive Director of Nursing, Deputy Director of Nursing, Deputy Director of Quality, Head of Healthcare Contracts, Head of Contracting – Finance, Senior Contracts Manager – Finance, 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 is a process in place where the Health Board receives regular information from providers on the quality of service its patients receive and meet with providers as required and in line with contract requirements.

2.1 At the end of the March 2023, Betsi Cadwaladr University Health Board (the Health Board) had six hundred and thirty-seven (637) active healthcare expenditure contracts in place with service providers, with an approximate total contract value of three hundred and sixty-four million pounds (£364m). The following table (Table 1) summarises the total number of contracts by type of care and anticipated value (in £millions):

Table 1: BCU Healthcare Contract value and number by Type.

Type of Care	Total Number	Anticipated Value £'million
Secondary / Specialist / Tertiary Care (inc. Insourcing/Outsourcing)	45	241.6
Care Homes / Domiciliary Care	266	76.0
Community Care / General Support and Signposting	131	21.5
Learning Disability / Mental Health / Secure Hospitals	150	11.9
Diagnostics / Testing	28	10.9
Other	17	2.1
Grand Total	637	364

Source – BCU Healthcare Contracts Team.

2.2 The contracts above have been agreed with a broad range of Welsh/non-Welsh NHS and independent sector providers to ensure that the population of North Wales have access to specialist services that the Health Board cannot offer or does not have the capacity to do so. Some of the services provided are subject to their own specific care quality assurance, framework agreements or national oversight arrangements e.g. Continuing Healthcare placements, Commissioning Care Assurance Performance System (CCAPS), Welsh Health Specialised Services Committee (WHSSC) and Care Quality Commission in England (CQC).

2.3 For this review we focused solely on the established quality assurance procedures pertaining to the 14 contracted healthcare services commissioned directly from English NHS providers by the Health Board. The following table (Table 2) provides a summary of Health Board contract activity with English NHS providers for the 2022/23 financial year:

Table 2: English NHS provider contracts by value 2022/23.

English NHS provider	2022/23 Contract £m	As percentage of total	Performance reports received by the Contracting Team (✓)
Countess of Chester Hospital	27.9	39.6%	✓
Robert Jones & Agnes Hunt	15.2	21.6%	✓
Liverpool University Hospital NHS Trust	9.1	12.9%	✓
University Hospitals of North Midlands	6.1	8.7%	
Clatterbridge	4.3	6.1%	✓
Wirral Hospitals	2.2	3.1%	✓
Shrewsbury & Telford	1.7	2.4%	
South Manchester	1.4	2.0%	
Liverpool Women’s NHS Foundation Trust	1.2	1.7%	✓
University College London Hospital (UCLH)	0.8	1.1%	
Midlands Partnership Trust	0.2	0.3%	✓
Wrightington, Wigan & Leigh	0.2	0.3%	
Cheshire & Wirral	0.1	0.1%	
Shropshire Community Health Trust	0.1	0.1%	
Grand total	70.5	100%	

Source – BCU Healthcare Contracts Team.

Note – We are advised that the UCLH is a Service Level Agreement for specific services, with the main contract held by WHSCC.

- 2.4 The Health Board does not have an overarching mechanism in place to support the healthcare commissioning /contracting process i.e. Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP).
- 2.5 For English NHS providers contractual agreements are developed by the Health Board Healthcare Contracts Team using the NHS England Standard Contract template and are issued and agreed annually. The Contracts Team review and build upon the previous year agreements, adjusting where necessary. During the development phase, draft contract documents are shared with various Health Board services for review, comment, and additions / amendments.

2.6 Contracts agreed with English NHS providers include standard provisions for quality and reporting requirements: Schedule 4 - Local Quality Requirements, and Schedule 6 - Contract Management, Reporting and Information Requirements. We received copies of the 2022/23 contract agreements for the following providers: Countess of Chester Hospital, Robert Jones & Agnes Hunt, Midlands Partnership NHS Foundation Trust, Liverpool Women's, and Shrewsbury and Telford Hospitals. We reviewed the relevant Schedules and noted the following:

- Quality is primarily a measure of performance against national and local quality requirements. Examples include RTT waiting times, diagnostic test waiting times, outpatient follow up delay, A&E waits, cancelled operations, mental health, never events, and complaints. However, the quality standards whilst consistent across all contracts reviewed, did not capture patient experience or feedback.
- We confirmed that the Health Board Quality Team had engaged in the 2022/23 draft contract review process and had amended Schedule 4 as necessary.
- Reporting templates for the Activity and Finance Report, and Service Quality Performance Report were provided in all contracts reviewed.
- Target thresholds, Consequence of Breach, and timing of application of consequence, are outlined for each National Quality Requirement. Examples of Consequence of Breach include:
 - Formal escalation of performance reporting to the respective Boards and the submission of an Action/Recovery plan to BCUHB.
 - No consequence other than formal escalation of performance reporting to the respective Boards.
 - Issue of contract performance notice and subsequent process in accordance with GC9.
- Schedule 6 specified provider reporting and information requirements and as with Schedule 4 was consistent across all contracts reviewed.

2.7 English NHS provider contracts include provision to stipulate frequency of review meetings. Of the five contracts reviewed, only one (Robert Jones & Agnes Hunt) had specified monthly review meetings – the field in the other contracts reviewed were left as "Ad hoc/Monthly/Quarterly/Six Monthly". Despite this, the Health Board has established monthly contract review meetings with the Countess of Chester Hospital as well as Robert Jones & Agnes Hunt. The meetings, facilitated by the Contracting Team, are a forum to review activity, quality, and performance, and are an opportunity to raise concerns or issues of significance directly with the providers. Minutes and action logs are recorded for each meeting, however there is no formal process in place to feedback meeting outcomes to the Health Board. We were advised that any issues of significance raised at the meetings are escalated directly with relevant departments / services. The Contracting Team

confirmed that they do not hold regular contract review meetings with the other twelve English NHS providers.

2.8 We reviewed minutes from the last three Countess of Chester Hospital and Robert Jones & Agnes Hunt contract review meetings and confirmed that quality and safety were standing agenda items at both meetings. However, there was no Health Board Quality Team representation present at any of the six meetings reviewed – apologies were recorded in each instance. The Contracting Team advised that they invite the Quality Team to attend all contract review meetings, share and request comments on provider quality performance data, and ask whether they want any quality related issues to be raised at the meetings in their absence. However, the role and remit of the Quality Team in reviewing provider performance is not clear or defined; the Deputy Director of Quality confirmed this and advised that resource availability was a limiting factor impacting engagement.

2.9 We reviewed the management of commissioned English NHS provider performance reports, quality data, and information flow within the Health Board and found the following:

- English NHS provider contract activity and performance reports are submitted to the Health Board Contracting Team.
- Despite inclusion in contractual agreements the Contracting Team currently only receive performance reports from seven of the fourteen (50%) English NHS providers (85.3% by contract value).
- The approach to information sharing and distribution of provider activity, quality, and performance data within the Health Board is inconsistent and not formally documented. The Contracting Team share provider data for the Countess of Chester Hospital and Robert Jones & Agnes Hunt with the Quality and Performance Teams as part of the monthly contract review meeting distribution. Additionally, maternity performance data relating to the Countess of Chester Hospital contract is also shared monthly with the Health Board Maternity Service – this arrangement was agreed following our 2022/23 review of Maternity Services: Cross-Border Arrangements. However, the Contracting Team do not routinely distribute the quality and performance data of other commissioned English NHS providers to Health Board services or other corporate functions.
- The Contracting Team undertakes basic validation checks of the data to facilitate payment i.e., confirming that the patients fall under BCUHB's responsibility, querying miscoding and duplications. However, they do not review or verify quality or clinical information.
- The Health Board Deputy Director of Quality confirmed that the Quality Team do not routinely review provider quality or performance data. He advised resource availability is a limiting factor, and the role of the Quality Team in reviewing provider information is not defined.

- NHS England healthcare providers are subject to external / third-party quality assurance (e.g., Care Quality Commission). However, these sources are not used to support or inform the Health Board's commissioned services quality assurance process.
- The Health Board Deputy Executive Director of Nursing and Deputy Director of Nursing stated that they do not receive any assurance regarding commissioned service patient quality issues, nor do they receive regular activity / performance reports relating to commissioned services from English NHS providers.

2.10 The Contracting Team advised that provider reporting requirements had been eased significantly during the COVID19 pandemic following English national guidelines, with financial year being. We confirmed that prior to the pandemic the Contracting Team maintained a spreadsheet to record and manage English NHS provider contract performance data which enabled tracking of quality and performance measures over time. Whilst not currently in use, we believe that this approach could inform future monitoring arrangements.

Conclusion:

- 2.11 Quality, reporting, and information requirements are defined and specified in agreed contracts. However not all providers meet their contractual reporting obligations.
- 2.12 The Health Board does not have an overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) in place to support the Health Board healthcare commissioning / contracting process – consequently lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are not clearly defined. Whilst the Health Board does receive provider activity performance and quality data from some providers, quality is not subject to scrutiny or review.
- We have concluded **no** assurance for this objective.

Objective 2: Where issues of concern are identified there is a process in place to ensure sufficient monitoring of the provider, including assurance on improvement actions.

- 2.13 Contractual agreements include provisions for addressing and monitoring breaches in performance against quality measures, including escalation of reporting to respective Boards and the submission of an action / recovery plan to the Health Board. However, the effectiveness of these controls is significantly impacted by the following limitations:
- English NHS providers are currently not meeting contractually agreed reporting requirements – only seven of the fourteen providers submit monthly activity, quality, and performance data.
 - The quality data submitted is not routinely reviewed or subject to Health Board scrutiny.

- The current process is reactive – there are no formal mechanisms in place to identify and address declining trends in provider performance prior to threshold breach.
- Action / recovery plan requirements, form, content, and timescales for demonstrating improved performance are not defined.
- The Health Board does not have a formal process in place to support the management, monitoring, and escalation of action / recovery plans.

2.14 The quality measures stipulated in the contractual agreements are the same for all English NHS providers regardless of the service provided and are predominantly focused on accessibility. Service specific quality measures are not outlined in the contractual agreements and the measures in place do not capture patient experience or feedback.

2.15 There are no formal controls or mechanisms in place to identify and escalate quality issues that fall outside the agreed measures. The exception to this is the maternity data provided by the Countess of Chester, which was agreed following quality concerns raised by the Health Board maternity service. It is not clear whether service specific quality concerns or issues of significance would be identified from the standard quality measures.

Conclusion:

2.16 The Health Board does not have robust arrangements in place to ensure effective monitoring of quality issues and concerns for services commissioned from English NHS providers. Whilst provider expectations, obligations, and requirements are specified in contractual agreements, there are no formal mechanisms in place to ensure adherence and manage and escalate issues of concern.

We have concluded **no** assurance for this objective.

Objective 3: There are appropriate reporting arrangements in place and assurance is provided to a Health Board Committee.

2.17 We reviewed current reporting arrangements to establish what assurance the Health Board and / or Committees receive regarding the quality of services commissioned from English NHS providers. We reviewed the agendas and minutes for the last three held Health Board Meetings, Quality Safety and Experience Committee (QSE), Performance Finance and Information Governance Committee (PFIG), and Partnerships People and Population Health Committee (PPPH), and noted the following:

- No assurances were provided to the Board or Committees regarding the quality of English NHS provider services during the period reviewed (September 2022 to March 2023).
- English NHS provider quality measures data is not routinely reviewed or reported, and therefore is not subject to wider Health Board scrutiny.

- We found examples of quality and assurance considerations for specific service contractual arrangements, for example Timely Access to Care Homes, CHC, Neurodevelopment, Quality and Improvement Outcomes Monitoring Framework for Third Sector Contracts, however English NHS provider reporting was limited to financial performance / information only.
- The Contracting Team submit an External Contracts Update paper to the Performance Finance and Information Governance Committee (PFIG) every six months. The report focusses primarily on financial performance. We reviewed the paper and relevant meeting minutes and confirmed that no questions, concerns, or issues of significance regarding quality were noted. We reviewed other key routine Health Board performance reports (Quality and Performance Report, Finance Report, Monitoring Return) and again found that English NHS provider quality issues and / or performance were not featured.
- A 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 following referral to a commissioned NHS Hospital Trust in England was presented at the November 2022 Quality Safety and Experience Committee (QSE) and referred to in the subsequent Board meeting (Quality and Patient Safety Report - 24th November 2022). No wider assurance was sought, nor questions, concerns, or issues of significance raised by Board or Committee members regarding the quality of commissioned services, per the minutes reviewed.

2.18 We were advised that a Healthcare Contract Assurance Group was established during 2021 to support the assurance provided to the Quality Safety and Experience Committee (QSE) and Performance Finance and Information Governance Committee (PFIG). There is a Terms of Reference for the Group, however it is not dated. It notes the following:

"In order to ensure the robustness of contractual performance management, the aim of the Healthcare Contracts Assurance Group (HCAG) is to establish and oversee a robust assurance process, supporting Area, Secondary Care, Women's Division, Mental Health & Learning Disability Division (the commissioners), Quality, Finance, Planning and Performance Departments to work in a multidisciplinary approach to support overall contract management arrangements".

2.19 The Healthcare Contract Assurance Group Terms of Reference outlined the purpose of the Group, membership, governance and reporting structures, secretariat and administration, and meeting details. Standard agenda items were also detailed and comprised:

- Performance (report from Performance Team including an analysis of reports received/provided to external providers commissioners).
- Quality (report from Quality Team including an analysis of reports received / provided to external providers commissioners).

- Finance (report from Contracts Finance Team on income and expenditure contracts).
- Contracts (report from HCT update on ongoing work and overview of current issues including exception reports where the procurement process has not followed SFI's and an overview of Single Tender Waiver requests and approvals).
- WHSSC (report from WHSSC update on ongoing work and overview of current issues).
- Informatics –a report by exceptions - general overview of issues.

2.20 Though we did not verify this, we were advised that the Group had not met since December 2021 due to ongoing discussions at the time concerning the governance structure of the Group and poor meeting attendance.

2.21 As outlined above, the Health Board does not have an overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) in place to support the Health Board healthcare commissioning / contracting process therefore reporting requirements are not defined.

Conclusion:

2.22 The Health Board does not have robust reporting or governance arrangements in place to support effective oversight of the quality of services commissioned from English NHS providers. There has been no assurance provided to the Health Board or its Committees during the period reviewed, and we found no evidence of quality data review or scrutiny. With limited controls and oversight there is a risk that the Health Board will fail to identify service quality issues that adversely impact patient care whilst also leaving the Health Board wholly dependent on the English NHS Trust or third-party to notify them of any quality issues after the fact.

We have concluded **no** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Process management (Design)		Impact	
<p>The Health Board does not have an overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) in place to support the healthcare commissioning / contracting process. Lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are not clearly defined.</p> <p>We reviewed current practice and noted the following issues and limitations:</p> <ul style="list-style-type: none"> • The role and remit of the Quality Team and Contracting Team in reviewing provider quality information is not clear. • Inconsistent distribution of provider quality data. • No evidence of quality performance data review or scrutiny. • Action / recovery plan requirements, form, content, and timescales for demonstrating improved performance are not defined. • There is no formal process in place to support the management, monitoring, and escalation of action / recovery plans. 		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Lack of clarity and consistency. • Lack of transparency and ownership. • Lack of engagement. • No review or scrutiny. 	
Recommendations		Priority	
1.1	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	
Agreed Management Action		Target Date	Responsible Officer
1.1	1. The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning,	31/07/2023	Associate Director of Healthcare Contracting. Deputy Director of Quality.

	<p>performance management, business intelligence / analysis and other professional services that input to contract management both where the health board is commissioner and provider.</p> <p>2. The Health Board will develop a training package for staff engaged in the contract management process to support the delivery of the CAF.</p> <p><i>Note: the development of the CAF is likely to identify significant gaps in resource across functions in respect of meeting the organisational need identified in this audit, which would therefore be subject to a business case to achieve the required improvement in contract management practices including quality oversight.</i></p>	<p>31/08/2023</p>	<p>Associate Director of Healthcare Contracting.</p>
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Matter Arising 2: Contractual obligations (Design)		Impact	
<p>English NHS providers are not meeting contractually agreed reporting requirements. Of the fourteen contracted English NHS providers only seven submit monthly activity, quality, and performance data.</p> <p>Whilst provider expectations, obligations, and requirements are specified in contractual agreements, there are no formal mechanisms in place to ensure adherence and manage and escalate issues of concern.</p> <p>The Health Board hold contract review meetings with only two of the fourteen English NHS providers.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Failure to meet contractual obligations. • Quality and performance data not submitted therefore not subject to review and scrutiny. • Lack of oversight. 	
Recommendations		Priority	
2.1	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	
Agreed Management Action		Target Date	Responsible Officer
2.1	1. The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings.	31/07/2023	Associate Director of Healthcare Contracting. Deputy Director of Quality.
	2. The Health Board will ensure all agreements with Providers are backed up by a signed contract.	31/08/2023	Associate Director of Healthcare Contracting.
	3. The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements.	31/08/2023	Associate Director of Healthcare Contracting

	<p>4. The Health Board will review re-establish the internal monitoring of Provider reporting returns to include the escalation process should information not be provided.</p>	<p>31/08/2023</p>	<p>Associate Director of Healthcare Contracting.</p>
	<p>5. The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective.</p>	<p>31/08/2023</p>	<p>Associate Director of Healthcare Contracting.</p>

Matter Arising 3: Quality measures (Operation)		Impact	
<p>The quality measures stipulated in contractual agreements are the same for all English NHS providers regardless of the service provided and are predominantly focused on accessibility. Service specific quality measures are not outlined in the contractual agreements and the measures in place do not capture patient experience or feedback. It is not clear whether service specific quality concerns or issues of significance would be identified from the standard quality measures, and there are no formal controls or mechanisms in place to identify and escalate quality issues that fall outside the agreed measures.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Ineffective quality measures. • Quality issues missed / not visible in data provided. • Quality issues not escalated and addressed. • Patient care not of expected standard. 	
Recommendations		Priority	
3.1	Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	High	
3.2	Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	High	
Agreed Management Action		Target Date	Responsible Officer
3.1	<p>1. For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements.</p> <p>2. The Health Board will review its quality measures and develop a standard suite of measures, retaining the flexibility to include contract specific measures including the capture of patient feedback and will seek to negotiate these into contract documents with Providers. This will take effect from the next contract period – 2024/2025.</p>	<p>30/08/2023</p> <p>31/03/2024</p>	<p>Associate Director of Healthcare Contracting.</p> <p>Associate Director of Healthcare Contracting.</p> <p>Deputy Director of Quality.</p>

	<p>3. The Health Board will, as part of the Commissioning Assurance Framework, review information already produced by Providers, Regulators etc and as part of that review assess what assurance can be taken from these sources and how that can be captured and utilised by the Health Board e.g. Lead Commissioner / CQC.</p>	<p>31/07/2023</p>	<p>Associate Director of Healthcare Contracting.</p>
<p>3.2</p>	<p>1. The Health Board will, as part of the Commissioning Assurance Framework mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required.</p>	<p>31/10/2023</p>	<p>Associate Director of Healthcare Contracting. Deputy Director of Quality.</p>

Matter Arising 4: Board assurance (Design)		Impact	
<p>There has been no assurance provided to the Board or Committees regarding the quality of English NHS provider services during the period reviewed (September 2022 to March 2023).</p> <p>English NHS provider quality measure data is not routinely reviewed or reported therefore is not subject to wider Health Board scrutiny. Reporting was limited to financial performance only.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Limited oversight and scrutiny. Lack of transparency. 	
Recommendations		Priority	
4.1	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	
Agreed Management Action		Target Date	Responsible Officer
4.1	<p>1. The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF.</p> <p>2. The CAF will establish the reporting requirements and governance process for Contract Management including the reestablishment of the Healthcare Contracts Assurance Group and the onward flow of reports regarding Finance, Performance and Quality including escalation routes.</p>	<p>31/10/2023</p> <p>31/08/2023</p>	<p>Associate Director of Healthcare Contracting. Deputy Director of Quality.</p> <p>Associate Director of Healthcare Contracting.</p>

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.
	No 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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Recruitment of Substantive and Interim Executive and Senior Posts (ESP)

Final Internal Audit Report

May 2023

Betsi Cadwaladr University Health Board



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University Health Board



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Committee:	Audit Committee



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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit 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.

Executive Summary

Purpose

The purpose of the audit was to assess if the controls in the engagement of Executive/Very Senior Managers (including Interim) comply with the requirements issued by Welsh Government; and if Interim appointments comply with the requirements of the Health Board Standing Orders and associated governing documents.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- Non-compliance with the Reservation of Powers to the Full Board in the appointment of Officer Members of the Board (Executives) or approval of the appointment of other Board level/senior employees – We believe the Model Standing Orders may require review as the Full Board includes Executive Directors; in our view, only the Chief Executive should be involved in their appointment along with Independent Members of the Board.
- Expected controls outlined by the WG Director General/Chief Executive NHS Wales and Director of Workforce & OD NHS Wales have not been complied with. The Health Board has acted outside its powers in agreeing a salary for one officer in our sample (having sought and received retrospective approval from Welsh Government during this review).
- Repeated non-compliance with controls governing the engagement of interims/agency appointments; it appears the norm for an initial appointment to be extended more than once without seeking further competition or approval. We are unable to provide any assurance of value for money in some engagements where individuals move posts.

Report Opinion



Limited assurance

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Trend

N/A

Assurance summary¹

Objectives	Assurance
1 The engagement and approval of appointments on Job Evaluation for Senior Posts (JESP) pay scales is in line with Welsh Government and Standing Orders requirements.	Limited
2 The engagement of interim appointments is compliant with Standing Orders and associated governing documents for posts over the equivalent top step point Band 9 £109,475 (2022/23).	Limited
3 The R&TS Committee is provided with sufficient information on recruitment of executive and senior posts to enable efficient oversight and compliance with their responsibilities within the Terms of Reference.	Limited

¹The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

- The R&TS Committee is not receiving assurance that expected controls around Welsh Government instructions/Health Board's own governing documents/first line of assurance are complied with.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Overall compliance with WGs Chief Executive and Director of Workforce & OD, NHS Wales requirements for the recruitment of JESP/VSM posts is generally poor. Of concern is that none of the current Officer Members of the Board and Board level roles have received procurement training, mandated by the Chief Executive of NHS Wales.	1	Operation	High
2	There appears an over reliance on interim appointments who have been in post for a prolonged period of time, with extensions being the norm. We believe the process for managing and replacing interims is ineffective with an apparent lack of operational planning and management control.	2	Operation	High
3	The Remuneration & Terms of Service Committee does not receive sufficient information relating to JESP level/ equivalent senior appointments, and the compliance of these with Welsh Government instructions. This impacts on the ability of the Committee to provide advice to the Board, in line with its Terms of Reference.	3	Design	High

1. Introduction

1.1 Welsh Government wrote to all Directors of Workforce & OD and Board Secretaries on the 18 January 2018 concerning Executive and Senior Posts and to NHS Wales Chief Executives on the 25 June 2021, reinforcing the governance requirements in recruitment for Executive Directors and Very Senior Management (VSM) positions.

The Health Board Standing Orders - Schedule of Matters Reserved to the Board, are specific in the recruitment for the Chief Executive, Executive Directors, other Board level appointments and other senior employees (Reservation of Powers to the Full Board 24; 25 and 27).

The Board Remuneration and Terms of Service (R&TS) Committee Terms of Reference state it is delegated by the Board to provide:

2.1.1. Advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;

2.1.2. Assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales;

The Board, following endorsement from the Audit Committee on 30 June 2022, has implemented a revised Scheme of Delegation to Executive Directors, Other Directors and Operational Budget Managers to reflect arrangements for the new operating model, with responsibilities included for Delegated Matter 10 (f) Personnel and Pay and Delegated Matter 11 Engagement of Staff Not On the Establishment.

1.2 The sole risk considered in this review was:

- Standing Orders and Welsh Government requirements are not complied with.

1.3 The review was limited to evaluating compliance with Welsh Government expected controls in the recruitment of Executives and Very Senior Managers. We did not review the process concerning pre-employment checks.

1.4 Our sample was identified from individuals engaged by the Health Board between June 2021 to January 2023.

2. Detailed Audit Findings

This report is based upon the information provided by officers supporting our review. We would like to express our gratitude to Officers in Welsh Government (WG) and Health Board People & OD (POD) for their input during 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 of the information provided.

Objective 1: The engagement and approval of appointments on Job Evaluation for Senior Posts (JESP) pay scales is in line with Welsh Government and Standing Orders requirements

2.1 We were provided with a list of substantive appointments to Executive/Very Senior Managers (VSM) posts where the salary was paid was a JESP scale - we reviewed all seven substantive appointments and one secondment. We were advised by People & OD that the list did not include any existing employee placed into a role through the Organisational Change Process (OCP).

2.2 The Director General Health and Social Services/NHS Wales Chief Executive wrote to all NHS Wales Chief Executives on the 31 August 2017 and 25 June 2021 outlining expectations concerning 'Governance in Recruitment'.

The then Interim Director, Workforce & Organisational Development, Welsh Government (WG) wrote to all Directors of Workforce & OD and Board Secretaries on the 18 December 2018, concerning 'Executive and Senior Posts' and principles on recruitment. Using all correspondence, we identified expected controls the Health Board must adhere to in appointing to JESP salaries and reviewed evidence available to confirm the recruitment of all roles sampled adhered to these controls.

2.3 We identified areas of non-compliance with expected controls, as follows:

Post	1	2	3	4	5	6	7
Expected control							
WG contacted prior to recruitment and appointment stage	No	Yes	No	No*	No*	No*	No*
Role advertised widely	Yes	Yes	Yes	Yes	Yes	Yes	Yes
WG representative on the interview panel	Yes	Yes	Yes	No*	No*	Yes	No*
Evidence of Job Evaluation (JE)/ Salary per WG requirements	No - Appointment letter is £400 below the minimum point	Yes	Yes - Business case approved by WG 16 June 2022	Yes	No - Paid on top of band	No - Paid on top of band	Paid higher than WG JE; Business case sent 9 February 2023 for retrospective WG approval, interview 15 November 2021.

Post	1	2	3	4	5	6	7
Expected control							
							Retrospective Welsh Government approval received on the 17 March 2023, sixteen (16) months post interview date.
R&TS Committee paper on appointment	Yes	Yes	Yes	Yes	Op. Model	No	Yes
Board Approval (Reservation of Power 27)	Not evident						
Mandatory procurement training for Executive Directors/officers involved in procurement	No	No	No	No**	No**	No**	No**

Key:

* Confirmation from Welsh Government to Internal Audit, 17 February 2023, that there is a requirement for the lead Welsh Government official to take part in the appointment process for all posts on the ESP scale even when they are not Executive Directors/Chief Executive, as long as there is a professional lead in Welsh Government for the role.

** As Very Senior Managers, we consider the post holder will be involved in procurement.

- 2.4 Post 8 related to an NHS Wales secondment – we received a copy of the secondment agreement proforma which was unsigned by the seconding Health Board and Health Board.
- 2.5 We noted one role appointed to a Board level position was not a JESP salary but did review the appointment in line with the Standing Orders. Whilst noting an Independent Member and external assessor were on the panel, the Welsh Government representative sent apologies, however the recruitment process continued.
- 2.6 The review of compliance with Standing Orders – Schedule of Matters Reserved to the Board: Matters 24 and 27¹ state only the Full Board can appoint Officer Members, any other Board level appointments and other senior employees.

¹ <https://bcuhb.nhs.wales/about-us/governance-and-assurance/standing-orders-and-financial-instructions/standing-orders-and-financial-instructions/bcuhb-standing-orders-v24-may-2021/> (Page 60 of 92)

From our review we have been unable to confirm that the Full Board has appointed or formally minuted any of the Executive Directors or Board level appointments in our sample. R&TS Committee remit is limited and it has no delegated authority to approve appointments:

"3.2.1. Comment specifically upon:

• The remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;"

Consequently we are unclear that current appointments meeting this criteria comply with Standing Orders.

However, as the Full Board includes both Independent Members and Executive Directors, the Model Standing Orders may require review as, except for the Chief Executive (Accountable Officer), we are uncertain that other Executives should have an appointing role to other Executive/Board level appointments.

