Bundle Audit Committee 19 March 2020

1.0 OPENING BUSINESS - OPEN SESSION

1.1 09:30 - AC20/01: Apologies for Absence

Apologies received from: Deputy Chief Executive / Executive Director Nursing & Midwifery, Executive Medical Director

1.2 09:31 - AC20/02: Declarations of Interest

1.3 09:36 - AC20/03: Procedural Matters

1. To confirm the Minutes of the last meeting of the Committee held on 12/12/19 as a correct record and to discuss any matters arising; and
2. To review the Summary Action Log; and
3. To note that Chair's Action has been taken on the following matters since the last meeting;

** Risk Management Strategy approval*
** Clinical Audit Policy approval*

AC20/03a: Draft Minutes Audit Committee_Open Session_12.12.19_Draft.doc

AC20.03b Summary Action Log Audit Committee live version.doc

1.4 09:46 - AC20/04: Issues Discussed in Previous Private Committee Session

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

AC20.04 Private Session Items Reported in Public.docx

1.5 09:48 - AC20/05: Joint Audit & Quality, Safety & Experience (JAQS) Committees Minutes

The Committee is asked to note the Joint Audit and Quality, Safety & Experience (QSE) Committee minutes of the meeting held on 05/11/19.

AC20/05: Minutes JAQS 5.11.19 Public V0.03 inc.docx

1.6 09:53 - AC20/06: Standing Orders Amendments (verbal update)

Acting Board Secretary in attendance

1.7 09:58 - AC20/07: Review of Amendments to Standing Financial Instructions (verbal update)

Acting Executive Director of Finance in attendance

1.8 10:03 - AC20/08 Structured Assessment / Annual Final Report

The Committee is asked to note the final report presented to Board in January 2020 and the management response that is now being monitored via the Audit Tracker.

AC20/08: Structured Assessment Final Report

2.0 10:08 - AC20/09: Schedule of Financial Claims

The Committee is asked to note the contents of the report and approve the Schedule of Losses and Compensation.

AC20/09: Claims Report for AC.docx

3.0 10:23 - AC20/10: Corporate Risk & Assurance Framework / Risk Management Strategy Update

The Audit Committee (AC) is hereby requested to:

1. Note, approve and recommend the Corporate Risk Register (CRR) to the Board and to gain assurance that the risks articulated on it are appropriately managed in line with the Health Board`s risk management strategy and best practice.
2. Review, scrutinise, approve and recommend the five new risks which were approved by the Quality, Safety and Experience Committee (QSE) for inclusion onto the CRR.
3. Recommend to the Board for approval, changes to risks that have been requested by the various committees.

AC20/10: CRAF Report to AC - 10-03-2020 - v4.docx

3.1 10:43 - AC20/11: Risk Management Group Chair's Assurance Report

The Committee is asked to note the report

AC20/