- 2.7 Of concern is that none of the current Officer Members of the Board and Board level roles have received procurement training, mandated by the Director General/Chief Executive of NHS Wales. Further, there has been a lack of engagement and notification between the Health Board and WG in appointing to JESP/VSM roles.

We have raised the matter of procurement training with both Interim Chief Executive and Interim Board Secretary on the 15 February 2023 but are unsighted if this has been progressed.

Conclusion:

- 2.8 Overall compliance with WGs Director General and Director of Workforce & OD requirements for the recruitment of JESP/VSM posts is generally poor. We note one post was appointed to a spot JESP salary above the actual job evaluation and minimum point and consider management acted without authority at the time – retrospective WG approval for this band was sought and received sixteen months post interview.

- 2.9 We have not seen evidence to support the appointment of individuals above the minimum point being considered by R&TS Committee (Posts 5 to 7 inclusive).

We have concluded **limited assurance** for this objective.

Objective 2: The engagement of interim appointments is compliant with Standing Orders and associated governing documents for posts over the equivalent top step point Band 9 £109,475 (2022/23)

- 2.10 We reviewed a sample of four bank and four agency engagements where the daily rate was over £533.45 per day (equivalent to £139,069.26 top of Band 9 with 27.03% on-cost). Our sample range varied between £700 and £1,726 per day, excluding any agency day rate fees.

2.11 The review has identified a range of compliance issues with Standing Orders, Welsh Government expectations and the Health Board's own standard operating procedure. We recognise that issues of compliance have been reported to R&TS Committee by People & OD (POD), but these matters continue.

2.12 A summary of our findings, including those identified by POD are noted as follows:

- Some Executive and Board level appointments have not followed Standing Order and/or Welsh Government recruitment requirements and none have received the mandatory procurement training.
- Interim Appointment Request (IAR) process was not followed for some appointments – this was also highlighted by POD to Committee.
- Breach of Standing Financial Instructions concerning No Purchase Order, No Pay where orders were raised retrospectively for some commitments – this was highlighted by POD to Committee.
- Movements of some individuals to other interim roles within the Health Board were not subject to open competition, consequently value for money in those appointments cannot be evidenced.
- The duration of interim engagements in our sample found the number of days ranged from a planned duration of 90 days to 607 days.
- Management agreed and committed to a six month period for one bank appointment and then moving to another bank post. POD evidence advising management this was 'unusual' for a bank engagement but was agreed by the Interim Chief Executive.
- There are no job descriptions for two agency appointments.
- The Scheme of Reservation and Delegation concerning *External consultancy support (total contract value for duration of service)* have been breached for three of the four agency engagements where it is evident engagements are extended more than once, thus circumventing further market testing:
 - One agency engagement has cost, to date, £729,760 against a purchase order (which has been extended several times) with no evidence that the Board and Chief Executive combined have approved.
 - Two further agency engagements and the review of requisition approval against respective purchase orders identified delegation from an Executive limit to individuals who have a lower delegated limit than the Executive.

2.13 We confirmed with WG whether there is a requirement for the lead WG official to take part in the appointment process for interim appointments (via agencies/Bank) where the agreed salary range is within the ESP pay scales/appointed to an ESP vacant post/pay scale. We were advised that they did not as *"...these are interim appointment **but we would expect the professional lead to be informed out of courtesy.**"*

Conclusion:

- 2.14 The controls and governance arrangements in place appear to be circumvented and there is a lack of joined-up oversight between People & OD and Financial processes.
- 2.15 The issues of non-compliance with the Scheme of Reservation and Delegation are concerning, with the current delegated matter *External consultancy support (total contract value for duration of service)* being easily by-passed without effective controls/checks in place – this operational delegation requires immediate attention.
- 2.16 There appears an over reliance on interim appointments who have been in post for a prolonged period of time, with extensions being the norm. We believe the process for managing and replacing interims is ineffective with an apparent lack of planning and management control to progress to a substantive appointment.
- 2.17 It is unclear how individuals can be appointed to any role, performance managed and/or appraised where no job description exists. This practice should, in our view, cease.

We have concluded **limited assurance** for this objective.

Objective 3: The R&TS Committee is provided with sufficient information on recruitment of executive and senior posts to enable efficient oversight and compliance with their responsibilities within the Terms of Reference

- 2.18 The Remuneration and Terms of Service (R&TS) Committee's Terms of Reference (ToR) purpose is to provide:

2.1.1. Advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government.

And further it is delegated and authorised by the Board to:

3.2.1. Comment specifically upon:

- The remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently.*

- 2.19 The Committee meetings held between 1 September 2022 and 22 December 2022 received reports from People & OD. These vary in detail, with only the report in September 2022 including an update on interim appointments in addition to Executive and Director appointments.

- 2.20 The report identified the following issues of non-compliance:

- Lack of Independent Member attendance at interview.

- Standing Financial Instructions – breach of No Purchase Order, No Pay as the requisitions and orders were raised after the engagement.
- Interim Appointment Request (IAR) procedure not followed or completed for some appointments.

2.21 A review of reports submitted solely for Executive and other senior staff identified:

- Reporting of Agenda for Change appointments (8D and 9) – this is not required per the Committee ToR.
- Not all JESP related/equivalent appointments are reported to the Committee for consideration, subsequent reporting to the Board or to confirm whether they were compliant with the Welsh Government instructions for VSM/JESP appointments. This does not comply with the ToR or Standing Orders – Schedule of Matters Reserved to the Board: Matters 24 and 27².
- Reports do not include the on-going cost of engagements/ or timescales for when management are set to recruit substantively.
- Management changes to post titles which the Board have not approved, as they impact the Operating Model structure.
- There is ambiguity concerning what agency/interim appointments constitute VSMs. It is unclear whether it is the day rates (per engagement) or whether they are backfill for an Agenda for Change post/JESP salaried role.

Conclusion:

2.22 The reporting to the Remuneration & Terms of Service Committee requires immediate overhaul to ensure it delivers against its purpose and the delegation from the Board.

2.23 Committee Members must be involved in determining the information they require for assurance and reporting/recommending to the Board.

We have concluded **limited assurance** for this objective.

² <https://bcuhb.nhs.wales/about-us/governance-and-assurance/standing-orders-and-financial-instructions/standing-orders-and-financial-instructions/bcuhb-standing-orders-v24-may-2021/> (Page 60 of 92)

Appendix A: Management Action Plan

Matter Arising 1: Appointment of substantive JESP/VSM Posts (Operating)		Impact	
<p>We found the Health Board was not compliant with several mandatory requirements as issued between 2017 and 2021 from both Chief Executive and NHS Wales, and the Director of Workforce & OD at NHS Wales, Welsh Government.</p> <p>Further we found that some appointments to both Executive, other Board level and Very Senior Manager posts are not compliant with Standing Orders – only the Health Board as such can appoint Executive and</p> <p>Of concern is that none of the current Officer Members of the Board and Board level roles have received procurement training, mandated by the Director General/Chief Executive of NHS Wales.</p>		Non-compliance with Health Board Standing Orders and instructions directed by Welsh Government.	
Recommendations		Priority	
1.1	Management must ensure all appointments to JESP/VSM roles are fully compliant with Welsh Government instructions and Health Board Standing Orders.	High	
1.2	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.		
Agreed Management Action		Target Date	Responsible Office
1.1	A new standard operating procedure, linked to a new WP1 safe recruitment policy, for all JESP/VSM appointments will be implemented. The new SOP will encompass reporting of compliance relating to Welsh Government instructions and Health Board standing orders, and will detail the lead officer for each area of responsibility.	31 st July 2023	1.1 The office of the Executive Director of People & OD
1.2	A new procurement training competence will be added to all JESP/VSM positions into ESR which will link to the training course needed to acquire the competence. This will be visible alongside all mandatory training for senior managers and enable effective reporting alongside all training requirements for the individuals.	1.2 31 st July 2023	

Matter Arising 2: Standing Orders Compliance (Operation)		Impact	
<p>There appears an over reliance on interim appointments who have been in post for a prolonged period of time. In our limited sample this ranges from ninety (90) to six hundred and seven (607) days, with extensions being the norm. This circumvents the established Scheme of Reservation and Delegation financial limits.</p> <p>Two interim appointments were appointed without a job description, and some other engagements were moved between roles without any further open competition. We noted one bank appointment was provided with a period of engagement which does not comply with the principles of a bank appointment.</p> <p>Our correspondence with Welsh Government relating to their involvement in the appointment process, confirms for interim appointments "...we would expect the professional lead to be informed out of courtesy." This has not happened.</p> <p>Reports from People & OD to the Remuneration and Terms of Service Committee, we noted non-compliance with Standing Financial Instructions concerning No Purchase Order, No Pay, as requisitions and due process had not been followed prior to start date. We found no consequence for breaches of compliance and how these are addressed.</p>		Non-compliance with internal controls and standing orders.	
Recommendations		Priority	
2.1	<p>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.</p> <p>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.</p>	High	
Agreed Management Action		Target Date	Responsible Office
	2.1a A recent revision to the standard operating procedure F18, senior non-clinical agency interim engagements (v11) now incorporates a maximum contract length of 4 month for every request. Similarly, the Executive Director of Finance is now a co-approver of all new interim requests. A	2.1a June 2023	The office of the Executive Director of People and OD

	<p>further addition will be made that will require a full contract value calculation to be undertaken by the requesting manager upon submitting the IAR, which will be validated against their SFI limits. This will require the requestor to liaise with their finance CFO to accurately quantify the total cost of the interim engagement.</p> <p>2.1b Non-compliance with WG required processes, Standing Orders and SFIs will be reported to RTS (quarterly) and PFIG (monthly). Repeated non-compliance with process, by a single department, will be escalated to audit committee; the parameters of which will be defined in the response to point 3 below.</p> <p>Upon requesting an interim worker for a VSM post, the IAR form will be updated so the requestor will be asked to confirm they have been in contact with WG head of profession. The recruitment team will ensure all VSM posts are communicated to the relevant WG leads before any appointment is confirmed.</p>	<p>2.1b June 2023</p>	
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Matter Arising 3: Remuneration & Terms of Service Committee – Reports for assurance (Design)		Impact
<p>The reporting to the Remuneration and Terms of Service (R&TS) Committee requires immediate overhaul to ensure the Committee delivers against its purpose and the delegation from the Board.</p> <p>Not all JESP related/equivalent appointments are reported to the Committee for consideration or whether they were compliant with the Welsh Government instructions for VSM/JESP appointments. This does not comply with the Terms of Reference or Standing Orders – Schedule of Matters Reserved to the Board: Matters 24 and 27.</p> <p>Reports do not include the on-going cost of engagements/when management are set to recruit substantively. We also found management changes to post titles which the Board have not approved, as they impact the Operating Model structure.</p> <p>The Committee cannot approve any appointment but advise and comment for the Full Board’s consideration. There is ambiguity concerning what agency/interim appointments constitute VSMs/Senior Employees.</p>		<p>The R&TS Committee is over-burdened on matters outside its delegated remit and does not receive the required information for it to discharge its ToR.</p>
Recommendations		Priority
3.1	<p>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.</p>	High
Agreed Management Action		Responsible Officer
	<p>3.1 R&TS committee Terms of Reference is being updated and will be ratified in May 2023. The R&TS committee will define the required parameters of the reporting structure and make it’s recommendations to board.</p> <p>3.2 A new reporting template for R&TS and the Executive Management Team will be implemented, to incorporate all JESP/VSM appointments, both interim and substantive, and whether the appointments are compliant with standing orders, SFIs and WG Instructions. In addition, the report will include details of permanent recruitment timeframes when a post has been filled by an interim.</p>	<p>Office of the Board Secretary</p>
		<p>3.1 30th September 2023</p> <p>3.2 Q3 R&TS meeting</p>

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.
	No 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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Planned Care Recovery & Transformation Group Final Internal Audit Report

June 2023

Betsi Cadwaladr University Health Board



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Committee:	Audit Committee



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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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Executive Summary

Purpose

To review whether the Planned Care Recovery and Transformation Group is operating in line with the requirements set out in the Terms of Reference. The review was limited to the operation of the Group, and has not validated the data reported.

Overview

We have issued limited assurance on this area. The matters requiring management attention include:

- The Group 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. We are advised there are resource issues affecting this.
- The Group is required to receive regular reports from groups / meetings taking forward planned care, however there is no consistency or standard template for the reporting.
- From the meetings that took place, there is no evidence of issues for escalation being discussed and escalated.
- There is no regular reporting to the Performance, Finance and Information Governance Committee, and the Transformation Executive Delivery Group.

Report Opinion

		Trend
 <p>Limited</p>	<p>More significant matters require management attention.</p> <p>Moderate impact on residual risk exposure until resolved.</p>	N/A

Assurance summary¹

Assurance objectives	Assurance
1. The information received at the Group is in line with the responsibilities set out within the Terms of Reference, and includes sufficient detail to enable informed discussions and decision making.	Limited
2. The group receives regular highlight reports from the meetings and groups outlined in the Terms of Reference.	Limited
3. Actions are captured and monitored, with areas of concern / slippage escalated as required..	Limited
4. There is regular and adequate reporting through the Performance, Finance and Information Governance Committee and the Executive Delivery Group.	Limited

¹ The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	There is insufficient evidence to demonstrate the Group is discharging its responsibilities as outlined in the agreed Terms of Reference, and the group has not been meeting regularly.	1	Operation	High
2	Reporting mechanisms to receive and provide assurance are not operating consistently, with a lack of evidence to demonstrate agreement of issues for escalation and information to be reported to the Performance, Finance and information Governance Committee and the Transformation Executive Delivery Group.	2/3/4	Operation	High

1. Introduction

- 1.1 In April 2022, the Welsh Government published *Our programme for transforming and modernising planned care and reducing waiting lists in Wales* which outlined the steps needed to "...ensure people waiting for appointments and treatment are seen as quickly as possible and in order of clinical priority."
- 1.2 The remit of the Planned Care Recovery and Transformation Group (PCRTG) includes providing assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented. The primary focus of the group is:
- Delivery of agreed activity and financial plans
 - Treatment of Patients
 - Transformation of Services
- 1.3 The review was limited to whether the Group is discharging its responsibilities in line with the agreed Terms of Reference.
- 1.4 The potential risks considered at the outset of the review were as follows:
- Welsh Government requirements are not complied with;
 - Impact on quality of care and patient experience, resulting in potential patient harm.

2. Detailed Audit Findings

The findings in this report are based upon the information provided by Health Board officers. We would like to express our gratitude to colleagues 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 of the information provided.

Objective 1 - The information received at the Group is in line with the responsibilities set out within the Terms of Reference, and includes sufficient detail to enable informed discussions and decision making.

- 2.1 A final version of the Group Terms Of Reference was issued in June 2022. This outlines the responsibilities of the Group, with the key ones being:
- *Align itself to the National Planned Care group, its Networks, local delivery and Improvement groups and oversee the local delivery plans and ensure implementation in line with national timelines.*
 - *Monitor the implementation, progress and delivery of the 6-point recovery plan and its associated work streams and projects ensuring timely delivery of key milestones are met. Ensuring the sustainable benefits where evidence suggests opportunities to improved safety, quality, outcome and efficiency are captured within the planning cycle of annual Planned Care plans.*
 - *Oversee and support the development and delivery of improvement programmes within the 4 designated work streams within an agreed timescale, ensuring intended outcomes (patient, quality, productivity, efficiency etc.) are realised.*

- *Establish clear goals and outcome measures for the Pathway groups and monitor delivery to the established goals.*
- *Develop and review clear and robust investment plans that support the development and prioritisation of funding bids, both internal and external; both new investment and invest to save funding in order to facilitate the delivery of the IMTP and a sustainable Planned Care.*
- *Monitor reporting of Key Performance Indicators (KPI's) to ensure delivery of the IMTP, waiting times are brought in line with National Access targets and the backlog is cleared. Ensuring these measures are delivered and the planned care expenditure is in line with the IMTP funding by reviewing and accepting a monthly financial report.*

2.2 At the time of reporting, the Group last met in December 2022; we are advised that when it was running it received verbal and written updates from several officers covering a range of topics:

- Welsh Government / NHS Wales;
- High Level Board meetings;
- Get it Right First Time programme;
- Any other updates relevant to Planned Care;
- Insourcing and Outsourcing performance on Planned Care position;
- Budget on Planned Care, additional funding planning team;
- Planning Cycle;
- Planned Care Transformation programme;
- Insourcing and Outsourcing team delivery against the programme;
- Network Managers;
- Integrated Health Communities;
- Regional Treatment Centres Programme.

2.3 The remit of the PCRTG includes providing assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented. The Group has not met since December 2022 and we could not establish sufficient evidence to confirm that the information received by the Group enable it to discharge its responsibilities as described above.

Conclusion:

2.4 We could not confirm that the Group is receiving the required information to discharge its responsibilities. If the Group is reinstated its Terms of Reference must be revisited to ensure it is fit for purpose and there are appropriate assurance mechanisms in place.

We have concluded **limited** assurance for this objective.

Objective 2 - The group receives regular highlight reports from the meetings and groups outlined in the Terms of Reference (Corporate Access Meeting, Planned Care Transformation Group, Planned Care Operational Group, Planned Care meeting).

2.5 The "Governance and Reporting Arrangements - Gains assurance from" section of the ToR states that "*The PCRTG will receive highlight reports for each pillar*

of Planned Care and escalate any unresolved issues or concerns to the Executive Delivery Group (EDG) or Performance, Finance and Information Governance Committee (PFIG). To receive highlight reports from:

- *Corporate Access Meeting (Weekly)*
- *Planned Care Transformation Group*
- *Planned Care Operational Group*
- *Planned Care Meeting”*

- 2.6 We requested papers/minutes/action logs for meetings between September 2022 to February 2023; we received meeting notes for September, November and December 2022. The Group met for the last time in December 2022. There have been resource implications within the Planned Care Transformation (PCT) Group, with only three members of the team (two of which were interim) to cover the Planned Care agenda. We were advised that it is hoped the Group would be reinstated upon the recruitment of the Associate Director Planned Care.
- 2.7 We reviewed minutes of the meetings provided to establish if the Group had received and discussed reports - Reports have not been received consistently, and minutes of the Group meetings lacked evidence to show regular reporting and discussion.
- 2.8 The Outsourcing & Insourcing Manager advised reporting templates had not been agreed from each of the four domain leads. In addition to this, a formal report was requested by PFIG and EDG whom required different information. Information was reported and escalated through both of these reporting mechanisms but not clearly defined at PCRTG.

Conclusion:

- 2.9 The Group met for the last time in December 2022 with several meetings being cancelled. Prior to this, there has not been consistent reporting from the required groups / meetings. We are therefore unable to evidence that the Group is receiving the information required.

We have concluded **limited** assurance for this objective.

Objective 3 - Actions are captured and monitored, with areas of concern / slippage escalated as required.

- 2.10 There is an action log attached to minutes of the meetings reviewed. A review of action logs for the September, November and December 2022 meetings highlight:

Meeting	Actions due	Actions complete	Actions outstanding
September 2022	9	8	1
November 2022	15	12	3
December 2022	As November 2022 above		

- 2.11 Minutes state the action log was not discussed at the September 2022 meeting, with the action log to be updated and circulated. Also, the December 2022 action log was identical to the November 2022 log, and we were unable to

confirm if new actions were recorded or establish progress / update on those that remained outstanding from the November meeting.

- 2.12 We could not see any evidence of outstanding actions escalated as indicated within the Group ToR.

Conclusion:

- 2.13 Action logs are in place and there is some evidence of review and update, however we cannot confirm that the most recent one (December 2022) included new actions. The minutes of the Group do not demonstrate discussion of issues to be escalated to either the Executive Delivery Group or Performance, Finance and Information Governance Committee.

We have concluded **limited** assurance for this objective.

Objective 4 - There is regular and adequate reporting through the Performance, Finance and Information Governance Committee and the Executive Delivery Group.

- 2.14 The "Governance and Reporting Arrangements - Reports to" section of the Group ToR states that:

"The PCRTG will report to EDG & PFIG on a monthly basis on the progress of the Planned Care Programme. The chair will produce a monthly highlight report, highlighting through an exception-reporting framework, the progress against agreed deliverables, and performance against measures of success for each pillar and project.

Any potential programme or project milestone slippages or additions must be reported in the highlight reports to enable the PCRTG to understand the impact(s) and agree alternative course(s) of action where necessary. A decision will then be made, if this requires escalation to EDG/PFIG for Information/Executive decision.

Any identified risks will be reported through the various work streams and will be documented within the work stream workbooks, which will feed into the Planned Care portfolio and be reflected within the Corporate Planned Care risk register, which will be reviewed within the agreed timeframes".

- 2.15 We could not see evidence to support the above; the Outsourcing & Insourcing Manager advised that highlight reporting was planned, but the template had not been agreed and due to resource implications on the PCT at the time, this had not progressed to meet the requirements of the EDG and PFIG.

Conclusion:

- 2.16 Regular and adequate reporting through EDG and PFIG has not been established.

We have concluded **limited** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Planned Care Recovery & Transformation Group (Operation)		Impact	
<p>The Terms of Reference for the PCRTG includes responsibilities of the Group and the governance and reporting arrangements. The Group met for the last time in December 2022, however when considering the meetings prior to this, there is not sufficient evidence to demonstrate the Group was receiving appropriate information to enable it to discharge its responsibilities, as set out in the ToR.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Welsh Government requirements are not complied with. • Impact on quality of care and patient experience, resulting in potential patient harm. 	
Recommendations		Priority	
1.1	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.	High	
1.2	Management should ensure there are sufficient resources allocated to the planned care agenda, to ensure the planned care programme is successfully implemented.		
Agreed Management Action		Target Date	Responsible Officer
1.1	A draft revised programme is awaiting formalisation and there will be an inaugural meeting to launch the programme before the end of July.	July 2023	Associate Director of Planned Care Interim Chief Executive Officer
1.2	Programme resources have been identified and we are working to appoint individuals into lead roles.	June 2023	

Matter Arising 2: Reporting (Operation)		Impact	
<p>There have been inconsistencies in receiving updates / reports as outlined in the Group ToR and minutes of the Group meetings lacked evidence to show regular reporting and discussions, this was in the main for reports and updates from the Planned Care Transformation Group and the Planned Care Operational Group.</p> <p>Reporting templates had not been agreed from each of the four domain leads and we could not see evidence of issues escalated as indicated within the Group ToR.</p> <p>We could not see evidence of regular and adequate reporting through the Performance, Finance and Information Governance Committee and the Executive Delivery Group. We are advised that highlight reporting was planned, but the template had not been agreed and due to a lack of resource at the time, this had not progressed to meet the requirements of the EDG and PFIG.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Impact on quality of care and patient experience, resulting in potential patient harm. • Committee members and Executives are not provided with sufficient assurance on the progress of Planned Care. 	
Recommendations		Priority	
2.1	Review the mechanisms for reporting, ensure requirements have been clearly established and expectations communicated with the relevant Groups / Committee.	High	
Agreed Management Action		Target Date	Responsible Officer
2.1	Reporting arrangements will be published once finalised with the programme initiation arrangements.	July 2023	Associate Director of Planned Care

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.
	No 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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Data analysis – Triangulation of data

Final Internal Audit Report

June 2023

Betsi Cadwaladr University Health Board



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Auditors:	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit Martyn Lewis, IT Audit Manager
Executive sign-off:	Angela Wood, Executive Director of Nursing & Midwifery
Distribution:	Matthew Joyes, Deputy Director of Quality Erika Dennis, Quality Lead Manager Christine Lynes, Deputy Director of Nursing Libby Ryan-Davies; Michelle Greene; Ffion Johnstone - IHC Directors Centre; East; West Iain Wilkie, Interim Director Mental Health & Learning Disabilities Fiona Giraud, Director of Midwifery and Womens Services
Committee:	Audit Committee



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

Acknowledgement

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

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Executive Summary

Purpose

The purpose of the audit was to consider how information/data within the Health Board is triangulated to ensure possible areas of risks are identified and are subject to scrutiny.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- We recognise the appetite to develop greater use and reporting of data quality across the different data systems– this must be developed at pace to ensure the Health Board can identify outliers/opportunities to share best practice from the data it already has.
- There are issues concerning data quality in Datix which will have a direct, negative impact on the Health Board’s ability to rely on the output.
- The evidence we received from operational services shows a range of data being reported to their Patient Safety related meetings. There are opportunities for all to build on this base to enhance the use of all data sets to support delivery of safe, quality patient care.
- There is no standard reporting template in use across the Health Board that stipulates the minimum quality and safety metrics/information that should be reported for operational scrutiny.
- Quality, Safety and Experience Committee Members should determine the data they require to discharge their delegated responsibilities by the Board for assurance.

Report Opinion



Limited assurance

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Trend

N/A

Assurance summary¹

Objectives	Assurance
1 Data captured is categorised appropriately to allow analysis and comparison of data.	Limited
2 Areas/Divisions regularly review the data available to them to identify areas of risk. Where issues are highlighted, appropriate action is taken and escalated appropriately within current governance structures.	Reasonable
3 There is sufficient information included in reporting to Area/Division Quality and Safety meetings, and the Health Board Quality, Safety and Experience Committee, to provide assurance that information / data is being used to identify areas of risk.	Limited

¹The 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 Health Board is data rich across several, independent patient driven systems but there remains inconsistencies in the capture of and quality of data.	1	Operation	High
2	There is no standard process/template to ensure all core data pertaining to patient quality and safety is reported to respective management teams/Committee.	2 & 3	Design	High
3	Whilst there is reporting to the Quality, Safety and Experience Committee, the information reported should be reviewed to ensure the Committee are provided with sufficient information and assurance to discharge its delegated responsibilities.	3	Operation	High

1. Introduction

1.1 The Health Board relies on a vast amount of information and data captured from many different sources to inform and learn about the level of care they are providing to patients, and to assist them in achieving their strategic goals and objectives. Some sources of this information include concerns, complaints, incidents, Never Events, Medication errors, Risk registers, Regulation 28 reports and Health Inspectorate Wales reports.

It is important that the Health Board triangulates the information and data available to allow identification of areas of risk so appropriate action can be taken.

1.2 The risks considered were:

- Information available from various sources is not documented and categorised appropriately to allow analysis.
- Areas/Divisions are not regularly reviewing data available, impacting their ability to identify areas of high risk and take action where appropriate.
- Areas of risks identified are not actioned or escalated appropriately.
- Areas/divisions and the Health Board are not receiving regular assurance that information available is being used effectively.

1.3 The review was limited to the quality and availability of data to underpin the review coupled with the papers/reports we received from services.

2. Detailed Audit Findings

This report is based upon the information provided by officers supporting our review. We would like to express our gratitude to all Officers for their input during the undertaking of the review, in particular the Quality Lead Manager. 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/accuracy of the information provided.

Objective 1: Data captured is categorised appropriately to allow analysis and comparison of data.

2.1 The Quality Lead Manager provided us with the following data sets we requested to support this review – Period January to December 2022 inclusive:

- Datix – all claims, incidents and complaints.
- Datix - inquests, redress and mortality; however we did not include this data in our review as the timescales of each recorded event differed significantly to our sample period.
- Matrons monthly audit checks.
- Patient feedback survey information.

2.2 Our review noted that there are a number of weaknesses in the data sets that

made it difficult to accurately correlate the different data:

- There is no set definition for 'location', with different terminology used in each dataset which undermines the ability to directly correlate data sets between unique identifiers for analysis.
- The Datix information includes numerous records assigned to a service with "do not use" in the name and creates an implicit uncertainty over the data quality.
- Datix has duplicated categories for some items e.g. "nutrition / hydration" and "nutrition / hydration issues" or "infection control" and "infection prevention and control", again this leads to a loss of clarity and confidence in the data.

We recognise that an all-Wales Datix System is in use and are advised that the Health Board is engaged in the review to refine the codes and standardise across all the Datix modules – we have not corroborated this assertion.

- The Matrons audit ward checks and patient survey contain questions that link, to some extent, to categories within Datix but there are opportunities to improve what is being asked, enabling better correlation.

2.3 We analysed the data from Datix and summarised to a service level (where there are enough items for the analysis to have meaningful output), creating an average number of items in each category. We assessed the deviation in items from the mean, identifying a number of potential anomalies to the mean which require further management focus.

The following was identified:

- 'Communication' incidence appear high for Cancer services.
- 'Information Governance' incidence appear high in Childrens services.
- 'Infection control' incidence is high in Childrens services.
- 'Nutrition' incidence is high in both Cancer services and Surgery.
- 'Personal injury' incidence is high in Mental Health and Learning Disabilities.
- 'Record keeping and confidentiality' incidence is high in Primary Care.

2.4 Taking the Datix information and matching to outcomes from the Matron's ward checks, we found the following:

- Surgical services has a high level of accident/falls, and also scores lowest on those checks – This implies a link and future risk could be identified in advance and mitigated, thus limiting further patient incidents.
- Surgery has a high level of nutrition/hydration incidents and also scores low on the ward checks.
- Mental Health and Learning Disabilities has a high level of safeguarding incidents and also scores low on the ward checks.
- Conversely, areas with infection control incidents do not adversely score on ward checks.

2.5 Finally, factoring in and including patient feedback, the overwhelming issue from

patients concerns communication. In terms of outlier, Primary Care has a slightly lower outcome but have an elevated Datix profile.

- 2.6 We recognise that recent structural changes within Corporate functions has impacted the ability to progress greater triangulation and use of data to drive patient safety and quality reporting. We note the ambition and intention of the Quality Lead Manager to further develop and improve the use of data – this should be developed at pace to ensure areas of risk are identified and mitigations enacted to prevent future harm/incident.

Conclusion:

- 2.7 The Health Board is data rich across several, independent patient driven systems but there remain inconsistencies in the capture of and quality of data through the standardisation of descriptors.

- 2.8 Management should ensure a standardisation of a naming convention for all Health Board functions, enabling seamless comparison of data sets by the same unique identifier e.g. location.

We have concluded **limited assurance** for this objective but recognise the appetite for greater use of data following recent operational changes.

Objective 2: Areas/Divisions regularly review the data available to them to identify areas of risk. Where issues are highlighted, appropriate action is taken and escalated appropriately within current governance structures.

- 2.9 We contacted the three Integrated Health Communities (IHC), Mental Health and Learning Disabilities and Womens Services Divisions requesting information reported to their Quality and Safety Group (or equivalent) meetings; we did not receive any response to our request for evidence from the IHC Centre.

- 2.10 It is evident that four respondents use data to supplement their respective Quality and Safety Group (or equivalent) meetings. Each had different proformas for assurance reporting but all consistently included detail around concerns, complaints, incidents, falls, healthcare acquired pressure ulcers (HAPU) amongst some specific matters e.g. HM Coroner reporting, HealthCare Inspectorate Wales (HIW) recommendation tracking.

We also found that:

- One service included Ward Accreditation spider graphs on specific ward performance although we did note that some data fields had not been completed to provide an accurate picture.
- One service included Ward Manager/Matron ward check summary findings.

- 2.11 Balancing the reports, they also included details of Compliments/Thank you feedback in some detail when compared to reporting on patient safety matters.

- 2.12 In reviewing a sample of minutes, generally there was limited evidence of Action/For Escalation focus on outliers; however we did identify some planned action relating to falls:

- *"Support is required via the IMTP for a falls service that serves all areas of the IHC and for the resourcing of the bedside learning programme".*
- *"The Committee is requested to support further analyses of potential falls patterns with support of skilled analysts. Division would benefit from securing falls expertise to assist in supporting areas with higher falls numbers (as well as general falls prevention and management initiatives)."*

2.13 For some, due to geographical spread and services provided, there is locality specific patient safety meetings (referenced in papers but outside the scope of this review) with apparent summary information via a Chairs Assurance report (or equivalent) reported to the main meeting. What appears missing from these reports is extracted, granular information of any outliers in service delivery for the respective management team to obtain assurance.

Conclusion:

2.14 Whilst there is evidence of data being used across the services we received evidence from, there are significant opportunities for this to be enhanced, enabling officers accountable for the service to use all data sets to identify areas of risk through effective triangulation.

We have concluded **reasonable assurance** for this objective.

Objective 3: There is sufficient information included in reporting to Area/Division Quality and Safety meetings, and the Health Board Quality, Safety and Experience Committee, to provide assurance that information / data is being used to identify areas of risk.

2.15 The review of the four Quality and Safety Groups (or equivalent) identified a mix of approaches to the information reported/presented.

2.16 The Duty of Quality, as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, came into force on 1 April 2023. Using this as a basis for determining reporting of information, we noted some were already reporting mortality, concerns and complaints with limited reporting on staff feedback.

2.17 We could find no standard report template in use across the Health Board that stipulates the minimum quality and safety metrics/information that should be reported for operational scrutiny.

2.18 There is no doubt that the evidence we received, the key data recorded/captured through Datix is the key vehicle for reporting, with other specific information included where relevant. This being said, there is no consistency in the reporting of information to ensure, as a minimum, all patient focused services are reporting on the same minimum data.

2.19 Using the IRIS reporting system, there are a number of data dashboards that do not feature consistently across the four services. Using the IRIS reporting tool, we obtained the overall Health Board picture for the *Matrons Monthly Quality Audit* (Figure 1) which shows a 46% completion of the audits in March 2023, producing an overall audit performance score of 90% compliance.

Figure 1: Matrons Monthly Quality Audit – March 2023 – Source IRIS reporting tool (11 May 2023 run by Internal Audit)



2.20 Using the *Ward Accreditation Audit by Compliance* (Figure 2) for the 1 November 2022 to 30 April 2023 we noted three red assessed questions, all relating to falls.

Figure 2: Matrons Monthly Quality Audit – March 2023 – Source IRIS reporting tool (11 May 2023 run by Internal Audit)

Ward Accreditation Audit Compliance By Question (Data Updated Hourly)							
Month/Year	Hospital	Ward Name/Number	Topic	510 Completed Audits			
Last 6 Months (Cal...)	All	All	All				
01/11/2022 - 30/04/2023							
Question Text	November 2022	December 2022	January 2023	February 2023	March 2023	April 2023	Total
PS-07: Can you name the main issues raised during the safety briefing?	88	82	83	90	94	84	52%
PS-08: Can you describe the correct processes for blood transfusion?	88	82	83	90	94	84	52%
PS-09: Can you describe examples where you would need to make a report to safeguarding?	88	82	83	90	94	84	52%
PS-10: Do you know how to report a safeguarding concern?	88	82	83	90	94	84	52%
HFC-01: Has the pressure ulcer risk assessment been completed within 6 hours of arriving on the ward?	85	82	81	90	93	82	52%
HFC-02: Has the patient had a visual skin inspection within 6 hours of arriving on the ward?	85	82	81	90	93	82	52%
HFC-03: Has the patient had a daily visual skin inspection during their stay on this ward?	85	82	81	90	93	82	52%
HFC-04: If a patient is at risk of pressure damage, do they have a plan of care?	85	82	81	90	93	82	52%
HFC-05: If a patient is at risk of pressure damage, have they been repositioned at frequent intervals?	85	82	81	90	93	82	52%
HFC-06: For patients over 65 years: is there an up to date falls pathway?		1					0%
HFC-07: Have all sections of the falls pathway been completed accurately?	85	82	81	90	93	82	52%
HFC-08: Has the patient received a minimum of 12 hourly observations, unless documented otherwise in the medical notes?	85	82	81	90	93	82	52%
HFC-09: Is there a NEWS score for every set of observations?	85	82	81	90	93	82	52%
HFC-10: Does the observation chart indicate when the next set of observations is due?	85	82	81	90	93	82	52%
HFC-11: For NEWS score of 6 or above, has the appropriate action being documented with escalation to Doctor or Nurse Practitioner?	85	82	81	90	93	82	52%
HFC-12: Has the patient been assessed for VTE?	84	81	81	90	93	82	51%
HFC-13: If the patient is at risk of VTE, have the correct preventative measures been put in place?	84	81	81	90	93	82	51%
HFC-14: Has the peripheral cannula bundle been completed accurately?	85	82	81	90	93	82	52%
HFC-15: Has the catheter maintenance bundle been completed accurately?	85	82	81	90	93	82	52%
HFC-16: Has the catheter insertion bundle been completed accurately?	85	82	81	90	93	81	51%
HFC-17: Have appropriate pressure relieving aids been used for patients at risk?	85	82	81	90	93	82	52%
HFC-18: Is there evidence that the falls pathway actions have been completed?							0%
HFC-19: Can you describe actions to be taken to reduce the risk of falls?							0%
HFC-20: Which patients on the ward are DNAR?	85	82	81	90	93	82	52%
MS-01: Are medication trolleys, cupboards and fridges locked?	85	82	81	90	93	82	52%
Total	49%	47%	46%	51%	54%	47%	

2.21 In reviewing the Quality Safety and Experience Committee minutes (most recent Minutes available 1 November 2022 presented at the 20 January 2023 Committee) noted for QS22.279 Patient Safety Report the following:

QS22.279.1 *The Chair was grateful that the near misses had been included in the paper this time but asked what the process for learning was and that this would need to be identified going forward. The Acting Associate Director of Quality Assurance noted that this would be included in future reports as well as themes organisationally.*

2.22 Committee minutes of other meetings also highlight a lack of assurance concerning lessons learnt.

Conclusion:

2.23 Whilst there is evidence of reporting key elements from Datix, there remains, generally, a gap in wider reporting upon which both operational management have oversight. We noted limited reporting of Matron Quality Audits along with other key metrics on IRIS which must be improved, otherwise questions must be asked as to why the data is being captured if not widely used.

2.24 Recognising the Quality Safety and Experience Committee has not published its minutes from the January 2023 meeting at the time of this review, we note Committee Members have previously requested additions to the Patient Safety Report – Committee Members should determine the information they require from the plethora of data the Health Board has.

We have concluded **limited assurance** for this objective, albeit on the basis of a small sample.

Appendix A: Management Action Plan

Matter Arising 1: Triangulation of Data sets using consistent naming conventions (Operation)		Impact	
<p>The Health Board is data rich across several, independent patient driven data systems but there remains inconsistencies in the capture of and quality of data through the standardisation of descriptors.</p> <p>Due to organisational change, the Quality Lead Manager has not had the opportunity to improve the use of data.</p> <p>Our own triangulation of data using analytics has identified outliers which are reported within Objective 1 of the detailed findings.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Management are not able to identify areas of risk across the Health Board, and are unable to take appropriate action to reduce future potential harm to patients. 	
Recommendations		Priority	
1.1a	<p>The Deputy Director of Quality:</p> <ul style="list-style-type: none"> 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	
Agreed Management Action		Target Date	Responsible Officer
1.1a	<ul style="list-style-type: none"> Following on from the re-alignment of the quality functions, a new Quality Insight and Systems Team is being created. New standard operating procedures for quality systems such as Datix are being developed which will include standardisation of analysis, reporting and dashboards. 	30/09/2023	Deputy Director of Quality & Quality Lead Manager

<ul style="list-style-type: none"> Working with the national Once for Wales RLDatix Team, a new locations and services hierarchy was implemented in April 2023 which aligns to national standards under the Once for Wales RLDatix programme and best practice. A change control process will be in place via the SOPs mentioned above. The findings from internal audit will be reviewed with the respective quality governance teams and findings will be shared with the executive-chaired Quality Delivery Group. 	<p>Completed</p> <p>31/08/2023</p>	
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Matter Arising 2: Template minimum data sets (Design)		Impact
<p>We could find no standard report template in use across the Health Board that stipulates the minimum quality and safety metrics/information should be reported for operational scrutiny.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Standard data is not being reported, impacting the ability to identify areas of poor patient quality and areas of good practice for sharing.
Recommendations		Priority
2.1a	<p>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.</p>	<p>High</p>
2.1b	<p>The Deputy Director of Quality should ensure the minimum quality and safety data sets are consistently used across all IHCs and Divisions</p>	

Agreed Management Action		Target Date	Responsible Officer
2.1a	A standardised organisation-wide Quality Dashboard is under development.	30/09/2023	Deputy Director of Quality
	A Workshop will be held with members of the Quality Delivery Group to agree the content of reporting from IHC/Divisional quality groups to the executive-chaired meeting. This will inform reporting requirements throughout the quality governance structure	31/08/2023	
2.1b	Once the above is agreed by the workshop and executive-chaired Quality Delivery Group, standard templates will be issued to divisions.	30/09/2023	

Matter Arising 3: Quality, Safety and Experience Committee reporting (Operation)	Impact
<p>In reviewing the Quality Safety and Experience Committee minutes (most recent minutes available 1 November 2022 presented at the 20 January 2023 Committee) we noted the following:</p> <p><i>QS22.279.1 The Chair was grateful that the near misses had been included in the paper this time but asked what the process for learning was and that this would need to be identified going forward. The Acting Associate Director of Quality Assurance noted that this would be included in future reports as well as themes organisationally.</i></p> <p>Committee Minutes of other meetings also highlight a lack of assurance concerning lessons learnt.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> The Quality Safety and Experience Committee does not receive sufficient information and assurance to discharge its duties to the Health Board.
Recommendations	Priority
3.1a The Quality, Safety and Experience Committee Members stipulate all the data it requires for assurance purposes.	High

Agreed Management Action		Target Date	Responsible Officer
3.1a	Following changes within the Board arising from Special Measures, the new members of the Committee are working with the Executive Director of Nursing and Midwifery (as executive lead for the QSE Committee) to revise the committee terms of reference and cycle of business. As a result, the reporting expectations and requirements will be revised. The special measures reviews of patient safety and quality governance systems by the Independent Special Advisors will also inform this work.	30/09/2023	Deputy Director of Quality

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.
	No 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*

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Performance Management – Quality and Performance Reporting and Accountability Arrangements Final Internal Audit Report

June 2023

Betsi Cadwaladr University Health Board



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Executive sign-off:	Steve Webster, Interim Executive Director of Finance
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Committee:	Audit Committee



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

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Executive Summary

Purpose

The purpose of the review was to consider the process in place to ensure the Health Board is provided with information on appropriate performance measures that are in line with the NHS Performance Framework, and that delivery of performance is adequately scrutinised at accountability meetings.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- Performance information provided to the Health Board and its Committees has been subject to recent review, with enhanced reporting provided in May 2023. Consideration needs to be given to the information provided at Committees and subsequent assurance arrangements to the Board, to ensure the Board are focused on significant matters.
- There is a process in place for collation of data and narratives to support the information in the performance report, however there is no documentation setting out the process, including roles and responsibilities, data standards, systems used etc.
- Improvement actions stated in performance reports are not subject to review to confirm whether actions are completed and have positively impacted performance. Further development of performance assurance is required.
- Accountability meetings are taking place, however these have not been consistent over a period of time and the process for recording and updating actions requires review and improvement.

We recognise there is work ongoing to improve performance reporting and have

Report Opinion

		Trend
	Limited More significant matters require management attention.	N/A
	Moderate impact on residual risk exposure until resolved.	

Assurance summary¹

Objectives	Assurance
1 Appropriate performance measures are in place to reflect the requirements of the NHS Performance Framework and the Health Board, including feedback and input from Committee and Board members.	Reasonable
2 There is evidence to support reported performance data and narrative.	Limited
3 Arrangements are in place within the operating model to ensure senior management are held to account for performance on a regular basis. Actions to address areas of low performance are SMART, with progress monitored.	Limited

¹The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

taken this into account within our recommendations.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Work is ongoing to review the performance reports provided to Committees and the Health Board, however there is further work required to ensure Committees and the Board are receiving relevant and accurate information and providing assurance where required.	1,2	Design	Medium
2	There is no procedure outlining the process for collation of the performance report, and assurances on the data provided. Further work is required to review the process and ensure roles / responsibilities are documented.	2	Design	High
3	Accountability meetings are taking place, however further work is required to ensure these are regular and actions are appropriately monitored.	3	Design	High

1. Introduction

- 1.1 The Welsh Government *NHS Wales Performance Framework 2022-23* was published in June 2022 and outlines the performance measures for Health Boards in Wales.

The *Integrated Quality & Performance Report* (IQPR) is presented to the Board and its key Committees outlining performance against key performance and quality measures identified as a priority for the Health Board.

- 1.2 The following risks were identified at the outset of the review:

- Performance measures are not appropriate to provide Board/Committee members with the information required to discharge their duties.
- Performance data and information is not accurate, resulting in misinformation to Board / Committee members.
- Senior management are not held to account for performance, resulting in continued under performance.

- 1.3 The audit was limited to a review of the Quality Performance reports presented to Committees, and evidence available to support reported information. It has considered the formal accountability meetings for Integrated Health Communities (IHCs) and pan North Wales services, and has not considered other meetings that may take place i.e. one to one or Executive meetings.

2. Detailed Audit Findings

Objective 1: Appropriate performance measures are in place to reflect the requirements of the NHS Performance Framework and the Health Board, with a process in place to receive feedback and input from Committee and Board members.

- 2.1 The Health Board are required to report on performance measures set out within the Quadruple Aims in the Welsh Government publication *NHS Performance Framework 2022-23*. These measures are reported within the Quality Performance Reports presented to the Health Board and its Quality Safety and Experience Committee (QSE), and Performance, Finance and Information Governance Committee (PFIG).

- 2.2 We reviewed the Quality & Performance Reports that were presented at the meetings of the Health Board, Performance, Finance and Information Governance Committee and Quality, Safety and Patient Experience Committee in January 2023 and February 2023 to determine if all measures were included within the reports. Of the 84 measures:

- Seventy-one (71) are reported in full (split across various Committees).

- Eight (8) are included within the reports but data is not yet available (new measures).
- Four (4) are not included (qualitative).

- 2.3 We reviewed the available minutes of the Health Board, PFIG and QSE meetings from July 2022 to January 2023 to establish whether any comments were raised that related to the content and format of the report. A number of comments were raised relating to the report being unclear, containing errors and being clear about how issues were being addressed.
- 2.4 A detailed update on performance, and an integrated dashboard was presented to the Health Board Leadership Team in March 2023. The minutes of the meeting highlight *“One of the significant tasks has been reviewing the information that is operationally available across wards, services and specialities to understand what is out there. There are currently a number of dashboards and reports that are used that need to be reconciled and it is critical that everyone to recognises and works with the same metrics. The aim is to have a consistent month end reported position but to also have a real time picture of what is happening any given week against the plan.”*
- 2.5 Performance reporting to the Performance, Finance and Information Governance Committee, and the Health Board meeting in May 2023 provides further narrative relating to the areas of significance for the Board to be aware of, including actions being taken to recover performance.
- 2.6 Whilst improvements have been made, there remains further work to be undertaken to ensure the Board are receiving appropriate assurance on some performance measures from its Committees, to allow them to focus on more urgent areas.

Conclusion:

- 2.7 The current measures reported in the Health Boards Quality Performance report is in line with the requirements of the NHS Performance Framework 2022-23, with the measures reported across the Committees of the Board. There are some measures where data is not yet available, and this is stated in the reports.
- 2.8 The report has been revised taking account of comments raised at previous meetings, and Health Board members were provided with an update on changes made to reflect comments received.
- 2.9 The information provided to the Health Board in May 2023 demonstrates positive changes in the information reported, with areas of concern and improvement actions noted, as well as providing the data for relevant measures. We recognise this is an ongoing piece of work to ensure members are receiving relevant and timely information, enabling focus on key areas; we believe the information reported to Committees is reviewed to allow the Board to receive assurance on some performance measures, so reports to the Health Board focus on more

significant / urgent areas of performance which may adversely impact achievement of its strategic objectives.

We have concluded **reasonable assurance** for this objective.

Objective 2: There is evidence to support reported performance data and narrative.

2.10 We received some evidence to demonstrate receipt of information to support data and narrative in the performance report, and were advised there is a process in place to complete the performance report:

- Data is collated from internal and external sources to populate tables and figures in the report.
- Quality and Performance Report narrative templates are sent out via email to relevant agreed leads.
- Report is merged into final report and inclusion of latest validated data.
- Quality and Performance Report sent to interim director of performance for QA prior to submission to the Office of the Board Secretary.

2.11 However, there is no formal standard procedure document, ensuring service continuity, for the collation of information for performance reports to ensure accuracy and integrity of data. Roles and responsibilities are not formally documented.

2.12 Whilst narrative is provided by leads within the Health Board, this is not subject to Executive review prior to submission of the report; there is limited time between receipt of the information and production of the report to review this in detail.

2.13 The performance report includes actions stated to improve performance, however there is no process in place to provide assurance that these actions have been completed or have improved performance.

Conclusion:

2.14 Whilst there is a process in place to request, receive and collate information for the performance report, this is not documented. Further work is required to ensure roles and responsibilities are clear, and standards for data collation / validation etc. are consistent and documented.

2.15 There is also a lack of assurance relating to accuracy of narratives provided in the report, and assurance on whether actions noted have resulted in improved performance.

We have concluded **limited assurance** for this objective.

Objective 3: Arrangements are in place within the Operating model to ensure senior management are held to account for performance on a regular basis. Actions to address areas of low performance are Specific, Measurable, Achievable, Relevant and Time-bound (SMART), with progress monitored.

- 2.16 There is a Performance and Accountability Framework in place, which is currently under review. This outlines *'the means by which the Health Board can easily identify areas of excellence for wider sharing and celebration and areas where additional support may be required'*. It includes the requirement for monthly performance meetings.
- 2.17 We are advised these meetings did not take place for a period of time due to Covid, and bi-monthly accountability meetings commenced in August 2022, following questions raised by the former Health Board Chair. These are held for each of the Integrated Health Communities (IHCs) and Pan BCU Services, they are not held for corporate areas. The Chief Executive and Executive Team lead these, with attendance from senior management.
- 2.18 We reviewed the papers for accountability meetings for August 2022, October 2022, and February 2023. The meetings in December were stood down. The content of the meetings follow a standard format and cover a wide range of information. We were not provided with dates of future performance meetings.
- 2.19 Actions are captured via an Action Tracker. At the time of review (April 2023) there were 70 outstanding actions. Several actions from November 2022 (10) do not have any update provided and are noted as *'awaiting feedback/further information'*. The tracker we received was dated April 2023, however all actions have not been updated, and several actions are not SMART, with updates varying from *'ongoing'* to very detailed, and *'meeting scheduled'* without any further information noted/referenced to the minutes of the accountability reviews. Consequently, it is difficult to evidence that actions have been completed appropriately and address original issues raised. Examples of actions from the tracker are included at Appendix B and highlight:
- Meetings scheduled but no detail of the outcomes of these / impact on original action.
 - Action showing on track from November 2022 with no update included.
 - Several actions awaiting feedback/further information.
- 2.20 Minutes are produced for the performance meetings, however there is no subsequent correspondence to senior officers i.e. a performance letter, setting out clear expectations and recognising areas of restriction that could impact improvement actions.
- It is therefore difficult to demonstrate how staff are held accountable if there are no improvements in performance, and the escalation procedure through the Health Boards governance processes.

Conclusion:

- 2.21 Accountability meetings are in place; however these have not been operating consistently over a prolonged period of time and do not include corporate directorates/functions and are unclear why.
- 2.22 Actions captured do not appear to be appropriately monitored to ensure completion/updates provided. Whilst minutes of meetings are provided, there is no formal correspondence (e.g. performance accountability letter to senior officers/managers) outlining the expected performance and requirements for the next performance meetings. This has been highlighted to the previous Interim Chief Executive and Interim Board Secretary, who were keen to adopt this approach.
- 2.23 Whilst we recognise that there is significant work ongoing to reset the performance and accountability framework, this is not yet in place and are unable to provide assurance that there are effective controls in place to hold senior officers/staff accountable for performance measures.

We have concluded **limited assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1 Performance report and measures (Design)		Impact
<p>There have been recent improvements to the performance information provided to Committees and the Health Board and recognise there is ongoing work to improve the reporting going forward to ensure members are sighted on relevant areas of focus. Further work is required to determine the information provided to Committees and the Board, to ensure the Board can receive assurance from the appropriate Committees, whilst focusing on more significant matters.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Board members are not aware of areas of poor performance and actions taken to address these. Information reported to the board is not accurate / validated.
Recommendations		Priority
1.1	<p>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 assure 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.</p>	Medium
Agreed Management Action		Target Date
1.1	<p>The Health Board is reviewing its governance / assurance structures in line with Special Measures – this includes looking at the oversight / performance frameworks and associated reporting, processes and documentation. This will involve the gradual 'integration' of reporting on operational delivery, quality, safety and patient experience, workforce and finance by the end of March 2024.</p>	31 March 2024
		Responsible Officer
		Executive Director of Finance & Performance

<p>Alongside this includes a Review of the content, editorial ownership and quality of the information and data contained within all performance reporting it. This includes work with Informatics to ensure all Operating Framework Metrics, trajectories and other KPIs included in the Board Report have a documented processes and signoff for submission nationally, locally etc. Closer editorial management of the Performance Report now sits with the Director of Performance role. Effective Feb 2023 a summary/highlight report has been introduced to direct reviewers to key points of variation and from June 23 includes NHS Wales published Organisation Performance Reports and where relevant/ available the comparative performance across all Wales' Board.</p> <p>Work continues alongside the revision of the Performance and Accountability Framework.</p>		
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Matter Arising 2: Procedures (Design)	Impact
<p>Whilst we received evidence of data collation and details of validation undertaken, there is no formal procedure in place documenting the process for data standards, collation and validation. This process is being reviewed as part of the improvement work ongoing.</p> <p>Narrative and actions are provided by leads in the Health Board, however there is a lack of assurance provided on whether the actions are improving performance, or whether other actions need to be considered.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Information reported to the Board is not accurate / validated. • Lack of assurance that actions taken are improving performance.
Recommendations	Priority

2.1	<p>Standard Operating Procedures should be in place for the process of collating information for the performance reports, including:</p> <ul style="list-style-type: none"> - 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 	High	
2.2	Further work is required to provide assurance to the Board that the actions stated in performance reports are improving performance/outcomes.		
Agreed Management Action		Target Date	Responsible Officer
2.1	The proposed establishment of a working group between Performance and Informatics colleagues is being developed – the first meeting of this meeting will focus on the process of external reporting of data, alignment with Wales Digital reporting guidance and other data definitions used within the NHS Wales Operating Framework and Welsh Government Aims. The remit of the Group will include all of the recommendations made in this report.	31 Mar 2024	Executive Director of Finance & Performance and Chief Digital and Information Officer.
2.2	Agreed – The documents editor has the responsibility to ensure all avenues of intelligence and assurance are incorporated into the analysis and reporting including external assurance if available.	31 Mar 2024	Executive Director of Finance & Performance and Chief Digital Information Officer.

Matter Arising 3: Accountability meetings (Design)		Impact
<p>Whilst there are accountability meetings in place, these have not been operating consistently over a period of time and do not cover Corporate Directorates/Divisions. Recognising the Performance and Accountability Framework is being reviewed, it is important that meetings are scheduled and held regularly with relevant staff.</p> <p>A review of the action tracker highlights several issues, such as lack of progress monitoring, lack of detail and lack of recent updates. There is also not formal letter to senior managers outlining the expected performance and requirements for the next performance meetings.</p> <p>We recognise there is work ongoing to review and update the Performance Accountability Framework and recommendations below reflect this.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Lack of accountability for performance • No improvements in performance, impacting on patient quality and safety
Recommendations		Priority
3.1	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
3.2	Review current action tracker to determine whether actions are still relevant.	
3.3	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	

Agreed Management Action		Target Date	Responsible Officer
3.1	Agreed – Interim Director of Performance working closely with Interim CEO to agree / consult on direction of travel. Underway and first draft anticipated Q2, 23/24.	31 Mar 2024	Interim Director of Performance
3.2	Action tracker to be reviewed for relevance by end of July 2023.	31 July 2023	Interim Director of Performance
3.3	This action will be aligned with the revised PAF process for Q2 Reviews, scheduled for Sept 2023.	30 Sept 2023	Interim Director of Performance

Appendix B: Extract from Action Tracker

	Action Area	Action	Due Date	Latest Update Position	Date of Latest Update	Action Status
Central IHC	Emergent Risks not yet on corporate Risk Register	Meeting to be scheduled regarding job planning (key priority) with [Health Board Officer]	14/11/2022	Meeting has been scheduled for early January 2023.	07/12/2022	On Track
Central IHC	Emergent Risks not yet on corporate Risk Register	[HB Officer] to provide update on position with regards to workforce Organisational development, job planning and optimizing resources.	14/11/2022	Update provided in the presentation of next review meeting scheduled for 12/12/2022 21.02.23 - December Accountability Reviews cancelled. Update to be provide as part of February Accountability Review.	21.02.23	On Track
Women's	-	Long Waiters – [HB Officer] highlighted that we have the detailed trajectories based on the capacity within the service and still other services to action Workforce gaps - To what extent have we done everything that is within GIRFT	14/11/2022		14/03/2023	On Track
Central IHC	Emergent Risks not yet on corporate Risk Register	Executive Support - Meeting to be scheduled to discuss financial recovery / budget.	14/11/2022			Awaiting Feedback / Further Information

East IHC	Success Progress Report	Medicines Management - Antimicrobial Optimisation - Total savings of £1,010,800 and 912 bed days saved was reported and East Team has not received any investment to support. In terms of antibiotic intervention across the health board/IMTP bid, [HB officer]Sue Hill will pick this up with Centre and West IHCs and feedback accordingly.	25/11/2022	Can this work sit under the Medicines Value Group?	13/04/2023	Awaiting Feedback / Further Information
MH&LD	-	Recruitment and Retention - It was agreed for a meeting to be scheduled with [HB officers] to discuss recruitment challenge further and to consider what needs to be done differently “what do we do as an organisation to give this challenge the priority it deserves” as part of transformation to link in with mental health improvement plan.	14/11/2022	Meetings and discussions regarding recruitment are taking place frequently	21.02.23	Awaiting Feedback / Further Information
Women's	Antenatal Health	Comms - It was highlighted that BCUHB is the only HB that provides this data.	14/11/2022	On-going	15/02/2023	On Track
Diagnos tics Specialis t Clinical Support Services	-	Plan on a Page - In terms of patients with pace-makers requiring a MRI scan – [HB officer] asked for a plan on a page that states these are the numbers/this is the plan to appoint a nuclear physicist.	18/11/2022			Awaiting Feedback / Further Information

Appendix C: 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.
	No 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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Risk Management & Board Assurance Framework

Final Internal Audit Report

June 2023

Betsi Cadwaladr University Health Board



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Committee:	Audit Committee



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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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Executive Summary

Purpose

The purpose of the audit was to consider the corporate risk management arrangements, including development of the BAF, and the oversight of Divisions, IHCs and Services risk processes.

Overview

We have issued Limited assurance on this area.

The significant matters which require management attention include:

- There is no description of duties for the corporate risk management department within the Risk Management strategy 2022- 2025 (version 10.0 RM01).
- There is a lack of scrutiny and challenge to the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) due to the cancellations of the Risk Management Group meetings and the Quality, Safety and Experience Committee meetings.
- A number of risks in the BAF do not have action plans noted, and detail varies, limiting the assurance provided on whether actions taken will address the risks identified.
- The Committee approval process pertaining to escalation/de-escalation of risks is not clear.
- There is limited oversight of risk management arrangements within the Divisions/IHCs due to numerous meetings being stood down.
- The Health Board and Audit Committee meetings are not provided with the CRR and BAF in line with the frequency stated within the Risk Management strategy 2022- 2025 (version 10.0 RM01), limiting effective scrutiny and challenge of risks.

Report Opinion



Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Trend



Reasonable¹
21/22

Assurance summary²

Objectives	Assurance
1 Risk management and assurance arrangements are defined within a risk management strategy and framework and aligned to the Health Board's objectives and strategic direction.	Reasonable
2 Principal risks and significant operational risks are proactively managed via the board assurance framework (BAF) and corporate risk register (CRR), and regularly reviewed by the Executive Team/Health Board Leadership Team and the Board (or appropriate Committee).	Limited
3 Corporate risks are escalated and de-escalated in a timely manner, in line with strategy requirements.	Limited
4 There is corporate oversight of division/IHC/Service risk management arrangements, ensuring accountability for implementing effective risk management arrangements	Limited
5 Established processes are in place to support the monitoring and review of key risks and assurance mechanisms across the Health Board, including at Committee and Board level.	Limited

¹ The 2021/22 review scope was not the same as this one; a downward trend does not necessarily indicate a worsening position.

² 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 Risk Management Strategy includes 'Risk Management Duties', however there is no description of duties for the corporate Risk Management Department, who have a vital role in ensuring risk management is embedded and operating throughout the Health Board.	1	Design	Medium
2	There is a lack of scrutiny and challenge to the CRR and BAF due to the cancellation of the Risk Management Group meetings and the Quality, Safety and Experience Committee meetings.	2 & 5	Operation	High
3	The BAF requires updating to ensure that members are assured that appropriate actions are in place to address risks identified.	2	Operation	High
4	The Committee approval process pertaining to escalation/de-escalation of risks is not clear	3	Operation	High
5	Oversight and scrutiny of risk management arrangements within the Divisions/IHCs by the Corporate Risk Management Department is inconsistent and is limited due to meetings either being stood down or not taking place.	4	Operation	High

1. Introduction

1.1 Effective risk management is a key component of corporate, quality and safety governance and is integral to the delivery of organisational objectives. The Board is responsible for setting the strategic risk appetite and ensuring that there is an appropriate risk management strategy in place.

The Board Assurance Framework (BAF) is pivotal to providing assurance to the Board and supporting the oversight of strategic risks. The BAF was refreshed following meetings with Executives and Independent members, with amendments made at a board workshop in June 2022. The revised BAF was presented to the Board in August 2022.

Whilst the BAF focuses on the strategic risks, the corporate risk register deals with the significant operational risks affecting the Health Board’s ability to achieve its objectives and deliver services in the ‘here and now’. Directorate and service level risk registers sit beneath the CRR, with escalation and de-escalation as appropriate

1.2 The risk associated with this review was:

- The Health Board is not able to achieve its strategic objectives and deliver safe, effective services to its patients.

1.3 The review has focused on oversight arrangements and processes and has not included a detailed review of directorate risk registers.

2. Detailed Audit Findings

Objective 1: Risk management and assurance arrangements are defined within a risk management strategy and framework, and aligned to the Health Board’s objectives and strategic direction.

2.1 The Health Board has a Risk Management Strategy (2022- 2025) and Risk Register procedure in place:

<p>Risk Management Strategy & Policy (RM01)</p>	<p>Outlines the arrangements for risk management activities within the Health Board including risk appetite, tolerance; roles and responsibilities; assurance and governance arrangements</p>
<p>Risk Register Procedure (RM02)</p>	<p>Explains the risk assessment process from identification to treatment of risks</p>

These documents are located on the Health Board intranet site. The Strategy is due for review in July 2023.

2.2 The Health Board does not have corporate/strategic objectives, so whilst the Risk Management Strategy is aligned to the strategic aims as outlined in the Living

Healthy, Staying Well Strategy, the BAF lacks the detail to ensure risks are appropriate and address specific objectives for the organisation.

- 2.3 Management duties and accountabilities are defined with section 9 of the Strategy, however, we note that there was no definition of the Risk Management Department within this section. Considering the key role the department have in the monitoring, review and oversight of the risk management arrangements across the Health Board, we would expect this to be included in the document.

Section 10 details the governance arrangements in place to oversee the identification, treatment and monitoring of risks in line with the strategic objectives.

Conclusion:

- 2.4 The Risk Management Strategy details the assurance arrangements in providing a framework to support the Health Board's strategic aims, however there are no corporate/strategic objectives for the Health Board.

The Risk Register Procedure supports the Risk Management Strategy by providing an understanding of how to develop and manage risks through the process of developing risk registers across the Health board.

We note that under section 9 of RM01 risk management duties, there is no description of duties for the risk management department.

We have concluded **reasonable assurance** for this objective.

Objective 2: Principal risks and significant operational risks are proactively managed via the board assurance framework (BAF) and corporate risk register (CRR), and regularly reviewed by the Executive Team/Health Board Leadership Team and the Board (or appropriate Committee).

- 2.5 The Board Assurance Framework is aligned to the Health Board's strategic aims, as outlined in the Living Healthy, Staying Well Strategy, however the Health Board does not currently have objectives. The BAF is required to be refreshed on an annual basis, and the Strategy states *the Executive Team will retain operational oversight, application and maintenance of the BAF*. There is evidence to support the refresh, and also regular review and updating of the risks via correspondence with Directors and the Interim Board Secretary, however there is no formal process in place for the BAF review and the BAF was last received at the Executive Team meeting in July 2022.
- 2.6 The Corporate Risk Register is reviewed regularly through updates provided by management, and reviewed by the Risk Management Department. This is presented to the Risk Management Group for review and scrutiny.
- 2.7 At the time of this review, there were 18 risks on the BAF and 31 risks on the CRR.
- We reviewed five of the highest risks on the BAF; all with a risk score of 20.
 - None of the risks had 'action plan due dates' – one had 'ongoing', one was blank, three were 'TBC' (the action plan description covers all three of the

risks).

We note that four risks on the BAF did not have an action plan in place and were currently under review. Also, the action plan description for some is very detailed, and others is merely one line i.e. 'Implementation of HIW Action Plan'. In our opinion, the level of detail included in the section should be reviewed to ensure that members are able to gain assurance that the actions being taken are appropriate to address the risk highlighted.

- We reviewed ten of the highest risks on the CRR; seven with a risk score of 20 and three with a risk score of 16.
 - All of the risks had risk response plans with actions to mitigate the risks.
 - Each action has a due date, these are not altered to give a true reflection of progress. There was a total of 72 actions underpinning the ten risks. Eighteen of these actions were out of date / delayed, however all had progress updates attached to them.

2.8 The Risk Management Group (RMG) is the key group to monitor and review risks, including assurances in place. The Group is required to meet bi-monthly, with meetings taking place in August 2022, October 2022 and April 2023. Meetings in December 2022 and February 2023 were stood down due to industrial action. As a result of this, the RMG were not able to discuss and scrutinise the Corporate Risk Register as well as any new risks for escalation onto the register. At the meetings that took place, there is evidence of discussion relating to:

- Newly escalated risks.
- Deep dive on various risks, this involves scrutinising a risk in more in-depth detail e.g. Manual Handling, Emergency Departments and Management of patient records.
- Full list of all corporate risks.
- Risk Register reports from divisions where the divisional risk registers are discussed.

2.9 Due to the cancelation of the RMG on the 6 December 2022, a summary paper was taken to the Health Board Leadership Team (HBLT) for noting and agreeing actions/decisions, as well as approving the CRR in preparation for presentation at the relevant committee meetings. Minutes from the HBLT meeting on the 18 January 2023 notes support of two new risks being added to the CRR however we were unable to confirm full scrutiny of the CRR from the minutes:

Health Board Leadership Team Meeting – 18 January 2022

HBLT23.19 Risk Management

HBLT23.19.1 – [Officer] attended to present the Risk Management update and bi monthly report. The recommendations in the report were discussed and all supported the proposal that the HBLT continue to receive a bi-monthly risk update.

2.10 The RMG meeting on the 7 February 2023 was also stood down; a governance and risk update was presented to the HBLT on the 15 February 2023. The HBLT were asked to review the papers and the Corporate Risk Register Report. Minutes from the meeting highlight two new risks added to the register which were supported for inclusion by the HBLT, however we have been unable to see full scrutiny of the CRR.

2.11 The Risk Management Group reports to the Quality, Safety and Experience (QSE) Committee, providing assurance on arrangements put in place by senior managers to identify and mitigate risk.

2.12 The QSE relies on reporting from the Risk Management Group to provide effective oversight arrangements to ensure the BAF and risk register are maintained. We reviewed the last three sets of minutes of QSE meetings and note that the full list of corporate risks, newly escalated risks, coversheet and risk field guidance can be seen being presented and discussed at meetings in September 2022, November 2022 & January 2023.

The QSE of the 7 March 2023 was stood down and we are unsighted on when it is scheduled to meet again.

2.13 The Partnership People Population Health Committee (PPPH), Performance Finance and Information Governance Committee (PFIG) and Mental Health and Capacity Compliance Committee (MHCC) receive significant corporate and strategic risks that fall within their remit. A review of the last three sets of minutes from each meeting show corporate risks, newly escalated risks and coversheets associated with the relevant PPPH and MHCC committees presented at all the meetings we sampled.

No discussions have taken place regarding the CRR & BAF within the PFIG for the last three meetings, however we note that there are currently no PFIG risks sitting on the CRR.

Conclusion:

2.14 Due to cancellations of the meetings mentioned above, particularly the Risk Management Group, there has been insufficient oversight and scrutiny of the full CRR and BAF. Although the HBLT had sight of the CRR and BAF this is not in line with the governance arrangements outlined in the Risk Management Strategy.

We have concluded **limited assurance** for this objective.

Objective 3: Corporate risks are escalated and de-escalated in a timely manner, in line with strategy requirements.

2.15 In accordance with the Risk Register Procedure, escalation and de-escalation for any risk graded above 15 should include the following:

- Evidence of authorisation by the responsible Executive Director.
- Review and quality check via a meeting between the risk lead and the Risk Management/Risk Assurance Manager.

- Transfer to the Corporate Risk Register Word Template.
- Presented to the Health Board's Bi-monthly Risk Management Group meeting for scrutiny and relevant committee approval.

- 2.16 We reviewed a sample of six risks that were put forward for escalation/de-escalation to confirm whether the correct process was followed. For all six, the correct documentation had been completed, including authorisation by the Executive Director, reviewing of the risk by the risk lead and Risk Assurance Manager and transfer of the risk to the CRR template.
- 2.17 The Risk Register procedure states that the relevant committee (where the risk sits) approve escalation & de-escalation of risks. However, we note that risks now put forward for escalation/de-escalation require approval from the QSE committee.
- 2.18 The process can be seen being followed prior to the to the cancellations of the RMG meetings (6 December 2022 and 7 February 2023) and the QSE meeting (7 March 2023), however we have been unable to observe the appropriate committee approval for the escalation / de-escalation of risks.
- 2.19 Two risks from our sample were put forward for de-escalation to the HBLT for approval on the 18 January 2023. We have been advised that these risks were challenged for not following the appropriate process and currently still sit on the CRR awaiting committee approval to de-escalate.

Conclusion:

- 2.20 The processes for the escalation and de-escalation of risks have been followed in regarding authorisation by the Executive Director, reviewing of the risk by the risk lead and Risk Assurance Manager and transfer to the CRR word template. However, we have been unable evidence the scrutiny and approval process of all risks due to the cancellation of relevant meetings.

Further clarification is required with regards to the role of the HBLT in terms of the CRR due to the lack of oversight by the QSE, as this process does not meet the strategy requirements.

Clarification is required on the committee approval process as previous risks were sent to the relevant committees for approval whereas it now appears that the approving committee is QSE.

We have concluded **limited assurance** for this objective.

Objective 4: There is corporate oversight of division/IHC/Service risk management arrangements, ensuring accountability for implementing effective risk management arrangements

- 2.21 To determine the arrangements in place to support and challenge Divisions and Integrated Health Communities (IHCs), we reviewed Risk Managers involvement in risk management meetings. There are three Risk managers located in the East, Central and West areas respectively; we considered the meetings they attend and

how often these take place. We reviewed a sample of the meetings – we noted the following:

- There is evidence of Risk Managers attendance at Divisions/IHCs risk meetings, however a number of meetings have been stood down, limiting the Risk Managers involvement.
- The Central Workforce Operation and Delivery (WOD) meeting where risks are reviewed has not met since the August 2022.
- IHC Risk Management Group meetings are set up in the East and Central IHCS, however we note some of these meetings have been stood down:
 - Risk Register meeting (now Central Integrated Health Communities IHC)- July, August and September 2022 cancelled.
 - East IHC Risk Management Group – March 2023 stood down due to site pressures.
- There is no current dedicated IHC Risk Management Group meeting in the West; other avenues are currently being sought to support the governance and risk process.
- All three most recent consecutive minutes of East Women and Maternity Risk Management Group were provided as evidence of good practice.

Conclusion:

2.22 Corporate oversight of the Divisions/IHCs is partially taking place through organised meetings, however the level of scrutiny is limited by risk meetings either not taking place or being stood down in IHCs.

Whilst there is evidence of Risk Manager involvement in risk management arrangements across the organisation, there is not a consistent approach within the Risk Management Department to ensure appropriate oversight of risk management across the Health Board.

We have concluded **limited assurance** for this objective.

Objective 5: Established processes are in place to support the monitoring and review of key risks and assurance mechanisms across the Health Board, including at Committee and Board level.

2.23 As noted above, the Risk Management Group is the key group to monitor and review risks, including assurances in place, and the group has not been meeting regularly to allow effective monitoring of corporate risks.

2.24 The Strategy states the Board will review the CRR on an annual basis and the BAF on a quarterly basis. The Audit Committee is required to receive the CRR on a quarterly basis for independent scrutiny and challenge of the risk management process. We reviewed minutes from both the Health Board and the Audit Committee meetings to establish when the CRR and the BAF were last reviewed.

2.25 Both the CRR and the BAF were presented at the Board meetings on the 4 August 2022 and 26 January 2023. The CRR was presented for review and scrutiny at the Audit Committee meeting in June 2022. Chairs assurance reports from the RMG meeting were presented at the Committee in March and June 2022. We note the Audit Committee meetings for 27 September 2022 and 21 March 2023 were cancelled.

Conclusion:

2.26 The Risk Management Group is not meeting regularly to enable effective review and scrutiny of risks and action plans. The Health Board and Audit Committee are not receiving the CRR and BAF at the frequency required stated in the Risk Management Strategy. We are therefore unable to confirm oversight and scrutiny arrangements are adequate and in line with the requirements of the Strategy.

We have concluded **limited assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Risk management department duties (Design)		Impact	
The Risk Management Strategy includes a section for responsibilities across the Health Board, however there is no description of the duties for the Risk Management Department, considering they have a key role in ensuring risk management is Under section 9 of RM01 risk management duties, there is no description of duties for the corporate risk management department.		Potential risk of: <ul style="list-style-type: none"> Lack of assurance that the Risk Management Department is operating as intended. 	
Recommendations		Priority	
1.1	The Strategy is updated to include the duties of the Risk Management Department.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1.1	The Risk Management Strategy to be revised to include the duties of the Risk Management Department.	30 August 2023	Head of Risk Management and Interim Board Secretary

Matter Arising 2: Oversight, scrutiny and challenge of CRR and BAF (Operation)		Impact	
<p>Due to the cancellations of several meetings within the Health Board, including the Risk Management Group and the Quality and Safety Committee meetings, there is limited scrutiny and challenge of the risks within the Corporate Risk Register and the Board Assurance Framework.</p> <p>The current review and scrutiny frequency by the Health Board and Audit Committee meetings do not line themselves with the frequency stated within the board and committee structure table (RM01 page 12 section 7 point 7.7).</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Non-compliance with the Risk Management Strategy • Inadequate review and scrutiny of Health Board risks. 	
Recommendations		Priority	
2.1	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.	High	
2.2	Clarification is required on how often the Health Board and Audit Committee receive the CRR and BAF for review and scrutiny.		
Agreed Management Action		Target Date	Responsible Officer
2.1	<p>Review of the CRR review frequency (RM Strategy), within the Board and committee structure.</p> <p><i>Audit comment: We note the management action to consider where the CRR is reviewed, however management need to ensure these meetings take place to ensure sufficient scrutiny of the CRR.</i></p>	30 August 2023	Head of Risk Management and Interim Board Secretary
2.2	The Health Board and Audit Committee to have a Cycle of Business to include the CRR and BAF for review and scrutiny.	30 August 2023	Deputy Board Secretary

Matter Arising 3: Board Assurance Framework (Operation)		Impact	
<p>A review of the BAF has highlighted the following:</p> <ul style="list-style-type: none"> Risks are linked to strategic aims rather than objectives (as the Health Board does not currently have objectives), so there is a lack of a specific focus / target to ensure risks are appropriate. Whilst there is evidence of review of risks via email, there does not appear to be a clear process in place to ensure risks are reviewed and updated regularly. A sample of risks had no date for 'action plan due dates'. Four risks on the BAF did not have an action plan in place and were currently under review. The detail of action plans against risks differs and does not provide sufficient information for members to gain assurance that the actions will address the risk. 		<p>Potential risk of:</p> <ul style="list-style-type: none"> The Health Board is not assured that BAF risks are appropriate and whether actions to address risks are adequate. 	
Recommendations		Priority	
3.1	The process for reviewing and updating the BAF should be documented and implemented.	High	
3.2	The BAF should be updated when objectives of the Health Board are agreed, to ensure focused actions.		
3.3	The sections of the BAF should be fully completed.		
3.4	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.		
Agreed Management Action		Target Date	Responsible Officer
3.1	Document the process for reviewing and updating the BAF with implementation date.	30 August 2023	Head of Risk Management, Assistant Director of Governance, Interim Board Secretary

3.2	Ensure objectives of the Health Board is incorporated into the BAF with focused actions.		
3.3	It is paramount that all sections of the BAF be completed for robust scrutiny and assurance. (see action 3.4 below)		
3.4	Review the action plans to ensure sufficient information is included in the BAF with appropriate actions.		

Matter Arising 4: Escalation and de-escalation of risks (Operation)		Impact	
<p>The approval process for escalation/de-escalation of risks currently sits with the Quality, Safety and Experience Committee, however the Risk Register Procedure (RM02 V3.9) states:</p> <p><i>Presented at the Health Board’s Bi-monthly Risk Management Group meeting - by the Executive Director or nominated Risk Lead, for consideration, and potential recommendation to escalate to the Corporate Risk Register on both Executive Team and <u>relevant Committee approval</u>.</i></p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Risks escalated or de-escalated are not scrutinised by the appropriate committee. 	
Recommendations		Priority	
4.1	Clarification is required on the Committee approval process for the escalation and de-escalation of risks.	High	
Agreed Management Action		Target Date	Responsible Officer
4.1	Review of the RM02 v3.9 to indicate the QSE approves the escalation/de-escalation of risks.	30 August 2023	Interim Board Secretary

Matter Arising 5: Oversight and scrutiny of Divisions / IHCs (Operation)		Impact	
<p>Oversight and scrutiny of the risk management arrangements within the Divisions/IHCs by the Risk Management department is inconsistent and limited due to meetings either being stood down or not taking place.</p> <ul style="list-style-type: none"> • East IHC Risk Management Group – March 2023 stood down due to site pressures. • Central Workforce Operation and Delivery (WOD)- monthly meeting is not currently meeting. • No west IHC Risk Management Group meeting is currently taking place. 		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Lack of assurance that risk is being managed appropriately across the Health Board • Non-compliance with the Risk Management Strategy and Risk Management Procedure 	
Recommendations		Priority	
<p>5.1</p> <p>5.2</p>	<p>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.</p> <p>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.</p>	<p>High</p>	
Agreed Management Action		Target Date	Responsible Officer
<p>5.1</p>	<p>At the Risk Team Meeting Regional Managers were asked to produce an excel spreadsheet of meetings which review and scrutinise risks for the rest of the year. Any cancellation of meetings and reasons why to be fed back during the Risk Team with repeat cancellation of meetings for escalation to the AD of Governance.</p>	<p>31 July 2023</p>	<p>Regional Risk Managers (East, West and Central)</p> <p>Interim Board Secretary</p>
<p>5.2</p>	<p>Regional Manager West is working with West IHC to provide assurance on its risk management arrangements without the Risk Management Group meeting taking place.</p>	<p>30 August 2023</p>	<p>Regional Risk Manager (West)</p>

	<p>Meeting arranged with IHC Medical Director, Interim Head of Risk Management and Regional Manager West on the 1st June 2023 for further discussion and action.</p> <p>Audit note: Actions will need to be reviewed following the outcome of the meeting on 1st June 2023.</p>		
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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.
	No 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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Hergest Unit Notice of Contravention (NoC) Action Plan

Final Internal Audit Report

August 2023

Betsi Cadwaladr University Health Board



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Committee:	Audit Committee



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

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.

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Executive Summary

Purpose

The purpose of the audit was to ensure the Health Board can demonstrate it has the evidence to support completion of the action plan developed to address the three Material Breaches identified by the Health and Safety Executive.

Overview

We have issued limited assurance on this area.

The one matter requiring management attention concerns:

- Whilst evidence has been provided for actions, it does not support completion of the actions, or provide assurance that actions are embedded as part of day to day processes across the Division. The action plan should be revisited with urgency to ensure the Health Board can demonstrate the above.

Report Opinion



Limited assurance

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Trend

N/A

Assurance summary¹

Objectives

Assurance

1 There is evidence available to support the progression or completion of actions.

Limited

¹The 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	Whilst there is evidence provided by management who have assessed implementation as complete, there are several actions that require review as the evidence is not sufficient to support completion; gaps remain to demonstrate the actions are embedded.	1 Operation	High

1. Introduction

- 1.1 Following an investigation of the death of a patient by ligature in the Hergest Unit in April 2021, the Health Board was issued with a Notice of Contravention (NoC) by the Health and Safety Executive in May 2022. It identified three material breaches:
- Risk Assessment and Care and Treatment Plans
 - Bed Safety
 - Ligatures and removal of property
- 1.2 An action plan to address the breaches outlined in the NoC was developed by the 'HSE NoC Improvement and Development Group' which was established to address the breaches and to reduce the ligature work across Mental Health and Learning Disabilities Service.
- 1.3 The sole risk considered in this review was:
- Actions that have been progressed or completed do not have sufficient evidence available to support implementation.
- 1.4 The scope was limited to reviewing the agreed actions and evidence available to support implementation. We have also not considered whether the actions identified by the service and captured in the action plan address the identified breaches.

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.

Objective 1: There is evidence available to support the progression or completion of actions.

- 2.1 We met with the Deputy Director of Quality and Investigations Manager on the 12 June 2023 to discuss the review to evaluate the evidence provided by the Mental Health & Learning Disabilities Division (MHLDD) in addressing the Action Plan, developed by the service, to address the three material breaches identified by the Health and Safety Executive (HSE).
- 2.2 We have used the action plan maintained by the Quality Directorate to complete the review as we are advised this is the plan to be shared with Counsel. We note there are some variances with the MHLDD developed action plan but have not verified the reasons.
- 2.3 Following issue of our draft report on the 6 July 2023 we received a MHLDD response to our findings on 14 July 2023, including further evidence to support their

assessment. We have considered the response and amended our findings where relevant.

2.4 We have reported our observations against each action; our findings are reported by breach/recommendation with the key to our observations noted as follows:

Table 1: Internal Audit observations assessment (Red/Amber/Green)

	Evidence provided does not support implementation of the action.
	Evidence exists but gaps remain supporting completion and require further action.
	Evidence is present to support completion – minor housekeeping matters may remain.

Breaches identified: Risk Assessment and Care and Treatment Plan

Recommendation 1: Ensure that effective risk assessment management is in place to ensure staff training is suitable and sufficient in the completion of risk assessments and that there is management overview to monitor and audit the completed documents to ensure they meet the requirements of the admissions policy.

Table 2: Action plan for Recommendation 1 including audit observations

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
1.01	Provide audit results regarding the Mental Health Measure risk assessments against Clinical Risk Management Procedure.	Complete	30/04/2023		<p>Whilst the reports do provide audit results, we are advised that non-operational auditors undertook the reviews due to service pressures.</p> <p>There is no evidence to address the amber/red findings with robust timelines. Whilst the key has been included in the standalone pdf file, the actual report does not record what the different five shades indicate when the report says its RAG rated.</p> <p>Recommendations are not SMART with expected timelines and management response. The Heads of Nursing Action Plan is incomplete with a lack of</p>

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
					<p>start date/end date and only one update against nineteen actions. There is an urgent need to address the red rated areas immediately, however, there appears no urgency in implementing recommendations.</p> <p>Undertaking a review towards the end of 2023 with such gaps does not provide assurance that the requirements are embedded across the Division and part of expected day to day practice.</p> <p>There is no evidence on the progress of Phase 3 or 4 as indicated in the introduction. The data sheet is difficult to read and when it's embedded makes no improvement to being readable.</p>
1.02	Provide audit results regarding compliance in WARRN (Welsh Applied Risk Network)	Evidence up to April 2023, however compliance in April is showing less than February	30/04/2023		<p>Using data from 2010 to date suggests more staff have been trained and does not reflect those who received training but have since left.</p> <p>We are advised this is a once only competency and that the Division identified nine hundred and sixty one (961) roles at November 2022 requiring the training. The 23 June 2023 WARRN Risk Formulation Training notes 81% of staff trained against seven hundred and twenty seven (727) roles. We are unclear as to the correct number of staff requiring the training and this must be clarified as a priority to</p>

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
					ensure accurate information is reported.
1.03	Provide audit results of observation charts measured against Therapeutic Observation Procedure	Complete See phase 1&2 audit reports above (1.1)	30/04/2023		<p>The form states 'monthly audit,' however only an audit from March 2023 was provided as evidence - we have been advised this is incorrect and should be quarterly.</p> <p>The Therapeutic Engagement and Observation Audit Forms shared were completed on 13 March 2023 but no further evidence of quarterly review (June 2023) is available. Action Plans have specific recommendations with all except one having an August 2023 completion date.</p> <p>There is no evidence of follow-up where issues were identified with the reviews undertaken by the Clinical Operational Manager.</p> <p>Providing the audit results does not demonstrate improvement and it is of concern that there are a number of 'No' responses recorded implying the process is not standard.</p>
1.04	Audit Care & Treatment Plans and provide evidence of completion/results	Complete See phase 1&2 audit reports above (1.1)	30/04/2023		<p>There is no assurance or evidence to demonstrate the WARRN training has become embedded or that the findings have improved as the re-audit published in June 2023 details a number of Red/Amber rated findings.</p> <p>Providing the audit results does not demonstrate improvement and it is of</p>

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
					concern that there are a number of 'No' responses recorded implying the process is not standard. The cover sheet included as evidence in the first round of evidence has not been updated.
1.05	Review Acute Care Operating Framework and make amendments in relation to frequency of updating Mental Health Measure documentation.	Complete	30/04/2023		We have seen evidence that MHL0001 Acute Care Operating Framework is noted as approved in the MHL Policy Sub-Group on the 13 June 2023 but have no evidence that records approval in the Strategic Patient Safety Group meeting of the 21 April 2023 as detailed on the cover page of the Framework. Also, reviewing the framework does not complete the action - there is no information that it has been communicated, how it has been monitored for compliance etc.
1.06	Ensure staff are trained in the Therapeutic Observation Procedure controls and types of observation practice.	Complete	30/04/2023		Evidence shows the Policy was updated May 2023, and training slides provided. Toolbox talk session training records detail the staff trained where all, except three staff, received training from April 2023 onwards. There remain gaps in staff training as noted in email correspondence of the 14 July 2023, where 56.5% of Hergest staff have completed Observation and Engagement training.
1.07	Review Acute Care Operating Framework and	Complete	30/04/2023		We have seen evidence that MHL0001 Acute Care Operating Framework is

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
	make amendments in relation to frequency of risk assessment review				noted as approved in the MHLD Policy Sub-Group on the 13 June 2023 but have no evidence that records approval in the Strategic Patient Safety Group meeting of the 21 April 2023 as detailed on the cover page of the Framework. Also, reviewing the framework does not complete the action - there is no information that it has been communicated, how it has been monitored for compliance etc.
1.08	Ensure staff are trained on risk assessments and policies / documentation	Complete see1.6	30/04/2023		Evidence shows training slides and Toolbox talk session training records detail the staff trained where all, except three staff, received training from April 2023 onwards. There remain gaps in staff training.
1.09	Ensure all staff are aware of record keeping	Complete	30/04/2023		Evidence shows issue of Memo/Alert in 2022 and a copy of the Health Board Patient records management policy, which is out of date. Phase 1 audit findings have identified gaps in compliance. There is no evidence to demonstrate "...all staff are aware of record keeping". There is also no evidence the memorandum/alert was actioned.
1.10	Put in place nursing supervision arrangements Ward to Board that has a		30/04/2023		The supervision guidance provided is in date and a memorandum was sent to respective leaders; we are advised this is a Division wide guidance and there are

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
	specific entry on monitoring of documentation review				plans to incorporate this within locality performance reports moving forward.
1.11	Audit compliance with nursing supervision against MHL D Supervision Procedure		30/04/2023		It is unclear how the sample size for the audits has been chosen (as one ward sampled 20% approx. and others 25% approx.) – assurance needs to be provided that the sample size is consistent and adequate. Evidence should be provided for areas across the division.
1.12	Put in place a documentation audit out with MHM and RA documentation to establish consistency of form filling compliance	Complete	30/04/2023		We are advised this relates to the creation of Phase 1 audit reviews and those detailed in Action 1.01 above, not actual compliance against expected controls. There is evidence present that the Phase 1 audits have been developed.
1.13	All MHL D wards to have a Corporate H&S Review within three months and then at 6 monthly intervals	Complete	30/04/2023		Whilst there is evidence of Corporate Health & Safety reviews provided in December 2022 and April 2023, all the action plans have not been updated to reflect whether gaps identified have been addressed. We note a report to the Strategic Occupational Health and Safety Group for Q1 April to June 2023 but there is no evidence of updated reviews in line with six monthly intervals.
1.14	Put in place a digital patient record system	The Welsh Community Care	30/04/2023		Not complete.

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
		Information System (WCCIS) is the EPR for inpatient mental health, a non-mental health pilot has started and the full roll out dates will be agreed in Q1 2023/24 subject to an evaluation			
1.15	Put in place robust local health and safety management system HSG65	Health and safety folders are currently in place on all wards. Reviews evidenced: Sept 2022,	30/04/2023		Examples of completed Health and Safety review / Self Assessments were provided, however, there is no further update since September 2022. There is no evidence that the corporate assessments cover all areas in the Division.
1.16	Provide a monthly update to MHL Division QSE on health & safety items of significance	Bi monthly exception reports are completed from local West Health and Safety meeting and are a standing agenda item on local QSE and escalated via exception report to MHL Divisional QSE and in	30/04/2023		The Health & Safety Group was only 'stood up' 14 February 2023 and the Quality and Safety Divisional Group (QSDG) meeting in March 2023 was noted as cancelled. A review of the April QSDG meeting papers show there was no report ' <i>due to acuity and Easter</i> '. We received evidence of three reports from the Local West Area, two for Divisional Health and Safety meeting and one for Divisional Service Quality Delivery Group but are unable to confirm the dates

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
		turn escalated to Health Board QSE			these papers were presented.
1.17	Put in place local Health & Safety Group and attend West Health Economy Health & Safety Group meeting	Bi monthly locality and divisional meetings are already in place Local H&S group in West, exception reports go to local QSE, issues for escalation feed to Divisional QSE.	30/04/2023		There is no evidence of attendance at the West Integrated Healthcare Community Health & Safety Group. Attendance at the local HSE NOC Group is poor. Minutes of the West Health and Safety Meeting of 21 March 2023 also shows poor attendance with no apologies recorded.
1.18	Ensure nursing staff attend BCUHB Health & Safety training	Complete	30/04/2023		Health, Safety & Welfare training compliance at 31 January 2023 shows 94% compliance and green. Updated evidence required as at 31 May 2023 for current picture of compliance.
1.19	Put in place a Nurse in Charge SOP to clarify roles and responsibilities for inpatient staff for handover and determine ongoing care		30/04/2023		Evidence available to support the action. The 'date activated' in the document requires completion.

Breaches identified: Bed Safety

Recommendation 2: Ensure that appropriate hospital beds are available based on the comprehensive risk assessment identifying the patients requirements.

Table 3: Action plan for Recommendation 2 including audit observations

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
2.01	Ensure awareness of the Bed Allocation Decision Making Guide	Bed type allocation for every patient is discussed at the daily acute care meeting. Audit of this process has just been completed.	30/04/2023		The Bed allocation process is noted as being issued on 23 June 2022 as part of a list of 'Memos captured within daily huddles', but we are unable to corroborate how many staff were made aware of the procedure. There is no evidence that recommendations in the Bed Standardisation Project have been completed. We have been advised that all beds in Hergest have been replaced with standard lower ligature fixed box beds but have not corroborated this assertion.
2.02	Audit compliance with Bed Allocation Decision Making Guide	Complete Evidence up to December 2022	30/04/2023		Audits have been undertaken between 21 and 30 December 2022 on three wards in Hergest, however several non-compliance issues were raised and there is no evidence that these have been taken forward. There is no evidence of follow-up audits since these were undertaken in December 2022.
2.03	Confirm the cessation of mixed cohorting of patients over 70 years of age	Cohorting of older adults has ceased as of February 2022 Exceptions of admission of >70 patients are reported	30/04/2023		The Quality, Safety and Experience Committee (QSE) on 3 May 2022 received a report under agenda item QSE22.92 titled <i>Mental Health & Learning Disabilities (MHL) an update regarding ligature reduction, cohorting and the divisional improvement</i>

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
		via datix as a service exception and DSLT are aware of the annual figures			<p><i>plan which noted 'The OA pathway group considered that there may be a number of exceptions that could indicate, it may still be in the best interests of an older persons individual needs, to be admitted into Hergest.....For this reason of assurance re the mitigations in place, the division has further required that any proposed exceptions are immediately escalated to Divisional Director(s) in the day time, MH silver on call at other times, and Datix entered as a an "inappropriate patient pathway".'</i> - the Committee accepted and received the update.</p> <p>We can find no reference in Datix – Incidents attributed to Hergest for 'inappropriate patient pathway' for one over 70+ admission in Aneurin Ward in April 2022 and two over 70+ admissions to Cynan Ward in September and December 2022 respectively (as detailed in the IRIS paper).</p>
2.04	Ensure there is an appropriate system to obtain a suitable bed and staff aware of escalation process if patient in the wrong bed type	Complete	30/04/2023		See 2.01

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
2.05	Put in place a (calendar) system of undertaking environmental anti ligature risk assessments	Complete	30/04/2023		The audit workbooks provided refer to an annual audit and we are advised this is in line with UK standard practice but have not corroborated this. Workbooks have identified issues/gaps with compliance; some actions have an update recorded, but not all. We also received a copy of the West Estates Action log which shows some progress but gaps remain.
2.06	Put in place training to complete anti ligature assessments		30/04/2023		A training slide deck was provided. An undated, unauthored <i>Evaluation of Anti Ligature Environmental Risk Assessment Training MHL D</i> paper details the number of attendees across four sessions at Bryn y Neuadd, Abergele and Wrexham in October and November 2022. Sixty-five attendees are noted as attending these sessions but there is no record of the number of staff who should have received the training.

Breaches identified: Ligatures - removal of property

Recommendation 3: a. Ensure a process of completing anti ligature assessments take place as per agreed control document and risks identified and mitigated. b. Ensure staff are aware of the search procedure and apply process.

Table 4: Action plan for Recommendation 3 including audit observations

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
3.01	Implement an auditing and monitoring system for risk assessment actions and care plan review actions as detailed in 1, 2 above	Completed, See 1.1	30/04/2023		<p>On 20 April 2022 a Restricted Items Policy Memo/Alert was sent to Heads of Operations and Nursing respectively.</p> <p>There is an auditing tool and it is evident it has been used; however there are a number of 'No' replies in the audit. Some of these are not translated to an action plan, and there is no evidence of follow-up to close the audit process and therefore demonstrate progress.</p> <p>April 2023 Phase 3 summary audit of compliance with restricted items and searching patients and their property report shows poor compliance for both elements detailed. Recommendations have no detailed action plan.</p>
3.02	Put in place training on how to implement the search procedure	Completed	30/04/2023		<p>Training slide deck and records of staff training attendance provided through the 'Toolbox Talks' records. Three hundred and fifty-eight (358) staff (78.9%) are recorded as receiving 'General Policies' training with ninety-six (96) staff (21.1%) still to receive training. There are no details how training is included when on-boarding new colleagues/updating the list of staff requiring training/left the Division.</p> <p>Please note: We have identified different training</p>

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
					records for this action and action 3.06 below.
3.03	Review the search procedure in terms of link to risk assessment		30/04/2023		MHLD 0013 Searching Patients and their Property Policy (v3.0) is noted as being live as of 30 June 2023. F01 – Patients Property and Monies – Wards and Departments finance procedure is out of date and was scheduled for review in November 2022.
3.04	Ensure staff are aware of procedure for what is required to be recorded when the search procedure is implemented		30/04/2023		A Memo/Alert was issued on 17 May 2023 to the Division including the following ' <i>Restricted items - Please ensure ward staff are aware of and follow the MHLD Division Restricted Items Policy, there has been a recent incident...</i> ' April 2023 Phase 3 summary audit of compliance with restricted items and searching patients and their property report shows poor compliance for both elements detailed. Recommendations have no detailed action plan.
3.05	Review the Patient Property procedure in terms of link to risk assessment and return of high risk items		30/04/2023		MHLD 0013 Searching Patients and their Property Policy (v3.0) is noted as being live as of 30 June 2023. April 2023 Phase 3 summary audit of compliance with restricted items and searching patients and their property report shows poor compliance for both elements detailed.

Action Number	Action	Update	Target Date for Completion	RAG	Internal Audit observations
					Recommendations have no detailed action plan.
3.06	Put in place training in Patient Property procedure		30/04/2023		Training slide deck and records of staff training attendance provided through the 'Toolbox Talks' records. Two hundred and ninety three (293) staff (78.1%) are recorded as receiving 'General Policies' training and we note three staff were trained in January 2023 with the remainder receiving training from May 2023 onwards. There are eighty-two (82) staff (21.9%) still to receive training. There are no details how training is included when on-boarding new colleagues/updating the list of staff requiring training/left the Division.

Conclusion:

- 2.5 Our review of evidence provided has identified significant gaps where we cannot corroborate or support the self-assessment that the actions are complete.
 - 2.6 There is no evidence to demonstrate actions are embedded across the site as provision of memorandums/training slides does not underpin this assertion.
- We have concluded **limited assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Action Plan evidence (Operating)		Impact	
<p>Our review has found there are significant gaps in the evidence provided to the action plan and the management assessment that actions are complete.</p> <p>Whilst there is evidence of audits being undertaken, training slides provided etc., there was no documentation included to show there had been a positive and sustained change in practice.</p> <p>We found the audit findings presented had a number of 'red' rated actions, consistently across the review areas, with no clarity that the gaps identified were subject to follow-up.</p>		<p>The evidence included has not been embedded in day to day practice exposing the Health Board to further risk of patient harm.</p>	
Recommendations		Priority	
1.1	<p>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.</p>	High	
Agreed Management Action		Target Date	Responsible Officer
1.1	<p>The Notice of Contravention (NoC) Group will continue until just after the revised Court hearing (postponed from 03.08.2023) and will take forward the findings of this internal audit to direct further work and provide further evidence, as well as ongoing monitoring arrangements and intervention where recovery actions are required.</p> <p>Post-hearing, the NoC Action Plan (and Group) will be transferred to the Special Measures NCCU Action Plan and associated leadership/assurance arrangements to ensure alignment with the inpatient quality and safety programme, the special measures programme and to ensure ongoing sustainability of the actions.</p>	31 October 2023	Director of MHLD

<p>A working group led by the Deputy Executive Director of Nursing will meet monthly for the next three months, culminating at the end of October 2023, to peer review, scrutinise and challenge the additional work and further evidence as a means of providing assurance to the HSE prosecution task force led by the Executive Director of Nursing and Midwifery (who commissioned the internal audit) in relation to improvements following the internal audit findings and closure of the NoC plan and transfer to the NCCU action plan.</p>		
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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	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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Clinical Audit – Tier 1 National Audits Final Internal Audit Report

August 2023

Betsi Cadwaladr University Health Board



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Executive sign-off:	Nick Lyons, Executive Medical Director
Distribution:	Joanne Shillingford, Head of Clinical Effectiveness Phil Meakin, Interim Board Secretary / Associate Director of Governance
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.

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.

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Executive Summary

Purpose

To review the Health Board’s participation in Tier 1 audits, including the submission of data and resulting actions.

Overview

We have issued limited assurance on this area. The significant matters requiring management attention include:

- The 2023/24 Clinical Audit plan has not been formally approved by an appropriate committee.
- The Health Board has participated in the majority of Tier 1 audits (32 out of 38); however, we are advised a lack of resources and insufficient clinical and administrative capacity have restricted achieving full completion of the Tier 1 plan.
- There is no clear reporting through governance structures on progress and any issues with Tier 1 audits.
- The Clinical Effectiveness Department does not have oversight of validation checks for the data collated for national audits.
- The Clinical Effectiveness department do not receive assurance that local Clinical Effectiveness meetings are taking place and are therefore unsighted on areas being discussed.
- Clinical Audit reports covering quarters 3 and 4, and the annual plan, have not been presented to the Quality, Safety and Experience Committee. We recognise this is due to Committees not taking place for a period.

Other recommendations / advisory points are within the detail of the report.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

		Trend
	<p>Limited More significant matters require management attention.</p> <p>Moderate impact on residual risk exposure until resolved.</p>	 2022/23

Assurance summary¹

Objectives	Assurance
1 Appropriate policies, procedures and governance structures in place to support engagement, with clinical leads appointed and effectively acting as champions and points of contact for every National Clinical Audit and Outcome Review.	Reasonable
2 Data is appropriately validated, and quality checks undertaken prior to submission.	Limited
3 There is a formally recognised process for reviewing the Health Boards performance when reports are published.	Limited
4 Learning from audit and review is shared and communicated across the organisation.	Limited

¹The 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 Clinical Audit plan for 2023/24 has not been formally approved at an appropriate committee.	1	Operation	Medium
2	Lack of staff resources and insufficient clinical and administrative capacity have been recognised as issues affecting full completion of the Tier 1 audit plan.	2	Operation	High
3	The Clinical Effectiveness Department is not involved in the verification of the data collection procedure for the services audits.	2	Design	Medium
4	We have been unable to identify any reporting of the progress or issues with Tier 1 audits through the governance structure.	3	Operation	High
5	There has been no update provided to the Health Board, via QSE Committee, on the progress of clinical audits for quarters 3 and 4, as well as the annual plan.	4	Operation	High

1. Introduction

- 1.1 *Clinical audit is one of a range of quality improvement methodologies that can deliver improved processes and outcomes for service users. Audit and feedback aim to improve patient care by reviewing clinical performance against explicit standards and direction action towards areas not meeting those standards.*¹

The NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP), published by the Welsh Government, confirms the list of National Clinical Audits and Outcome Reviews that all health boards are expected to participate in (where the service is provided), and is the source for the 'Tier 1' audit plan. It sets out the responsibilities for health boards in Wales, is the source for the Tier 1 Audit Plan.

- 1.2 The associated risks were as follows:

- Failure to undertake mandatory national audits,
- Patient outcomes not improved, and
- Actions not taken to address identified issues.

- 1.3 Tiers 2 and 3 of the clinical audit process have not been included as these have been reviewed previously (2022/23).

2. Detailed Audit Findings

Objective 1: There are appropriate policies, procedures and governance structures in place to support engagement, with project leads appointed and effectively acting as champions and points of contact for every National Clinical Audit and Outcome Review.

- 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.

- 2.2 The Tier 1 audit plan for 2023–2024 lists forty-one audits, three of which were not applicable to the Health Board since services were commissioned elsewhere, leaving thirty-eight audits that the Health Board is required to complete.

A designated Clinical Effectiveness Facilitator from the Clinical Effectiveness Department and project leads from the East, Central, and West areas were all allocated to each of the 38 clinical audits. From 23 clinical audits 28 had assigned a Health Board lead, leaving 10 with no lead at the time of writing this report.

¹ *Best Practice in Clinical Audit, Healthcare Quality Improvement Partnership (HQIP), April 2020*

Following meetings with the Clinical Effectiveness Department we were informed that the majority of the clinical leads engage with the Clinical Effectiveness Facilitators, providing regular assurance on the progress of the Tier 1 audits.

When there are outliers and communication is not taking place, the Clinical Effectiveness Department escalate this to the IHC Medical Directors, who will then contact the appropriate service. We are advised this process is effective in improving engagement.

2.3 The Clinical Audit Policy and Procedure MD22 states: -

7.0 Organisation structures -7.3 Audit Committee

The Audit Committee is the approving committee for the annual audit plan ensuring it is fit for purpose.

We reviewed the minutes for the 2023 meetings of the Quality, Safety, and Experience Committee (QSE) and the Audit Committee but were unable to locate any reference to the Audit committee having approved the annual audit plan.

We received a paper entitled "Clinical Audit Plan 2023/2024 and Cycle of Business for Clinical Effectiveness Group". This was due to be presented to the QSE on 7 March 2023 with the recommendation of approving the annual plan, however the meeting did not take place.

Conclusion:

2.4 There is a Clinical Audit Policy and Procedure in place, with an updated version recently added to the Health Board intranet site.

There is effective communication from service project leads on the progress of Tier 1 audits, and an appropriate escalation is in place to address any issues.

The clinical audit plan for 2023/24 has not yet been formally approved; we note that the QSE did not meet between 20th January 2023 – 19th May 2023.

We have concluded **reasonable assurance** for this objective.

Objective 2: Data is appropriately validated and quality checks undertaken prior to submission. We will consider the completion of the Tier 1 audit plan for 2022/23.

2.5 The published NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) includes priority areas (nationally mandated projects) in which the Health Board is expected to participate (where the relevant service is provided). The NCAORP provide national data as well as the Health Board data, the audit results feed in from a range of networks.

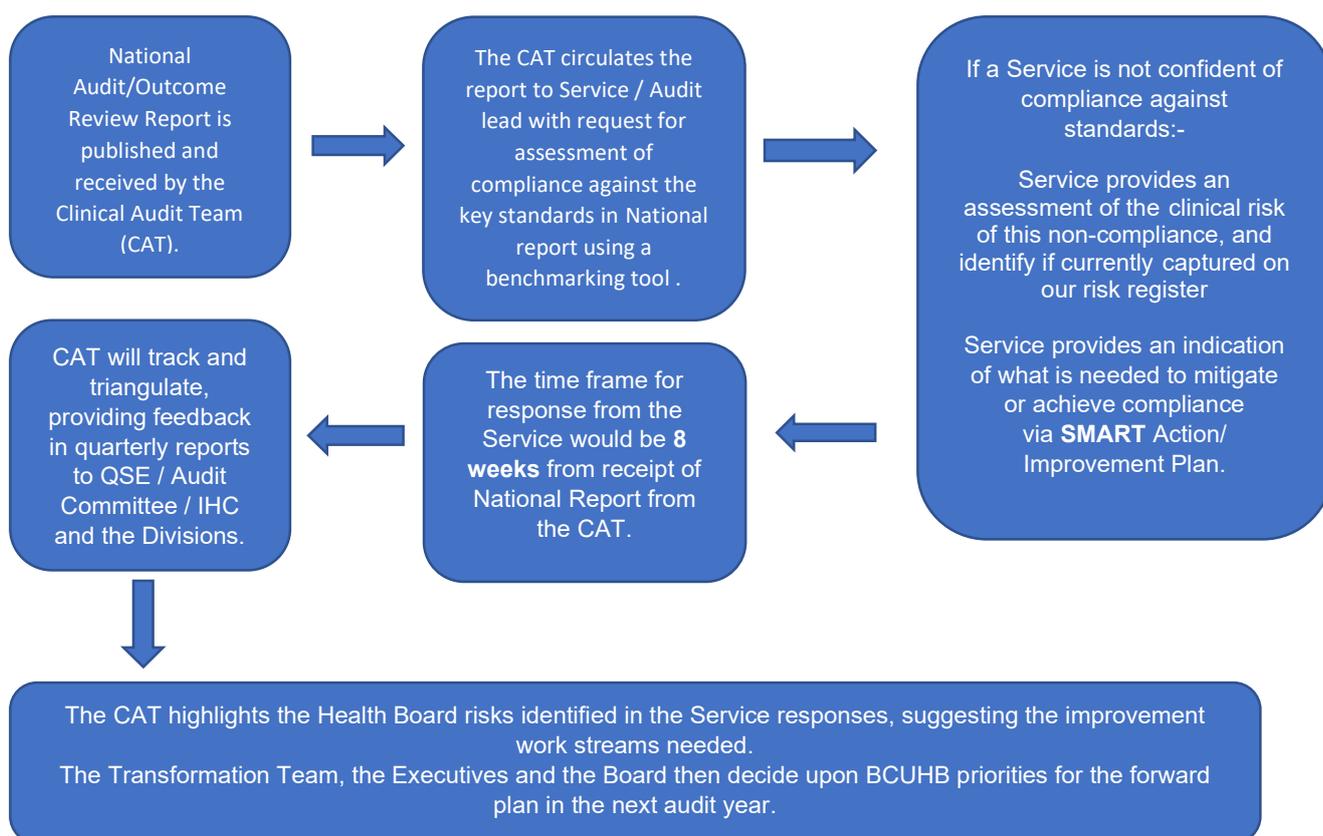
Various systems are used to collate the data throughout the year. CANISC (cancer) and Diamond (diabetes) are examples of two systems which currently capture data input by the services, other areas will use bespoke systems.

Through discussions with the Clinical Effectiveness Department, we determined that it is the services' duty to ensure that data is entered and verified by clinicians before input.

2.6 The Clinical Audit & Effectiveness Facilitator obtains data relating to the Health Board and the nationally reported results and populates a benchmarking tool, which has been developed in-house to help support and be used as an indication for areas for improvement.

2.7 All Nationally mandated projects are expected to complete a service assessment of compliance form developed by the Clinical Effectiveness Department, summarising the improvements plans and progress made between data collection.

Below is the current process for managing the national clinical audits:



2.8 Once the service 'assessment of compliance' form is returned the Clinical Effectiveness Team reviews the form. The Head of Clinical Effectiveness and the Deputy Executive Medical Director are then given the final draft for their approval.

We sampled all quarter 3 and 4 of the Tier 1 audit plan for 2022/23 to determine if the service assessment of compliance form had been completed and returned for each audit.

From the eight audits sampled, six service assessment of compliance forms had been completed. Out of the six forms, five had been completed using SMART actions to identify how the service will achieve compliance. One had achieved full compliance with two outstanding:

- National Early Inflammatory Arthritis Audit (NEIAA) – currently in draft, final action plan still not received.
- FFFAP: In-patient Falls Audit – no action plan response still outstanding.

2.9 We reviewed the completion of Tier 1 plan for 2022/23.

There were thirty-seven clinical audit projects which were identified as relevant to the Health Board, of which thirty-two were fully completed. Four were only partially completed, with the Clinical Audit Annual Report stating that a lack of staff resources prevented a full audit from being finished. There was no participation in one Tier 1 audit with “Insufficient clinical and administrative capacity” being given as the reason.

Conclusion:

2.10 We were informed that the data input to various systems in the Health Board is vetted by clinicians prior to submission. The Clinical Effectiveness Department do not have oversight of the validation / verification checks on the data to ensure it is accurate.

The Clinical Effectiveness Department has implemented benchmarking tools and Service assessment compliance forms to track the development between audits.

A lack of staff resources and insufficient clinical and administrative capacity have been recognised as issues impacting the participation in Tier 1 audits.

We have concluded **limited assurance** for this objective.

Objective 3: There is a formally recognised process for reviewing the Health Boards performance when reports are published, including consideration of improvements and escalation of issues around participation, and risk identification.

We reviewed the following meetings to establish whether performance and progression against Tier 1 audits is being monitored, and whether any issues were being escalated.

2.11 Quality Development Group for quality (QDG).

We were provided with the last three consecutive minutes for the Executive Development Group for quality.

The Strategic Clinical Effectiveness Group (SCEG) chair's reports and quality highlight reports from the East, Central, and West IHCs quality meetings were both included as standing items. However, the minutes do not include any discussions taking place around the performance and progress of clinical audits.

2.12 Strategic Clinical Effectiveness Group

We were provided with the three latest sets of consecutive minutes for the SCEG, which do not include any discussions relating to clinical audit Tier 1 performance and progress.

2.13 Local Clinical Effectiveness Groups (LCEG)

Evidence of the most recent Local Clinical Effectiveness Groups (LCEG) minutes from the East, Central, and West areas were provided to support the discussion of Tier 1 performance.

We noted the following:

East

- Issues around time and staff resources.
- CEG only met once between September 2022 and April 2023.
 - December 2022 meeting took place, but was not quorate.
 - October & November 2022 - no meetings scheduled.
 - January – March 2023 – Meeting paused whilst IHC wide meeting established.

West

- There was no evidence of discussions taking place regarding the current position of the Tier 1 progress and performance.
- November 2022 – March 2023 meetings were stood down.

Central

- There is evidence of discussions taking place as an agenda point around the progress of the Tier 1 audits, including non-compliance and engagement issues.

2.14 Issues relating to improvements and risk are captured within the *service assessment of compliance* form. The form requests the appropriate level of assurance identified for the Service by the National findings. If the service is not confident of its compliance, then an assessment of the clinical risk is required. An action plan is developed as an indication of what is needed to mitigate or achieve compliance of the national standards.

The department has created a spreadsheet to track the actions which have been developed by the services, however after viewing the spreadsheet, it is evident that it is not being updated by all the department. Therefore, we have been unable to establish how many actions are currently outstanding.

The Clinical Effectiveness Department is in the process of introducing a system *Audit Management and Tracking Database (AMaT)*. We were informed that the department will eventually utilise this system to enter the Tier 1 actions plans to keep track of and review all actions.

At the time of reporting, the system is only being used within the department but is hoped that it will soon be launched across the Health Board which will further underpin the monitoring of risks.

Conclusion:

2.15 There is limited evidence to demonstrate local Clinical Effectiveness Groups are discussing issues and progress of Tier 1 audits. We were unable to identify a clear reporting method for issues of escalation. We note that the creation of the new IHCs has potentially interrupted this.

Improvements and risk are being captured through the completion of the service assessment of compliance form. Action plans are developed and entered onto the AMaT system and monitored by the clinical effectiveness department.

The AMaT system needs to be developed further beyond the department and utilised throughout the Health Board to ensure effective oversight of audit progress.

We have concluded **limited assurance** for this objective.

Objective 4: Learning from audit and review is shared and communicated across the organisation, including assurance provided to the Health Board.

2.16 The question "*where has the learning from the audit been disseminated*" is asked in a section of the service assessment of compliance form. Numerous local service meetings, such as Clinical Governance meetings and Improvement groups, were mentioned in the responses drawn from our sample.

We were informed that minutes of the meetings were not provided as evidence to the Clinical Effectiveness Department in order to provide assurance that the meetings had taken place and learning from the published audits has been discussed. As a result, we were unable to confirm that the audits were appropriately communicated throughout the Health Board.

2.17 The Clinical Audit Policy and Procedure MD22 states: -

8.3 Clinical Effectiveness Department Support and Assurance

The Clinical Effectiveness department will be responsible for:

Providing the Quality, Safety and Experience Committee (QSE) with cumulative quarterly reports leading to an annual report that monitors progress against the plan.

Quarter 1 and 2 reports for 2022/23 were presented to the QSE on 1 November 2022 and 20 January 2023. We received the quarter 4 report and the annual report for 2022/23, however we have not seen these, or the quarter 3 report, being presented to the QSE Committee.

We note that the QSE did not meet between the 20 January 2023 and 19 May 2023.

Conclusion:

2.18 When completing the '*service assessment of compliance*' form, services identify local meetings as a part of the learning and communication process. The Clinical Effectiveness department do not request evidence to confirm the learning has been discussed and shared.

Quarter 3 and 4 Clinical Audit updates, and the Clinical Audit Annual Report have not been presented to the QSE Committee.

We have concluded **limited assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Clinical Audit Plan 2023/24 (Operation)		Impact	
<p>The Clinical Audit Plan for 2023/24 has not been approved by an appropriate committee. It is recognised that a number of committee meetings have not taken place over a period of time.</p> <p>Whilst the Tier 1 audits required by the Health Board are mandated as part of the NHS Wales National Clinical Audit and Outcome Review Plan, it is important the full clinical audit plan is supported and approved by the Health Board.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> The Health Board is not aware of the requirements for participation in mandated Clinical Audits. 	
Recommendations		Priority	
1.1	The Clinical Audit Plan for 2023/24 should be formally approved at the appropriate committee.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1.1	<p>The Clinical Audit Plan for 2023/2024 was prepared and submitted initially to the Strategic Clinical Effectiveness Meeting on 14th February for discussion and agreement. Following this the Clinical Audit Plan was prepared and submitted to Quality, Safety and Experience Committee (QSE) on 7th March, the meeting was then stood down.</p> <p>The paper was then submitted to Quality Delivery Group (QDG) on 17th April, due to QSE not having any further dates to present at that time and due to changes in Board membership all of the Committees were not meeting at that time. It was therefore appropriate Nick Lyons signed it off as Executive Medical Director and Acting Chief Executive Officer at that time.</p>	31 July 2023	Head of Clinical Effectiveness

Matter Arising 2: Clinical Audit participation (Operation)		Impact	
<p>The Tier 1 plan for 2022/23 included thirty-seven audits; of which:</p> <ul style="list-style-type: none"> - Thirty-two were fully complete - four were partially complete, reason stating '<i>lack of staff resources prevented a full audit from being finished</i>' - the Health Board did not participate in one, reason stating '<i>Insufficient clinical and administrative capacity</i>' <p>A lack of staff resources and insufficient clinical and administrative capacity were identified as the rationale for the non-completion of all audits. The NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme (2022/23) states:</p> <p><i>To ensure the maximum benefit is derived from the clinical audit programme health boards and trusts should:</i></p> <ul style="list-style-type: none"> • <i>Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.</i> 		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Non-compliance with the requirements of the National Clinical Audit and Outcome Review Plan. 	
Recommendations		Priority	
2.1	The Health Board to ensure resources are available to participate in audits in order to fully comply with the mandated audits.	High	
Agreed Management Action		Target Date	Responsible Officer
2.1	On the next Strategic Clinical Effectiveness Group (CEG) agenda on 8th August a request was made that each local CEG discuss and identify resource gaps and how they come to that conclusion and bring back to CEG 12 th September meeting relevant information for us to capture in Chairs Report to escalate to relevant Health Board meetings.	30 September 2023	IHC, Divisions, specialities

Matter Arising 3: Validation of Data (Design)		Impact	
The Clinical Effectiveness Department is not involved in the verification of the data collection procedure for the services audits.		Potential risk of: <ul style="list-style-type: none"> data submitted for national audits not appropriately validated 	
Recommendations		Priority	
3.1	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	
Agreed Management Action		Target Date	Responsible Officer
3.1	Team are non-clinical and would not be able to validate this. At the next Strategic Clinical Effectiveness Group (CEG) agenda on 8th August we will request that when each Tier 1 audit is published that the area will need to validate how the data was collected. This will provide assurance and we can capture within our minutes and quarterly reports which will be submitted at relevant Health Board meetings. The Clinical Audit Facilitators will have this as one of a list of criteria when monitoring audits with IHCs and Divisions to note.	30 September 2023	Head of Clinical Effectiveness and Clinical Audit Facilitators

Matter Arising 4: Progress reporting of Tier 1 audits (Operation)		Impact	
<p>The minutes of local Clinical Effectiveness Groups (CEGs) demonstrate some discussions regarding Tier 1 audits, however this has been limited due to a number of meetings being stood down.</p> <p>We have been unable to identify specific reporting of the Tier 1 audits through an escalation process. We recognise that this may have been disrupted by the development of the new IHCs.</p> <p>Audit Management and Tracking Database (AMaT) system currently only being used internally within the department.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Being unaware of current issues which are impacting the Tier 1 audit progress. • Being unable to track updates on previous 	
Recommendations		Priority	
4.1	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	
4.2	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	
Agreed Management Action		Target Date	Responsible Officer
4.1	<p>The quarterly reports that are produced from Clinical Audit Team capture which audits have been published in relevant quarter and includes all BCU identifiable data – plus process and completed actions and outstanding issues. These are followed up by Clinical Audit Facilitator at local CEGs.</p> <p>We have recently set up an Audit /NICE monthly meeting and we would capture any areas of concern that need taking to Strategic CEG to close the loop. A cycle of business (COB) has been developed to ensure relevant papers go to appropriate meetings</p>	31 March 2024	Head of Clinical Effectiveness

4.2	We do currently update AMaT with all Tier 1 information and add on action plans however we need to review if beneficial to be using outside of department. Will look at piloting within couple of Tier 1 areas for feedback at relevant meetings.	31 December 2023	Head of Clinical Effectiveness and Clinical Audit Facilitators
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Matter Arising 5: Learning from audits (Operation)		Impact
<p>The minutes from local service meetings, where the learning from audits is shared, are currently not being received by the clinical effectiveness department.</p> <p>The Clinical Audit updates for quarter 3 and 4 and the annual report, which should include the results of audits / learning, have not been presented at the QSE committee meeting. The QSE did not convene between 20th January 2023 – 19th May 2023, which has impacted the submission/approval of these documents.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Health Board is unable to evidence learning from clinical audits. • Lack of assurance provided to the Health Board on the performance
Recommendations		Priority
5.1	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
5.2	<p>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.</p> <p>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.</p>	High
Agreed Management Action		Target Date
		Responsible Officer

5.1	Following recent meeting with Internal Auditor the Service assessment form was amended July 2023 to request evidence of discussions and how these are shared as part of the assurance process. Clinical Audit Facilitators will ensure that all details are completed before accepting the form as completed and the update will be included in the relevant quarterly report.	23 July 2023	Head of Clinical Effectiveness and Clinical Audit Facilitators
5.2	All papers are on Cycle of Business (COB) and when to be presented at relevant meetings. As the QSE has stood down on a number of occasions, after being submitted at the Strategic Clinical Effectiveness Meeting, papers have been submitted at Quality Delivery Group for submitting in August. They will then go to QSE and Audit Committee now that dates have been re-established and agenda confirmed.	30 September 2023	Head of Clinical Effectiveness

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.



GIG
CYMRU
NHS
WALES

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

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Internal Audit Plan 2023/24 – October 2023 to March 2024 September 2023

Betsi Cadwaladr University Health Board

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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 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.

1. Introduction

The Audit Committee approved the six-month Internal Audit Plan for the Health Board, covering April – September 2023 and the Internal Audit Charter in May 2023.

This document sets out the plan for the second half of the year, covering October 2023 to March 2024 (the Plan), and details the audits to be undertaken and an analysis of the corresponding resources.

We have not included details of the planning process within this document, as these were included in the plan approved by Audit Committee in May 2023.

2. Planned internal audit coverage

2.1 Internal Audit Plan 2023/24 (April to September 2023)

The six-month Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register, related systems of assurance and outline scope. The scope, objectives and timing will be refined when developing the audit brief in discussion with the responsible executive director(s) and operational management.

The Audit Committee will be kept apprised of performance in delivery of the Plan through routine progress reports to each Audit Committee meeting.

The audit work will be undertaken by our regionally based team with support from our national Capital & Estates team, in terms of capital audit and from our Digital & IT team regarding Information Governance, IT security and digital work.

2.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

The development of a six-month plan ensures we can focus on priority risk areas, business critical systems, and the provision of assurance to management across the year ahead. We will, as always, keep the plan under review to ensure it remains fit for purpose.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan enabling us to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales will take place to coordinate planned

coverage and ensure optimum benefit is derived from the total audit resource.

3. Resource needs assessment

The plan has been put together on the basis of the planning process described in the plan approved in May 2023. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

4. Action required

The Audit Committee is invited to consider the Internal Audit Plan for October 2023 to March 2024 and:

- approve the six-month Internal Audit Plan for October 2023 to March 2024; and
- note the Audit Universe/Rolling plan and the risks identified for consideration for April to September 2024.

Dave Harries CMIIA QiCA

Head of Internal Audit – Betsi Cadwaladr University Local Health Board
Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2023/24 – October 2023 to March 2024

Planned output, Outline scope, Review reference	Strategic Objective (SO) / BAF Risk (BAF)/ Corporate Risk Register (CRR) / Special Measures (SM) links	Executive Lead/Responsible Director	Planned start
Corporate Governance and Regulatory			
<p>Board Assurance Framework and Risk Management (Full review including follow up of actions)</p> <p>We will review the implementation and application of the Health Boards Risk Management and Board Assurance processes.</p> <p>We will also assess implementation of the management actions agreed because of the limited assurance review in 2022/23</p>	SM: 1.6 Risk	Interim Board Secretary	February 2024
<p>Health and Safety</p> <p>We will review compliance with the Health & Safety Policy.</p>	SO: 4 BAF: 4.1 (score 20) CRR21-16 (score 16), CRR23-47 (score 15)	Deputy Director of People	October 2023
<p>Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality</p> <p>We will review the processes in place to comply with Standing Orders (Order 8): Values and Standards of Behaviour.</p>		Interim Board Secretary	November 2023

Follow-Up of Internal Audit recommendations

We will review the implementation of Limited assurance report recommendations not subject to full review and those defined as 'High Risk' in other reviews.

Interim Board Secretary

October 2023 to March 2024

Strategic

No specific risk identified for coverage in October 2023 to March 2024

Financial

Charitable Funds (Full review including follow up of actions)

Interim Executive Director of Finance

January 2024

We will review compliance with the Health Board's own procedures and a sample of Charity Commission guidance.

We will also assess implementation of the management actions agreed as a result of the limited assurance review in 2022/23.

Delivery of Health Board Savings (Follow up)

Interim Executive Director of Finance

October 2023

We will review the implementation of agreed actions following the no assurance review in 2022/23 and undertake a review on the steps the Health Board has established to identify savings opportunities in 2024/25 and 2025/26.

Budgetary Control

CRR23-50 (score 15),
CRR23-51 (score 16)

Interim Executive Director of Finance

December 2023

We will review whether the Health Board has effective controls in place to manage its financial

budgets, including delegation and information available to budget holders.

Clinical governance, Quality and Safety

Contracted Patient Services: Quality and Safety arrangements (Follow up)

We will assess implementation of the management actions agreed as a result of the no assurance review in 2022/23.

Executive Director
of Nursing and
Midwifery

January
2024

Deprivation of Liberty Safeguards (DoLS)

We will review the process in place for the management of DoLS activity in the Health Board, including procedures, staff training, monitoring and escalation of cases.

CRR21-14 (score 20)

Executive Director
of Nursing and
Midwifery

January
2024

Technology

Records Management – Fragmented Care Records

We will review the steps being taken to address the fragmented care records as specified in Special Measures SM: 3.10.

CRR22-32 (score 16),
CRR23-46 (score 15)
SM: 3.10 Address the
fragmented care record
concerns

Chief Digital and
Information Officer

November
2023

Digital Health Record (Cito) – Patient Records Transition Programme

We will review governance and delivery of the digital record following revision of the programme initiation document as reported to the Performance, Finance and Information Governance Committee in February 2023.

CRR20-06 (score 16)

Chief Digital and
Information Officer

February
2024

Operational service and Functional management

Integrated Health Community – Central

We will review the effectiveness of governance arrangements within the IHC. This review will also incorporate the follow-up of the review of governance arrangements at Ysbyty Glan Clwyd.

SO: 1
BAF Risk: 1.1 (score 20)
CRR22-30 (no score)

Interim Executive
Director of
Operations
October
2023

Womens Services

We will review the effectiveness of the governance arrangements within the service.

CRR22-30 (no score),
CRR23-57 (score 16)

Interim Executive
Director of
Operations
November
2023

Discharge arrangements /patient flow management

We will review the arrangements in place within the Health Board for the timely and safe discharge of patients and whether there is adherence to local and national policies and guidance.

SO:1
BAF: 1.3 (score 20)
CRR23-39 (no score),
CRR23-41 (score 16),
CRR23-54 (score 16)

Executive Director
of Nursing and
Midwifery
October
2023

Workforce management**Operating Model**

We will review the costs associated with the operating model and whether the revised structure has delivered the benefits intended.

CRR22-24 (score 15),
CRR22-28 (no score),
CRR22-29 (no score),
CRR22-32 (no score)
SM: 3.2 – operating model
stocktake

Interim Chief
Executive
October/
November
2023

Corporate Legislative Compliance: National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005

We will review the engagement of Consultants in line with Statute and Health Board procedures.

Deputy Director of
People/Executive
Medical Director
November
2023

<p>Recruitment of substantive and interim executive and senior posts (Follow up) We will assess implementation of the management actions agreed as a result of the limited assurance review in 2022/23.</p>	<p>SO: 2 BAF: 2.1 (score 16) CRR22-30 (no score) SM: 3.7 Interims review</p>	<p>Deputy Director of People</p>	<p>December 2023</p>
<p>Grievance procedure and case management We will review the process for the management of grievances, considering the length of time to resolve, independence of officers and communication of outcomes.</p>	<p>SO:3 BAF: 3.2 (score 16) SM: 3.4 Senior HR cases</p>	<p>Deputy Director of People</p>	<p>February 2024</p>

Project/Programme

<p>Wrexham Maelor Continuity Following submission of the business case, a review of progress will be undertaken in line with expected contractual stages and controls – Progressing this review is subject to Welsh Government approving the business case.</p>	<p>CRR22-35 (score 16)</p>	<p>Interim Executive Director of Finance</p>	<p>October 2023 to March 2024</p>
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Property

No specific risk identified for coverage in October 2023 to March 2024

Appendix B: Audit Universe/Rolling Plan

The review topics detailed is not an exhaustive list of all services/processes identified and some will reflect a whole system, upon which elements will be reviewed.

The ✓ and ✓✓ in 2023/24 indicates we intend to provide assurance in this area. The R records an identified risk area which we have considered as part of the 2023/24 planning process. Due to the risk based approach and resources available, we will not undertake reviews in all those identified areas and the Committee/management may wish to ensure they have adequate second-line assurance reporting in place.

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March Ⓡ = Risks identified	Ⓡ = Risks identified
Corporate governance, risk, and regulatory compliance							
Welsh Language Measure (Wales) 2011		Limited			Limited	✓	
Board Assurance Framework & Risk Management	Reasonable		Reasonable	Reasonable	Limited	✓✓	Ⓡ
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016	Limited					Ⓡ	Ⓡ
Corporate Legislative Compliance: Social Services and Well-being (Wales) Act 2014							

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
COVID-19 Governance & Associated reviews			Assurance not applicable*2	Assurance not applicable*2			
Corporate Legislative Compliance - Civil Contingencies Act 2004							(R)
Partnership governance		Limited		Limited		(R)	(R)
Regional Partnership Board/Integrated Service Board				Limited			
Standards of Business Conduct - Declarations of interest, gifts, and hospitality	Reasonable			Limited		✓✓	(R)
Board, Executive, Divisional Governance	Limited		Limited	Assurance not applicable	Limited	(R)	(R)
Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation (SORD)					Reasonable	(R)	(R)
Policies & Procedures						(R)	(R)
Receipt of External Reviews/Reports						(R)	(R)
Targeted Intervention/Special Measures				Reasonable		(R)	(R)

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Impact Assessments		Limited		Reasonable			
Welsh Risk Pool – Claims Management		Reasonable	Substantial				
Annual Report/Annual Governance Statement	Reasonable		Assurance not applicable			Advisory	
Preparations for EU Exit (BREXIT)			Assurance not applicable				
Strategic risk							
Performance management & Reporting			Reasonable		Limited	(R)	(R)
Strategic planning - Including IMTP						(R)	(R)
Annual Operational Plan	Reasonable						
Business Continuity Planning/Arrangements	Limited		Limited	Limited		(R)	(R)
Healthcare Commissioning						(R)	(R)
Transformation / Project Management					Assurance not applicable		(R)
Communication and Stakeholder engagement						(R)	(R)

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Financial risk							
Asset management						(R)	(R)
Benefits Realisation						(R)	(R)
Budgetary Control & Financial reporting	Reasonable	Reasonable	Reasonable	Reasonable	Reasonable	✓✓	(R)
Business Case - Capital and Revenue	Limited					(R)	(R)
Accounts Receivable - Cash and Bank/Petty Cash/Cash receipting						Reasonable	(R)
Charitable Funds					Limited	✓✓	(R)
Costing							
Counter Fraud					Reasonable		
Financial planning/Sustainability							
General Ledger						(R)	(R)
Lease Cars							(R)
Losses and Special Payments						(R)	(R)
Standing Financial Instructions - Procurement	Reasonable	Reasonable*2		Reasonable		✓	(R)
Private / Overseas Patients						(R)	(R)

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Patients Monies and Property	Limited	Assurance not applicable	Assurance not applicable				
Payment Card Industry Compliance							(R)
Savings - Identification and Delivery	Reasonable		Limited		No	✓✓	(R)
Stores							(R)
Value Based Healthcare							
Year-end processes						Reasonable	
Clinical governance quality & safety							
Annual Quality Statement	Reasonable	Reasonable	Reasonable				
Clinical audit				Limited		Limited	
Clinical coding	Assurance not applicable						
Clinical Commissioning - Quality & Safety					No	✓✓	
Corporate Legislative Compliance: Health and safety at Work etc. Act etc. Act 1974		Reasonable	Assurance not applicable			Limited ✓✓	

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020						(R)	(R)
Deprivation of Liberty Safeguards (DOLS)		Limited				✓✓	
Decontamination		Limited				(R)	(R)
End of Life Care						(R)	(R)
Follow-up Healthcare Inspectorate Wales				Assurance not applicable			
HASCAS & Ockenden Follow-up		Reasonable	Reasonable	Assurance not applicable			
Incident management							
Infection Prevention and Control	Reasonable					(R)	(R)
Medical equipment and devices							
Nutrition and Hydration	Limited						(R)
Patient experience						(R)	(R)
Patient Safety Notices etc			Reasonable				
Public Health					Reasonable	(R)	(R)
Concerns/Complaints/Putting things right/Learning Lessons	Limited			Reasonable	Limited	✓	(R)

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Quality Improvement Strategy		Limited				(R)	(R)
Research and Development							(R)
Safeguarding		Substantial					(R)
Security			Limited	Assurance not applicable			(R)
Ward accreditation						(R)	(R)
World Health Organisation (WHO) Checklist							(R)
Technology							
Informatics governance	Assurance not applicable		Assurance not applicable				
Digital Strategy / Digital Operating model					Reasonable	✓	(R)
Digital readiness							(R)
Service Management (ITIL)						(R)	
Access Controls							
Identity and certificate management							
Cyber security		Reasonable		Reasonable		Substantial	
Change Control							

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Data analytics / data led organisation							(R)
Business process automation / robotics						(R)	
IT equipment / end user device management						(R)	
IT infrastructure / network management (inc. NIS Directive)				Reasonable		(R)	
IT Projects						(R)	
Software / system development							
Disaster recovery and resilience			Limited				(R)
Cloud migration							
Medical records management, control, and access						✓✓	
Patient records & Digital Integration / digitisation						✓✓	
Safe Care							
Data quality							
Corporate Legislative Compliance: Freedom of information Act	Reasonable						(R)
GDPR		Reasonable					
Welsh IG Toolkit (inc. Caldicott)				Substantial		Substantial	

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Locally managed IT systems - Where control rests outside of DDaT						(R)	
Datix Web							(R)
IRIS							(R)
WOREQ2							
CWS							
E-expenses							
Electronic Staff Record							
Wellsky Pharmacy Management System						(R)	
Oracle E-financials							(R)
PACS & Radis							
Welsh Clinical Portal							
Welsh Demographic Service							
WPAS							(R)
Operational service and functional management							
Bereavement Services							

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Integrated Health Community - Central				Assurance not applicable		✓✓	
Integrated Health Community - East	Reasonable				Limited		(R)
Integrated Health Community - West					Limited		
Cancer Services							(R)
Womens Services				Reasonable		✓✓	
North Wales Managed Clinical Services							(R)
Mental Health and Learning Disabilities	Limited Assurance not applicable	Assurance not applicable	Limited	Assurance not applicable	Reasonable		
Cluster management and development				Reasonable			(R)
Clinical Trials							(R)
Discharge / Patient Flow management						✓✓	
Continuing Health Care					Reasonable		
Education							

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Emergency Medical Retrieval and Transfer Service Cymru (EMRTS)							
Energy							
Falls Management	Limited					✓	
General Dental Services							
General Medical Services							
General Ophthalmic Services							
GP Out of Hours	Assurance not applicable					✓	
Looked After Children (LAC)							
Managed GP Practices		Reasonable				(R)	
Medical Physics							
Non-Emergency Patient Transport Service		Reasonable					
Operational Estates and Facilities	No assurance						(R)
Primary Care – Transformation Fund/Other	Limited						
Transport Management							(R)
Unscheduled care					Limited	(R)	
Waiting list management	Limited			Limited		(R)	
Planned care delivery					Limited	(R)	(R)

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Prison Healthcare Services							
NHS Wales Act - Section 33 Agreements		Limited					(R)
Veterans							
Workforce management							
Agency Staffing/IR35			Limited			(R)	
Annual leave							
Approved Clinicians and Section 12(2) approval			Reasonable				
Case Management & Disciplinary process	Limited					✓✓	
Corporate Legislative Compliance: National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005						✓✓	
Consultant Contract/Job planning							(R)
Consultant Revalidation							(R)
Staff Benefit Schemes							
Corporate Legislative Compliance - Equality Act 2010							
Roster management			Limited	Limited		(R)	

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Job evaluation							
Manual Handling							
Medical Staffing				Reasonable			
NHS Wales Staff Survey		Limited					
Occupational Health							
On-Call				Limited			(R)
Operating model						✓✓	
Payroll/Salary Overpayments	Limited	Limited					
PADRs							
People & OD Strategy						(R)	
Professional Registration						(R)	
Raising staff concerns/Safehaven/Speak out Safely					Reasonable		(R)
Recruitment		Limited		Reasonable	Substantial		
Engagement of Interim appointments			Limited		Limited	✓✓	
Sickness absence management						(R)	
Staff Leavers				Limited			
Staff wellbeing							
Statutory and mandatory training							

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Temporary Staffing							
Upholding Professional Standards in Wales (UPSW)				Reasonable			
Violence & Aggression			Limited				
Voluntary Early Release Scheme (VERS)				Reasonable	Reasonable		
Volunteers							
Waiting list initiative							
Project and programme risk							
Integrated Audit Plans - Major capital schemes assurance	Reasonable	Reasonable*5	Reasonable		Reasonable	✓ ✓✓	(R)
Discretionary funded schemes & equipment procurement						(R)	
Capital Systems	Reasonable		Reasonable	Substantial			
Vehicle, Equipment & IT Procurement		Assurance not applicable					
Property							
Corporate Legislative Compliance - Asbestos Management				Reasonable			(R)
Corporate Legislative Compliance - Fire Safety		Reasonable					(R)

Review topics	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/23	2023/24	2024/25
ANNUAL OPINION	Limited	Reasonable	Reasonable	Limited	Limited	✓ = April - September ✓✓ October - March (R) = Risks identified	(R) = Risks identified
Corporate Legislative Compliance - Water Safety			Limited			✓	
Medical Gases							
Electricity Safety Regulations						(R)	
Backlog Maintenance							
Minor works							
Maintenance and operations							
Control of Contractors			Limited				
Waste Management				Reasonable			
Residential Accommodation							(R)
Property management	Limited				Substantial	(R)	
Carbon Reduction Commitment	Substantial	Substantial					
Order/Decarbonisation	Reasonable	Reasonable	Substantial		Advisory	✓	
Environmental Sustainability							
Analysis of reviews							
Substantial	1	2	3	1	3	1	0
Reasonable	14	18	9	16	10	2	0
Limited	14	10	12	9	11	2	0
No assurance/Unsatisfactory	1	0	0	0	2	0	0
Assurance not applicable/Advisory	4	3	7	8	2	0	0
TOTAL number of reviews	34	33	31	34	28	5	



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4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: [Audit & Assurance
Services - NHS Wales Shared
Services Partnership](#)



Teitl adroddiad: <i>Report title:</i>	Audit Wales Update Report			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Friday, 15 September 2023			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>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.</p> <p>We also provide additional information on:</p> <ul style="list-style-type: none"> 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. 			
Argymhellion: <i>Recommendations:</i>	<p>The Audit Committee is asked to:</p> <ul style="list-style-type: none"> Receive the Audit Wales Update Report 			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Phil Meakin, Interim Board Secretary and Associate Director of Governance			
Awdur yr Adroddiad: <i>Report Author:</i>	Andrew Doughton, Audit Wales			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	<p>I'w Nodi <i>For Noting</i></p> <p><input checked="" type="checkbox"/></p>	<p>I Benderfynu arno <i>For Decision</i></p> <p><input type="checkbox"/></p>	<p>Am sicrwydd <i>For Assurance</i></p> <p><input checked="" type="checkbox"/></p>	
Lefel sicrwydd: <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i></p> <p><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i></p> <p><input checked="" type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i></p> <p><input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i></p> <p><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>
<p>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:</p> <p><i>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:</i></p>				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	Well-led.			

<p>Goblygiadau rheoleiddio a lleol:</p> <p><i>Regulatory and legal implications:</i></p>	<p>The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.</p> <p>Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.</p>
<p>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></p>	<p>N/A</p>
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>N/A</p>
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>Failure to fulfil the statutory duties as described above.</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>N/A</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>N/A</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>N/A</p>
<p>Cysylltiadau â risgiau BAF:</p>	<p>N/A</p>

<p>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p>Links to BAF risks: (or links to the Corporate Risk Register)</p>	
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p>Reason for submission of report to confidential board (where relevant)</p>	<p>N/A</p>
<p>Rhestr o Atodiadau:</p> <p>List of Appendices:</p> <ul style="list-style-type: none"> • Appendix 1 - Audit Wales Update Report 	

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: August 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.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

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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	Interim Director of Finance	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 opinions on the financial statements of the health board.	The audit is substantially complete. We intend issuing a qualified audit opinion and accompanying substantive report to the Senedd. Further detail will be set out in our	Audit of Accounts Report to be presented to Audit Committee on 24 August 2023.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
			Audit of Accounts Report.	
Charitable Funds: <ul style="list-style-type: none"> • Planning • Audit of Charitable Fund Financial Statements 	Interim Director of Finance	<p>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.</p> <p>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.</p>	Not yet started	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.	Draft report issued	October 2023
All Wales thematic work	Adele Gittoes, Interim Executive	This work has been carried forward from the 2020 Audit Plan, after having initially been	Draft reporting	October 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
on Unscheduled Care Arrangements: Phase 1 work on patient flow and discharge planning	Director of Operations	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		
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.	Fieldwork in progress	October 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
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.	Planning	December 2023
Structured Assessment 2023	Carol Shillabeer – Chief Executive Officer	<p>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:</p> <ul style="list-style-type: none"> • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning, management, and performance arrangements. <p>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.</p> <p>In addition to the core structured assessment work, we will also undertake</p>	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		<p>“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.</p>		
<p>Local thematic project: Use of additional Welsh Government strategic assistance funding</p>	<p>Interim Director of Finance</p>	<p>This work will consider the use of the additional strategic Welsh Government funding that was allocated to the Health Board following de-escalation from Special Measures in November 2020. ,</p> <p>Note this work was postponed in last year’s audit plan and replaced with the Review of Board Effectiveness.</p>	<p>Not yet started</p>	<p>To be confirmed</p>

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
<u>Orthopaedic Services in Wales – Tackling the Waiting List Backlog</u>	March 2023
<u>Digital Inclusion in Wales and Key questions for public bodies</u>	March 2023

Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
<u>Forward work programme Audit Wales</u>	May 2023

There are no relevant Audit Wales consultations currently underway.



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

Digital inclusion in Wales

Report of the Auditor General for Wales

March 2023



This report has been prepared for presentation to the Senedd under the Government of Wales Act 2006.

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

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

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

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Summary

- 1 This report provides a high-level overview of issues relevant to digital inclusion in Wales. Digital inclusion is complex, and our report is not intended to be comprehensive. We summarise terminology, key data and interventions in Wales. **Appendix 1** provides more information about our work. We have also released a document alongside this report that sets out questions for public bodies to ask themselves as they consider their approach to digital inclusion.
- 2 In summary, our report highlights:
 - **7% of adults in Wales are ‘digitally excluded’**, meaning they have not personally used the internet in the previous three months.¹
 - the percentage of households with **access to the internet has steadily increased since 2012** but some groups in society are more likely to be excluded.
 - while there is enough data to suggest high-level trends, **there are data gaps** that make it difficult to give a complete picture and gain an understanding of the ‘lived experience’ of people who are excluded.
 - digital inclusion is **complex and is not simply an issue of access to technology**. It is not just an issue of rurality or just an issue for older people. Even when people have access and digital skills, some people may still prefer to access services face-to-face.
 - there is a trend of public bodies moving some of their services online, which has many potential benefits but also **risks disadvantaging digitally excluded people**.
 - While the UK Government is responsible for digital infrastructure across the UK, the **Welsh Government is investing in broadband infrastructure**.
 - the **Welsh Government has a specific mission around digital inclusion** and is investing in digital inclusion projects.

1 Welsh Government, [National Survey for Wales, 2021-22](#). Adults are defined as people aged 16 and over.



The Welsh Government has invested heavily in improving broadband infrastructure and the past few years have shown how reliant many of us have become on good quality internet access. However, spending on infrastructure needs to be balanced with work to tackle the root causes of digital exclusion to manage the risk of creating a two-tier society when it comes to access to public and other services.

We have published a key questions document alongside this report to help public bodies reflect on their approach to digital inclusion.

Adrian Crompton
Auditor General for Wales



Background

3 **Exhibit 1** defines terms used in our report. Our work follows several other reports related to digital inclusion, infrastructure and connectivity in Wales. These include, among others, our 2015 report on the Welsh Government’s Superfast Cymru agreement with BT², the 2020 National Infrastructure Commission for Wales report on digital infrastructure strategy³, and the 2022 Senedd Climate Change, Environment, and Infrastructure Committee report on digital connectivity.⁴

Exhibit 1: definitions of key terms



Digital is a term that describes internet or technology-based activities for example emailing, internet shopping or booking an appointment online.



Digital exclusion describes the challenges people face when they do not have access, skills or confidence to use the internet.

Digital inclusion is the opposite of digital exclusion. Being digitally included means being willing and able to use digital tools or services independently.



Internet speed is a key measure of how effective and suitable internet access is for users. The greater the speed, the more users and activities that can be accommodated using that internet connection.

Upload speed: the speed information moves from your device (phone or computer) to the internet. For example, uploading a document to send in an email.

Download speed: the speed information moves from the internet to your device. For example, loading a shopping webpage or watching a film on your tablet or computer.

Megabits per second (Mbps): the speed of an internet connection is measured in megabits per second. This is the standard measure for how fast information moves over the internet to your device.

2 Auditor General for Wales, [Welsh Government investment in next generation broadband infrastructure](#), May 2015

3 National Infrastructure Commission for Wales, [Digital Communications Infrastructure in Wales](#), December 2020

4 Senedd Climate Change, Environment, and Infrastructure Committee, [Digital connectivity – broadband](#), August 2022

Exhibit 1: definitions of key terms



Broadband is a way of connecting to the internet, which is seen as generally faster and more reliable than older internet connections.

The following describe types of broadband:

- **Asymmetric Digital Subscriber Line (ADSL)** was used mostly in the earlier days of the internet. Uses copper telephone lines. Depending on the line, ADSL speeds can be around 1-8 Mbps.
- **Broadband connections through fibre-optic lines.** Fibre can be used for the whole line (full fibre) or part of the line alongside copper. Quicker and more reliable than ADSL.
- **Superfast broadband** has no single definition but suggests faster internet access than ADSL. Can mean full-fibre or partly through fibre cabling. UK telecoms regulator, Ofcom and the Welsh Government define superfast as a speed of at least 30 Mbps.
- Ofcom defines **ultrafast** as broadband with download speeds of greater than 300 Mbps.
- **Gigabit broadband** describes an internet connection that can deliver speeds of 1 gigabit per second (Gbps). 1 Gbps is equal to 1,000 Mbps.



Mobile based internet access is another way people can gain access to the internet. It can be used alongside broadband or as an alternative to broadband. An example of mobile based internet access is using a 4G smartphone.

2G/3G/4G/5G: These numbered terms describe advancing ‘generations’ of mobile communications technology. 2G was the initial technology for mobile to allow calls and text messages. 3G added the option of accessing the internet. 4G and 5G use similar radio signal technology, but these newer generations can provide faster internet speeds.



Satellite technology is another way people can gain access to the internet. Satellite related broadband access can be used by businesses or individuals, and can be suitable in particular for more remote locations.

Why digital inclusion is important

- 4 The internet has changed many of our everyday tasks. The benefits of using the internet were highlighted during the height of the COVID-19 pandemic when many people relied heavily on internet-based services. **Exhibit 2** shows how people can benefit.

Exhibit 2: benefits of using the internet



'I can connect with family, friends and communities'



'I can work from home'



'I can use the internet to access research, learning or education opportunities'



'I can access businesses online and/or my business can reach more people'



'Public services and organisations can share and/or collect information online'



'I can book or pay for services online'



'I can try and find the best offer or access a wider range of choices'



'I can access hobbies, culture and leisure activities'

Source: Audit Wales

- 5 Digital inclusion is important in the context of public services ‘digitising’. This means moving services online and/or using technology to deliver services. Examples include virtual classrooms, online record keeping and online forms to access public services. For all organisations and sectors ‘digitising’ services, there is an inherent risk that the needs of digitally excluded people could be overlooked.
- 6 Our recent report on Poverty in Wales highlighted that shifting services online continues to grow in importance for councils, but digital exclusion remains a major challenge, especially for people who experience or live in poverty.⁵ We found that most Welsh councils recognise the problem of digital inclusion, with 14 of the 22 having adopted a digital strategy and many of these focusing on tackling digital inclusion. However, only 12 councils were providing people with access to a digital skills inclusion programme.
- 7 **Exhibit 3** summarises the main reasons for people being digitally excluded. Digital exclusion can be a real problem, for individuals and for public bodies. It can make it more difficult to keep in touch with friends, family and organisations. It can mean that people miss key information from public bodies. And it can mean people miss the chance to take advantage of cheaper goods and services offered online.⁶

Exhibit 3: main reasons for digital exclusion



Digital infrastructure not available

- To get online and access the internet, people need broadband or mobile infrastructure to be available.
- The infrastructure needs to deliver sufficient internet speeds for everyday use.



Can't afford to be digital

- There are people who can't afford electronic devices, sufficient data and/or broadband/mobile contracts.
- The rising cost of living risks excluding more people who can't afford digital devices or ongoing internet costs.

5 Auditor General for Wales, [Time for change – Poverty in Wales](#), November 2022

6 Good Things Foundation, [The economic impact of digital inclusion in the UK](#), July 2022. Good Things Foundation is a digital inclusion charity in the UK.

Exhibit 3: main reasons for digital exclusion



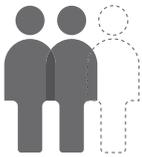
Lack of basic digital skills

- Some people lack the skills, motivation and confidence to use the internet.
- People need to know how to find support, training or learning to develop their digital skills.



Accessibility, usability and language

- Some people are excluded because they need additional help or different solutions to help them use and access technology.
- People need to be able to access technology using the language of their choice, including the Welsh language.
- Examples of tools to support accessibility include text to speech readers, translation services, larger fonts and other assistive technologies.



Some people choose not to use digital services

- Some people might have the access and skills but from time to time choose not to use digital services and choose to access services in person.
- There will always be some people who prefer not to be digitally included, which is of course their choice. This does not mean that they are necessarily digitally excluded, but by choice are not digitally included.



Safety online can be a barrier

- Some people might be excluded because they do not feel able or confident to use online services because of worries about online safety and security issues.
- Online safety as a barrier could be linked to affordability of secure technology.

Data on digital inclusion – gaps and challenges

- 8 **Exhibits 4, 5, 6 and 7** summarise key data about digital inclusion in Wales. Some of the data focuses on access to digital and telecommunications infrastructure, while the National Survey for Wales provides data about whether people have personally used the internet in the previous three months.⁷ However, there are limitations with this data. For example, the data relies on self-assessment and an imperfect definition of someone being classed as digitally included if they have personally used the internet once in the past three months. However, with the same question being asked over time, the data are still helpful in showing trends.
- 9 Ofcom⁸ reports data and information about premises that can access broadband or mobile coverage as well as some data on take-up rates of full-fibre and superfast broadband.⁹ This data helps provide key information about premises that can access internet services and the coverage of broadband networks. However, the data alone does not provide a complete picture of whether premises and individuals are fully exploiting the opportunities from the digital infrastructure available.
- 10 While the data suggests most areas of Wales have access to the internet, the reality on the ground for people using the internet may be quite varied. There might be data limits on phone packages, download limits on some broadband contracts or unstable connections. Cost of living pressures may also force people to reflect on the affordability of their current arrangements for internet access. Feedback we collated about people's experiences of using the internet highlights connectivity issues even when homes have access. For example, one person described how 'when we are using the internet it constantly loses connection ... This can be frustrating as the issue can take several hours to be resolved.' Another person stated: 'I work from home a lot and at peak times of the day there is an impact on my internet speed'.

7 Welsh Government, [National Survey for Wales](#), 2021-22. While not without its limitations, data about whether people have used the internet in the last three months is a widely used indicator across the UK and beyond. It is an indicator used for example by the [Office for National Statistics](#), [Organisation for Economic Co-operation and Development](#) and the [University of Oxford](#).

8 Ofcom is the UK telecommunications regulator and has responsibility along with the UK Government for most telecommunications policy in Wales. Ofcom aims to make sure people get the best from their broadband, home phone and mobile services.

9 Ofcom's [Connected Nations](#) reports include data on communications infrastructure such as performance of broadband and mobile networks. The data reported covers the UK and Ofcom produce an annual [Wales Report](#). Ofcom releases annual reports and two further updates each year.

- 11 Rurality has been a long-standing theme around digital connectivity challenges in Wales.¹⁰ Ofcom's 2021 Connected Nations report (see **footnote 9**) highlights key differences in performance and availability of internet connections in rural and urban premises. Data sets can overlook the additional challenges and costs of delivering infrastructure transformation within the landscape of Wales. Data sets can also overlook the complexity of challenges in rural areas. In 2020, British Telecommunications plc (BT) produced a report about digital connectivity in rural Wales. The report highlighted evidence that infrastructure is only part of the picture and emphasised the importance of understanding the wider barriers to making greater use of the digital infrastructure which is increasingly available in rural areas.¹¹

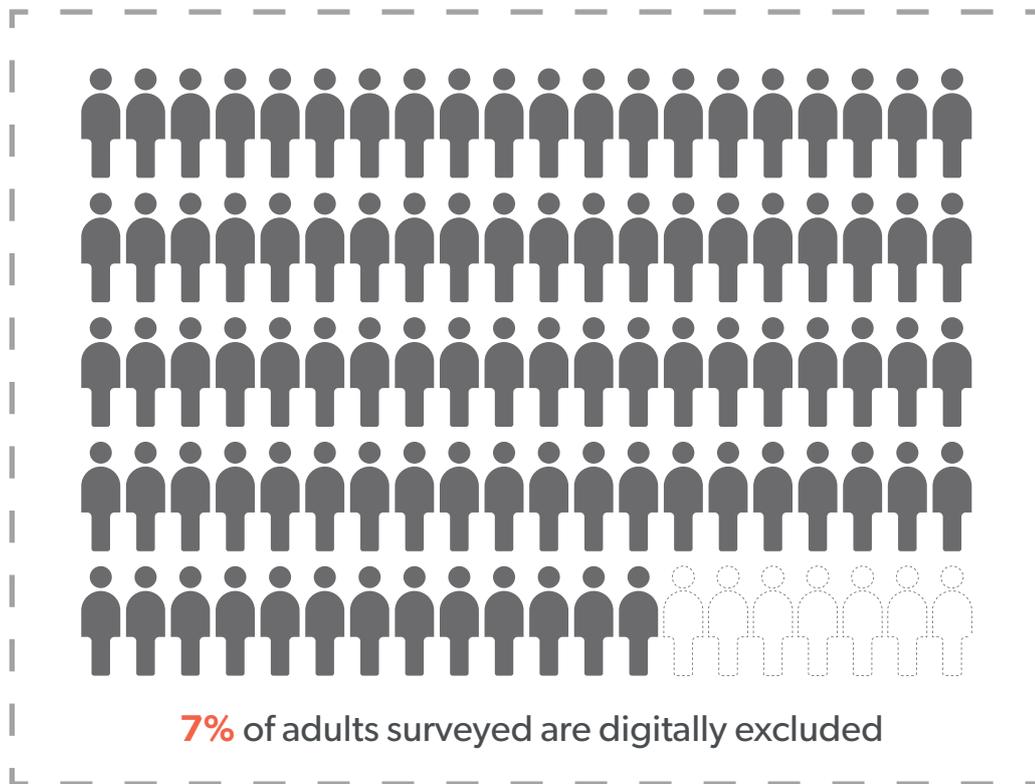
10 Welsh Government Farming Connect website, [Digital disregard and inequality in rural areas](#), October 2020 and Cardiff University's Superfast Broadband Business Exploitation Project, [Digital technologies and future opportunities for rural businesses and areas in Wales](#), January 2019.

11 [BT, Smart rural – The utilisation of digital infrastructure by the agricultural and tourism sectors in rural Wales](#), September 2020

Data on digital inclusion – what does the data show?

Exhibit 4: data on who is digitally excluded in Wales in 2021-22

In the Welsh Government’s **National Survey for Wales**, people were asked about their **personal use of the internet** and whether they have used the internet in the last three months



32% of people aged 75+ are excluded

14% of social housing residents are excluded

12% of those with a limiting long-term illness are excluded

Source: Audit Wales analysis of data from the Welsh Government’s [National Survey for Wales](#), 2021-22

Exhibit 5: data on digital skills in Wales in 2021-22

In the Welsh Government’s **National Survey for Wales**, people were asked if they had completed activities on the internet. These activities were then grouped into five digital skills categories below:

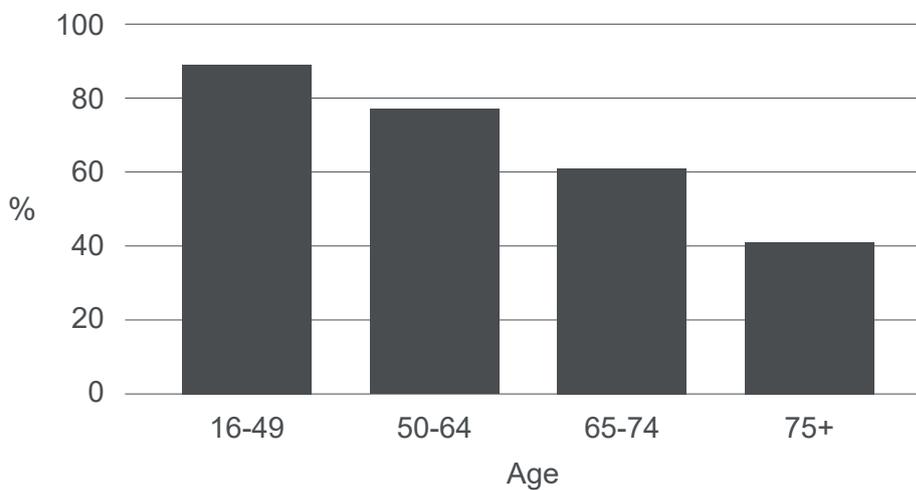
- 1 Handling information and content
- 2 Communicating
- 3 Transacting
- 4 Problem solving
- 5 Being safe and legal online



78% of adults surveyed had accomplished **five digital skills** in the previous three months

41% of internet users **over 75** had all five digital skills compared to **89%** of internet users **aged between 16-49**

The percentage of people surveyed who had accomplished **5 digital skills** in past 3 months by age category

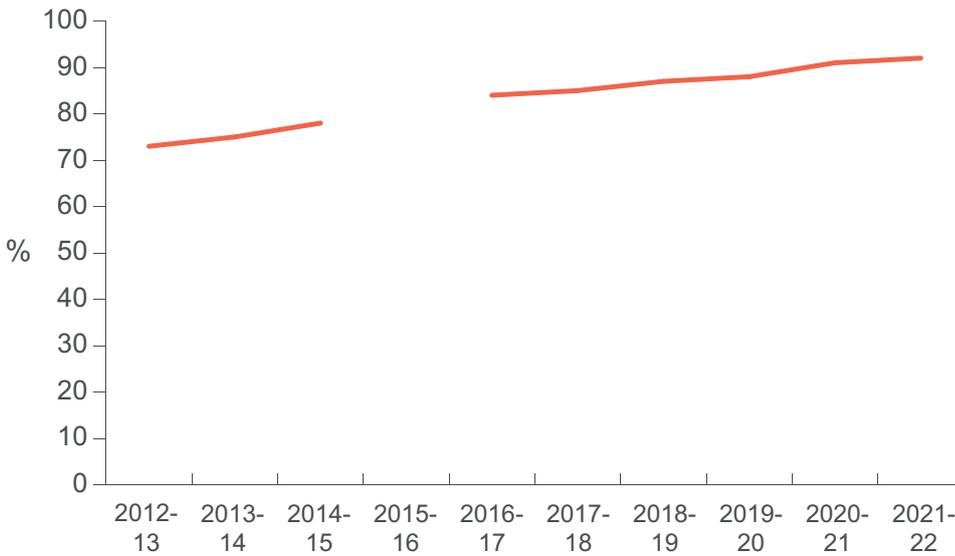


Note: The five digital skills are widely recognised across the UK and based on the essential digital skills framework developed by the UK Government. The framework is aimed at those involved in supporting adults to improve their essential digital skills.

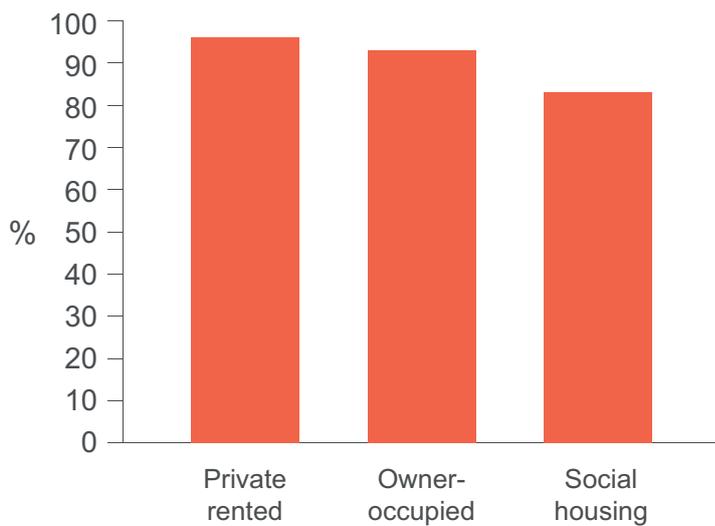
Source: Audit Wales analysis of the Welsh Government’s National Survey for Wales, 2021-22

Exhibit 6: data on digital infrastructure in Wales

The percentage of households that have access to the internet has **steadily increased** since 2012-13



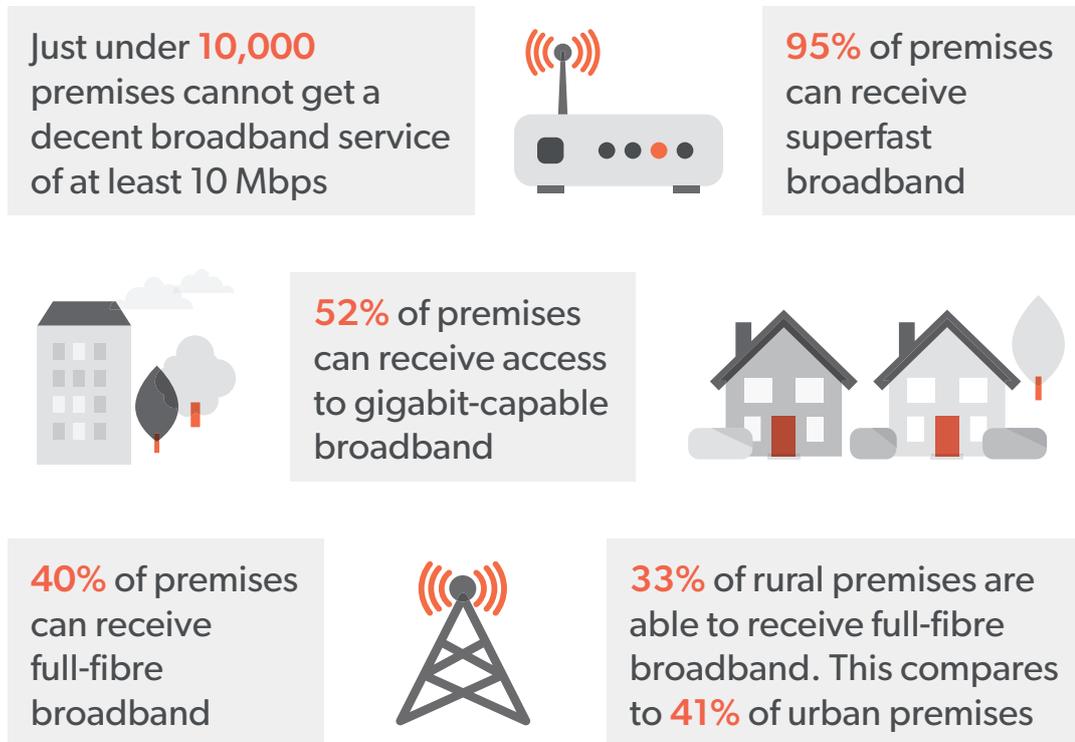
Private rented tenants and **owner-occupiers** were more likely to have access to the internet compared to **social housing** tenants in 2021-22



Note: No data was available for 2015-16 in relation to the percentage of households that have access to the internet. Access is defined as where people have the necessary connectivity to the internet and choose to use it.

Source: Audit Wales analysis of the Welsh Government's [National Survey for Wales](#), 2021-22

Exhibit 7: Ofcom data about premises in Wales where an internet connection is available



Note: Decent is defined by Ofcom as broadband services of at least 10 Mbps download speed and 1 Mbps upload speed from either fixed or fixed wireless networks.

While we have used data reported by Ofcom across the measures in this Exhibit, other live modelled data on broadband coverage for Wales, calculated using a different methodology, is published on the [Local Broadband Information website](#). At 2 March 2023, that live data indicated superfast broadband coverage in Wales of 97%

Source: Audit Wales analysis of Ofcom, [Connected Nations 2022 Wales Report](#), December 2022

People's experiences of digital inclusion and exclusion

- 12 Digital inclusion is crucially about people and people's experiences. As part of this project, we made an appeal for people in Wales to tell us about their experiences of digital exclusion. **Exhibit 8** sets out some of the stories and experiences that people shared. We have included further extracts and information in **Appendix 2**.

Exhibit 8: a sample of experiences that people shared with us

“ [Internet affordability is] a big issue ... There was a time several years ago now when financially I was very stretched and lost access to internet when couldn't pay the bill. Fortunately, I was able to rectify this within a few weeks but the effect at the time was profound. ”

“ **I'm not always interested in accessing online services. I prefer face to face or speaking to someone on the phone. ”**

“ [The internet has] become part of life and somewhat a necessity ... people are expected to do everything online. Every phone call is linked to a website and the automated service will initially guide you to [a] ... website page unless you want to wait an hour on the phone or go over an automated service that cuts off or doesn't take you where you needed to go ... Families struggle to provide phones for their children. You have to have a phoneline to have TV these days ... and in the current climate people are talking about not running phone lines so children won't have access to internet at home unless they have a phone to access. ”

Source: Audit Wales analysis of public responses to our call for case studies, issued via Digital Communities Wales's Digital Inclusion Alliance Wales

The national strategy on digital inclusion

- 13 The Welsh Government's Digital Strategy for Wales¹² includes a mission on 'digital inclusion' to 'equip people with the motivation, access, skills and confidence to engage with an increasingly digital world, based on their needs.' The Welsh Government's Digital Strategy supersedes its Digital Inclusion Forward Look,¹³ which set out aims to help people gain greater confidence in the digital world. In March 2022, the Welsh Government published a digital inclusion progress report, summarising its work to date in addressing the priorities set out in the Digital Inclusion Forward Look to tackle digital exclusion.¹⁴
- 14 In addition to the Digital Strategy, the Welsh Government has recognised the complexity of digital inclusion and the need for further research around the topic. For example, the Welsh Government has commissioned a project to look at a Welsh Minimum Digital Living Standard. The project team published an interim report, which summarised the work carried out since February 2022, with a final report due in early 2023. The project has considered the minimum features needed to be digitally included in Wales including, for example, type of device, internet access (broadband and/or mobile) and level of digital skills.¹⁵
- 15 Responsibility for digital inclusion policy sits within the Welsh Government's Financial and Digital Inclusion Team. This team chairs a Digital Inclusion and Skills Programme Board, which includes representatives from across the Welsh Government and external stakeholders, to discuss digital inclusion policies and issues. While individual public bodies have their own roles to play in promoting digital inclusion, including for example Digital Health and Care Wales, the Welsh Government is also providing additional funding to support delivery of its digital strategy through the work of Centre for Digital Public Services (CDPS) and the Digital Communities Wales (DCW): Digital Confidence, Health and Well-being programme. Other policy measures across the Welsh Government or steps taken by other public bodies may also contribute to digital inclusion. For example, the new Curriculum for Wales includes digital as a cross-curricula set of skills.¹⁶

12 Welsh Government, [Digital Strategy for Wales](#), March 2021

13 Welsh Government, [Digital Inclusion Forward Look](#), December 2020

14 Welsh Government, [Digital inclusion progress report: towards a digitally confident Wales](#), March 2022

15 Yates et al. (for the Welsh Government), [Towards a Welsh Minimum Digital Living Standard: Interim Report](#), July 2022

16 Auditor General for Wales, [The new Curriculum for Wales](#), May 2022

- 16 The DCW programme is a key Welsh Government programme for tackling digital inclusion. Cwmpas, formerly the Wales Co-operative Centre, delivers the programme in partnership with the Good Things Foundation and Swansea University. DCW receives £2 million annually from the Welsh Government's digital inclusion and health teams. This funding was initially in place from the start of the programme in July 2019 until June 2022 and has now been extended to 2025. DCW supports organisations to develop digital inclusion projects and to increase the digital skills and confidence of the people they support. DCW coordinates Digital Inclusion Alliance Wales (DIAW), which is made up of a multi-sector group of organisations. DIAW aims to coordinate, promote and shift the agenda around digital inclusion activities.
- 17 **Exhibit 9** sets out the four DCW key performance indicators (KPIs) and information about performance. Following the agreement to extend the programme, the Welsh Government and DCW agreed revised KPIs for July 2022 to June 2025, taking account of previous performance and other factors. **Exhibit 9** also sets out the revised targets for the period 2022-2025.

Exhibit 9: summary of Digital Communities Wales performance since April 2021

	Target April 2021 – June 2022	Actual performance April 2021 – June 2022	Target July 2022 – June 2025	Actual performance July 2022 – September 2022
KPI 1 People supported to become digitally confident (motivation, basic skills and confidence)	32,500	45,872	102,000	3,709
KPI 2 Volunteers providing support to citizens	1,250	1,193	3,000	67
KPI 3 Support to ensure digital inclusion is recognised and embedded within organisational strategy and delivery	35	44	55	2
KPI 4 Health and care, public, private and third sector staff supported to become digitally confident	1,750	1,870	4,050	555

Note: performance against targets for July 2022 to June 2025 has been rebased to zero and does not include previous activity. When the contract with DCW first started in July 2019 there were nine KPIs. Following an independent evaluation, both parties agreed a revision to four KPIs. The original nine KPIs were reported between July 2019 and March 2021. The four new KPIs have been in effect from April 2021 to June 2022.

Source: Digital Communities Wales, Quarter Report – Key Performance Indicators, April to June 2022 and July to September 2022

- 18 The CDPS launched in June 2020, with the Welsh Government committing £4.9 million each year from 2020 to 2025 to fund its activities. CDPS works across the Welsh public sector and aims to encourage digital transformation and delivery of services around the needs of the people who use them. The Welsh Government set out in CDPS's term of the Senedd remit letter (2022 to 2026), the expectation that the CDPS would focus on themes including leadership and culture around digital policy, digitising public services, collaboration and digital transformation.
- 19 **Exhibit 10** shows CDPS's objectives and examples of activities to meet them. One example of CDPS's activities is a landscape review, part of which considered what organisations across Wales are doing to support people to get online. The evidence base included a survey of public bodies and any other organisation carrying out or involved with digital inclusion activities. The review also collected information and data from the Welsh Government and Digital Communities Wales. The output from the project summarised some comparisons of digital inclusion activities across the UK nations and beyond. The output of the digital inclusion activities survey is not yet publicly available, but the Welsh Government is looking to build on it and collect further information for release during 2023. The Welsh Government is developing an interactive map to be hosted on its website. The interactive map is aimed at organisations and trusted people to help those digitally excluded to find places where they can get help, for example, to develop basic digital skills, use a device or access the internet.

Exhibit 10: Centre for Digital Public Services objectives and examples of activities

Examples of activities in 2021-22 to meet the objectives

Objective 1

Help people in Wales to use modern digital services

- Used teams of digital experts to work in partnership with others, for example through showing best practice and providing skills transfer when developing public sector digital services.
- Developed and promoted Digital Service Standards for Wales, helping organisations meet the standards and build services that meet the needs of all users.

Objective 2

Prepare leaders for digital transformation

- Developed and delivered digital skills training for senior leaders. This included information around the benefits of digital services for end users.
- Held webinars and established ‘Communities of Practice’ networks, that aim to connect digital expertise and help support people working around digital in the public sector.

Objective 3

Stimulate innovation in our economy

- Designed plain English procurement templates to help the Welsh public sector when buying digital contracts or services.
- Showed Welsh suppliers the public sector’s approach to ‘procuring digital’ with the aim that more Welsh suppliers win Welsh public sector contracts.

Objective 4

Build skills for digital engagement

- Developed a landscape review of digital inclusion initiatives in Wales (see **paragraph 19**)
- Used expert content designers who specialise in creating accessible content, to show examples to those delivering public services in Wales.

Source: CDPS’s objectives as set out in their annual review [Centre for Digital Public Services, Looking back: CDPS year in review 2021-22](#)

Improving digital infrastructure

- 20 Telecommunications and broadband infrastructure are reserved matters and therefore the responsibility of the UK Government and Ofcom. As such, the UK Government has taken steps towards funding infrastructure in Wales, for example through 'Project Gigabit'.¹⁷
- 21 Despite telecommunications infrastructure not being a devolved area, the Welsh Government has chosen to invest in broadband infrastructure over the past decade or so. An example is the Superfast Cymru programme that we examined in 2015.¹⁸ Since 2015, the Welsh Government has continued to help fund or subsidise broadband infrastructure costs, for example through extending Superfast Cymru and other projects such as Access Broadband Cymru. The Welsh Government has provided such investment through economic development powers, aiming to fill gaps where it considers there have been gaps in investment from either the UK Government or the private sector.
- 22 The Welsh Government has carried out several market reviews to capture and analyse the premises in Wales that would benefit from existing commercial rollout of broadband investment. There are areas and locations in Wales where the private sector has judged it is not commercially viable to invest, and therefore public investment has been required to fund projects in full, or in part, alongside private investment. The Superfast Cymru agreement between the Welsh Government and BT from 2012 included over £200 million in public sector investment. Other examples of investment in broadband infrastructure include work between smaller telecommunications businesses and local authorities to improve connectivity in Wales. **Exhibit 11** provides an overview of key broadband infrastructure projects in Wales where the Welsh Government has contributed capital funding.

17 UK Government, [Project Gigabit](#), first published in April 2022. This project funds 'gigabit-capable' broadband in all areas of the UK and includes a voucher scheme for rural areas.

18 See footnote 2

Exhibit 11: key examples of Welsh Government capital investment in broadband projects since 2012

Project	Public funding	Objectives	Outcomes
<p>Superfast Cymru 2012 - 2018</p> <p>The original Superfast Cymru agreement between the Welsh Government and BT was announced in 2012. There have since been further phases to the work including Next Generation Access Broadband Wales, see below.</p>	<p>£213.7 million (actual) of which:</p> <ul style="list-style-type: none"> • £93.3 million – EU funding • £67 million – UK Government • £53.5 million – Welsh Government 	<p>The project aimed to provide superfast broadband to 95% (approximately 700,000) of premises within the intervention area by 2015. The number of premises and the timeframe was extended to 726,000 premises by 2018.</p>	<p>By the end of December 2014, 47% (346,000 premises) within the intervention area covered by the agreement could access superfast broadband. This had increased to over 730,000 premises in Wales by December 2018.</p>
<p>Access Broadband Cymru (ABC) 2016 - 2023</p> <p>This Welsh Government grant helps fund or part-fund alternative broadband solutions for premises. Funding is based on eligibility criteria. New connections must deliver a significant change in speed (at least twice the current download speed), with the new connection providing a minimum download speed of at least 10 Mbps.</p>	<p>£10.5 million (budgeted) – Welsh Government</p>	<p>ABC funding is specifically focused on helping premises that would otherwise not benefit from existing broadband infrastructure available through private sector broadband providers.</p>	<p>Our 2015 report noted the relatively low take-up of this grant. The National Infrastructure Commission for Wales (NICW) report included a recommendation for reviewing this scheme (see footnote 3). The Welsh Government accepted this recommendation.</p> <p>A review of the approach to funding will be undertaken to ensure that all schemes, including ABC, meet the requirements of home and businesses across Wales.</p>

Project	Public funding	Objectives	Outcomes
<p>Next Generation Access Broadband Wales</p> <p>2018 – 2023</p> <p>A further example of a grant award to BT following a procurement process. Aiming to bring fibre broadband to premises in addition to those targeted in the Superfast Cymru agreement</p>	<p>£57.0 million (budgeted) of which:</p> <ul style="list-style-type: none"> • £36.2 million – EU funding • £18.8 million – Welsh Government • £2.0 million – UK Government 	<p>This project aims to enable premises to have access to full-fibre or ‘fibre to the premises’ broadband. The project aimed to help 39,000 premises to gain full fibre broadband access by March 2022 (now extended to end of March 2023).</p>	<p>The project has delivered access to gigabit capable broadband to 29,959 premises (position at the end of March 2022).</p> <p>The Minister for Climate Change’s July 2022 statement noted that the Welsh Government recognises the project has so far delivered less than the anticipated number of premises. The Minister noted some premises were de-scoped, for example those that gained access to gigabit broadband under other rollouts.</p> <p>The Welsh Government forecasts that the total premises improved will exceed the 39,000 target when the project closes in March 2023.</p>

Project	Public funding	Objectives	Outcomes
<p>Local Broadband Fund (LBF)</p> <p>2019 - 2025</p> <p>Aimed at local authorities and social enterprises to help local communities gain access to faster broadband services. The emphasis is to support local solutions and innovation or creative solutions to connectivity challenges. Local authorities and social enterprises are encouraged to work together on applications but can also submit their own. Applications are sought every six months.</p>	<p>£20.0 million (budgeted) – Welsh Government</p>	<p>Aims to provide funding for local projects to deliver fast and reliable broadband to areas of Wales currently without access to 30 Mbps.</p>	<p>11 projects have been funded by the LBF. The majority of projects received funding in the previous 12 months. All projects have differing timescales, ranging from 12 months to longer term timescales that will end in March 2025.</p> <p>The spend and implementation to date for this project is described by the Welsh Government as slower than anticipated. The Welsh Government has cited the COVID-19 pandemic and applicants facing challenges with contracts as the cause of delays.</p>

Note: Appendix 1 explains our rationale for the scope of the broadband infrastructure projects that we have included. The figures cover capital investment and do not include revenue funding. Figures are budgeted values (due to projects being live), unless stated otherwise. The figures for Superfast Cymru are based on actual reported costs between 2012-2018. Figures are rounded-up to the nearest decimal point. The Superfast Cymru agreement also included a BT contribution, and the Welsh Government contributed a further £1.7 million towards Superfast Cymru communications. Openreach is a wholly owned subsidiary of BT Group and a legally separate business.

Source: Audit Wales summary of information provided by the Welsh Government. We have not audited this information. The Welsh Government's [Written Statement on Superfast Cymru](#) in December 2018, provided an update about the number of premises that have benefited from Superfast Cymru. The Welsh Government website sets out the full [Eligibility Criteria for Access Broadband Cymru](#) and further details about the [Local Broadband Fund](#). Information about the ABC scheme review is detailed in the [Welsh Government response to the National Infrastructure Commission for Wales Report on digital infrastructure](#), September 2022. Data reported on NGABW premises is outlined in the Minister for Climate Change's [Written Statement: Update on Digital Connectivity in Wales](#), July 2022.

- 23 Our 2015 report focused on Superfast Cymru. The original agreement for the intervention area included a public sector contribution capped at £205 million, and £26 million from BT (£231 million total capital contribution). Outside of the agreement, BT also committed to invest around £19 million of capital expenditure and £82 million up to 2023 during the operational phase to support, operate and maintain the network. Variations in the capital contributions shown in **Exhibit 11** compared to the 2015 report reflect the extension of the Superfast Cymru agreement and the fact that we have now been able to include actual reported costs.
- 24 An element of the Superfast Cymru agreement between BT and the Welsh Government was a 'claw-back' arrangement. The terms of the 'claw-back' set out that if take-up exceeded 21% within the period to the end of 2023, then BT would distribute 50% of its profit margin on its wholesale services back to the Welsh Government. Some claw-back funding has already been used to help fund further phases of Superfast Cymru.¹⁹ The Welsh Government is expecting to claw-back around £80 million in total.
- 25 Mobile phone-based internet infrastructure is also not devolved. However, the Welsh Government has developed a mobile action plan covering its work around the topic of mobile-based internet infrastructure with the mobile phone industry and Ofcom.²⁰ The UK Government funds a UK-wide Shared Rural Network programme focused on improving 4G coverage. The Welsh Government has not invested additional funding specifically to improve mobile phone coverage to date.

19 UK Government, [Superfast Broadband Programme evaluation](#), first published October 2021

20 Welsh Government, [Mobile Action Plan](#), October 2017

Appendix 1 – About our work

Audit question and scope

Our high-level review asked, ‘What is the current extent of digital inclusion in Wales?’. As part of the project, we looked at the overall picture of digital connectivity in Wales including the Welsh Government’s investment in broadband infrastructure and digital inclusion projects.

We have not carried out an updated detailed examination of Superfast Cymru since our 2015 report, because several other reports have since looked at that project. We have included a high-level summary of Welsh Government capital investment in some key broadband infrastructure projects, for example Superfast Cymru and Next Generation Access Broadband Wales. The rationale for our coverage was to focus on the role the Welsh Government has played in funding capital investment in Welsh broadband infrastructure as a key element of getting Wales connected to the internet to support digital inclusion. We have not considered other areas of the Welsh Government’s investment around wider digital infrastructure or Welsh Government revenue funding of smaller projects in Wales as these were not directly linked to digital inclusion. For example, we have not looked in detail at the Welsh Government’s contribution towards projects such as Public Sector Broadband Aggregation²¹ or superfast exploitation business support.²²

We have not examined commercial broadband investment, the role of the communications regulator Ofcom, or the technological merits of different internet connections, as these would not fall within the remit of Audit Wales. There are other UK projects around digital infrastructure and digital inclusion, for example Project Gigabit. We have not considered these projects as they are not funded by the Welsh Government. Our report will inform a shared learning event on the theme of digital later in 2023. During this forthcoming year, we will also be undertaking audit work looking at Local Government’s digital strategies and vision. As part of our ongoing audit planning, we are considering the option of further work in future years to look at the implementation of the Welsh Government’s Digital Strategy.

21 The Welsh Government contributes revenue funding towards a cloud network for the public sector in Wales. The contract for managing and running the [Public Sector Broadband Aggregation](#) (PSBA) is currently held by BT.

22 Welsh Government, [Superfast Business Wales](#). The Welsh Government offers support and advice for businesses to try and use digital connectivity opportunities.

Methods

- **Document review:** We reviewed documents and research articles on digital inclusion. These included the Welsh Government’s strategy, plans and delivery documents relating to digital and digital inclusion. We considered the evidence, reports and recommendations from various Senedd committees on and around the topic of digital infrastructure and digital inclusion, including the work of the Public Accounts Committee (Fourth Senedd)²³ and Economy, Infrastructure and Skills Committee (Fifth Senedd),²⁴ as well as the current Climate Change, Environment, and Infrastructure Committee.²⁵ We also considered other reports about digital inclusion, technology and digitising services from the Older People’s Commissioner for Wales,²⁶ Wales Centre for Public Policy,²⁷ Nesta / Y Lab,²⁸ and National Infrastructure Commission for Wales (see **footnote 3**).
- **Interviews:** We interviewed officials from several Welsh Government departments. We also interviewed representatives of DCW, the Older People’s Commissioner for Wales, the Equality and Human Rights Commission, Data Cymru, CDPS and Ofcom.
- **Data analysis:** We reviewed data from open sources including Ofcom and the National Survey for Wales. The National Survey for Wales is a Welsh Government survey involving around 12,000 people each year. Questions cover various topics, including internet, skills and media. Audit Wales recently released a data tool, which provides information about the context and challenges around poverty in Wales, and also includes information about trends of internet use across Wales.²⁹
- **People’s experiences:** With thanks to DCW for distributing our call for evidence to their DIAW. Our call for evidence was opened between 14 October 2022 and 14 November 2022. We received 51 anonymous responses.

23 Senedd Cymru, [Welsh Government investment in next generation broadband infrastructure – The Fourth Assembly](#), March 2016

24 Senedd Cymru, [Digital infrastructure in Wales](#), February 2021

25 Senedd Cymru, [Digital Connectivity – broadband report](#), August 2022. The report was debated and noted at a [Senedd Plenary meeting, 17/11/2022](#). The debate included a response from the Welsh Government. The Welsh Government accepted all recommendations in the Committee’s report.

26 Older People’s Commissioner for Wales, [Ensuring access to information and services in a digital age: Guidance for Local Authorities and Health Boards](#), September 2022

27 Wales Centre for Public Policy, [What does ‘blended’ digital and face-to-face provision mean for access to services during the cost-of-living crisis?](#), November 2022

28 Nesta, [Data Poverty in Scotland and Wales](#), April 2021

29 Auditor General for Wales, [Tackling Poverty in Wales data tool](#), November 2022

Appendix 2 – What people told us about their experiences of digital inclusion and exclusion

Introduction

Our call for evidence (see **Appendix 1**) aimed to gather views, experiences and stories about people's experiences of using the internet. These are anonymous accounts from people in Wales.

We asked the following questions to people about their experiences of using the internet:

- Do you feel you have good internet that meets your needs?
- Do you feel you have the right skills and confidence to do everything you would like to do online?
- Have you ever had help to get online or use the internet? Or have you ever helped someone else?
- Do you use or contact public services such as council services online?
- Do you feel the cost of having the internet and/or mobile phone data is manageable for your household budget?

Do you feel you have good internet that meets your needs?

Most people noted that they had **fast and reliable access to the internet** but even when people do have access to the internet, **the internet access is not always stable**

Some people highlighted **particular challenges** due to **living in a rural area**

Many noted the **importance of good internet** for **working at home**

“ I live in a rural (area) and my **internet connection was poor** with very few options to improve the speed via internet service provider due to the modern infrastructure (fibre) not being in place and not likely to be in place for another 4-6 years. **I then took matters into my own hands and purchased a satellite service.** It is an absolute miracle device. We went from 2Mbps to 200Mbps instantaneously. It is an expensive service, but worth considering if you are a long-time sufferer of poor connectivity. We have dropped other services to help budget for the monthly cost ”

“ In part, although being rural it can be **difficult to maintain connection** and you never know when it might drop off which makes it **difficult to work at times** ”



Do you feel you have the right skills and confidence to do everything you would like to do online?

Most people felt **they have the skills and confidence**, but many identified areas where they might benefit from **further developing their skills and confidence**

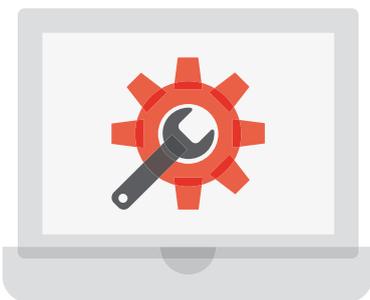
“ Yes. Although I do feel as my son gets older and closer to using the internet and social media himself that I **might not have the necessary knowledge to keep him safe** ”



Some expressed their awareness around **future changes and developments in technology and the need to keep pace**



“ **Yes and no. I do not have enough confidence to try new things** ”



“ Yes, pretty much. **And I know how to find out information if I need to do anything new.** However, I carry an anxiety that things are **moving very fast** and will soon **move too quickly away from my current skills and knowledge** ”

Have you ever had help to get online or use the internet? Or have you ever helped someone else?

Most people **access the internet without any help**, but many people play **key roles in helping friends, family and colleagues to use the internet and be digitally included**



“ Both. **Needed help to resolve problems I was unable to solve.** Also helped others to access internet, get online, set up router, log-in, set up accounts, download apps, etc. ”

“ Recently my elderly next-door neighbour was admitted to hospital where he spent 6 weeks in hospital following a fall and fractured hip. Due to ongoing (COVID-19) restrictions there was very limited visiting allowed on the ward.

The television on the ward (was) too far away for him to see properly and the channels that were put on mainstream TV he was not interested in watching.

He does not have the internet at home, no mobile phone etc and is reluctant to use / learn anything digital as ‘he doesn’t trust it’. As a result, (he) had limited contact with the outside world during his stay.

I wanted to try and help. He is an avid fan of cricket, I set up a sports app and wrote out step by step instructions and provided him with a set of earphones to plug in so that he didn’t disturb others with the sound. He’s quite deaf and needs the sound on loudly to hear. Feedback was that this ‘was a Godsend’ and helped alleviate his boredom, engaged him in what was happening and gave him something to talk about to others ”

Do you use or contact public services such as council services online?

Most people said **they use public services online**, however some highlighted **challenges in general with using websites**

Some respondents indicated that they **could use services online**, but have to or **chose to speak to someone instead**

“ I use the local council website to arrange visits to the recycling centre ”



“ Yes. I generally use online first. My doctor’s surgery has online consulting so I complete a survey and a doctor calls me back. The experience has been positive ”



“ My first attempt is always to **get information or contact services online**. However, their websites are often rubbish and the only way to get answers or services is to telephone them ”

“ Very rarely, again I prefer to speak to someone about any issues ”

Do you feel the cost of having the internet and/or mobile phone data is manageable for your household budget?

Most respondents said they felt **the cost was manageable** however many **highlighted concerns** and difficulties with affording the cost

Most respondents see the **internet as essential**

“ It is an essential service just like one of your utilities (water, gas or electricity) you have to manage budgets accordingly. If budgets are tight then we have to prioritise the important things first. A connection to the internet for us in a rural location is our window out onto the world, it’s our library, our school our hobbies, our entertainment and our health centre ”



“ It’s an essential for me so I need to make sure I budget for it ”

“ just about manageable. We are considering moving to ‘sim only’ ”



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Teitl adroddiad: <i>Report title:</i>	Orthopaedic Report			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Friday, 15 September 2023			
Crynodeb Gweithredol: <i>Executive Summary:</i>	Wales Audit Office undertook a review of Orthopaedic Services in Wales – Tackling the Waiting List Backlog which was completed on the 6 June 2023. The BCUHB response is attached against individual points for noting.			
Argymhellion: <i>Recommendations:</i>	The Committee is asked; • To note the response to the report.			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Phil Meakin, Interim Board Secretary			
Awdur yr Adroddiad: <i>Report Author:</i>	Phil Meakin, Interim Board Secretary			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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:				
<i>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:</i>				
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			

<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	<p>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).</p>
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>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).</p>
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>N/A other than those relating to individual audit reviews / recommendations</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>N/A other than those relating to individual audit reviews / recommendations</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>N/A other than those relating to individual audit reviews / recommendations</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>Final Report reviewed by the Interim Board Secretary</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	<p>N/A other than those relating to individual audit reviews / recommendations</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Confidential</p>
<p>Next Steps: <i>Implementation of recommendations</i></p>	
<p>List of Appendices: WAO Recommendations Responses to report Orthopaedic Services in Wales – Tackling the Waiting List Backlog None</p>	

Organisational response

Report title: Orthopaedic Services in Wales – Tackling the Waiting List Backlog

Completion date: [06/06/23]

Document reference: National Report and 3290A2022

Ref ¹	Recommendation	Organisational response <small>Please set out here relevant commentary on the planned actions in response to the recommendations</small>	Completion date <small>Please set out by when the planned actions will be complete</small>	Responsible officer (title)
R3	<p>The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to:</p> <p>a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and</p>	<p>The Health Board had its Orthopaedic GIRFT deep dive review in February 2022 and the recommendations were published in April 2022. Other speciality GiRFT deep dives have since taken place. As such we have since recruited Allison Beale (on an interim basis) from the GiRFT team to assist our approach toward implementing GiRFT recommendations and establishing a robust governance process. The Health Board is also making preparations for a twice monthly GiRFT Summit to ensure oversight and scrutiny of how we implement the</p>		IHC Director - Central

	<p>b) ensure that clear action plans are in place to address the things that get in the way of improvement.</p>	<p>recommendations. This process will also facilitate a clear action plan and a route of escalation where required.</p> <p>Actions Governance arrangements embedded and clearly highlighted.</p> <p>All short term actions derived from the April 2023 GiRFT workshop to be completed.</p> <p>Recommendations from the February 2022 GiRFT deep dive to be reviewed and a clear action plan mapped out for any outstanding recommendations.</p>	<p>31/7/23</p> <p>31/9/23</p> <p>31/07/23</p>	
R4	<p>Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to:</p> <p>a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and</p> <p>b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and</p>	<p>BCUHB has a well-established CMAT service however there are recognised staffing variations across the IHCs. Recruiting to vacant positions has been a challenge and therefore as a response some staff work flexibly across the Health Board as and when required.</p> <p>The Health Board recognises and in the main satisfies the Welsh Government CMATs guidance (2017). The exception being that there is no sports medicine consultant, however this is compensated for by the rounded skillset of the lead clinicians and full MDT approach.</p> <p>FCP services (working out of GP surgeries and Urgent Primary Care Centres) are also present across the North Wales region with close links to</p>		<p>Consultant Musculoskeletal Therapist</p>

	<p>CMATS to reduce duplication and minimise waits.</p>	<p>the CMAT services. FCPs refer into secondary care using the same mechanisms as GPs which is effective in reducing pathway variation and duplication. Furthermore, many FCPs in North Wales also work within BCUHB CMATs. This not only reduces duplication, but reduces referrals, improves communication and maintains a high level of service consistency.</p> <p>Actions Conduct a detailed analysis of CMATs staffing (including types of staff & skill set) as well as hours available for CMATs services across the Health Board and identify any remedial action required.</p> <p>Ensure clear FCP-CMATs pathways exist to reduce duplication & minimise patient waiting times for both services.</p>	<p>31/7/23</p> <p>31/9/23</p>	
<p>R5</p>	<p>There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to:</p> <p>a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level;</p>	<p>BCUHB is committed to reducing the length of wait for orthopaedic appointments and procedures. PROMs are a mechanism which will assist this process through more appropriate follow up and waiting list management. Whereas PREMs, which are currently used within our outpatient departments and in-patient wards, help inform our services and aid decision making at a patient and service level. The Health Board clinicians and operational teams are committed to fully utilising both PROMs and PREMs as a mechanism of recovery and also sustainability. Furthermore, the BCUHB Value in Healthcare team are engaged in the procurement process of the National Electronic</p>		<p>Network Clinical Lead</p>

- b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and
- c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.

PROMs platform. This platform will allow a reduction in administration, increase the pace of PROMs roll out and consistency of use. It will also provide a national databank for effective orthopaedic benchmarking and transformation at a service level. The current go live date is December 2023.

The Health Board has nominated IHC orthopaedic clinical leads and sub-speciality clinical leads who have a responsibility to minimise ineffective interventions. Furthermore, current governance arrangements will provide accountability for these processes being embedded and to ensure they are effective.

The Transformation and Improvement team within BCUHB are looking to provide advice on 'remaining healthy' and 'waiting well' at all stages of the orthopaedic pathway. This includes public health prevention, living with a long-term health condition, as well as all of the intervening stages.

BCUHB are looking at how chatbot technology could support patients waiting for treatment, as well as provide further communication and advice via this medium. As a Health Board we are developing and enhancing our digital media platforms. This will enable more improved signposting and self-directed management of orthopaedic and musculoskeletal conditions, as well as a resource accessible by primary care.

As a Health Board we recognise that long waiting times for appointments and treatments

may result in patient harm. We will ensure (through existing governance structures) that this is reported in a transparent manner and acted on accordingly.

Finally, collaborative working by the Health Board and third sector organisations is being undertaken to more effectively support and signpost patients. This includes long waiting patients but also upstream prevention. In addition to this work is also being undertaken between the Health Board and NHS111 to provide better access to information for all orthopaedic patients.

Actions

Lower limb arthroplasty PROMs roll out.

31/8/23

Foot and Ankle PROMs roll out

31/9/23

Systems established to inform and promote reductions in ineffective interventions.

31/7/23

Explore opportunities for chatbot technology to communicate with patients and provide a means of monitoring.

31/9/23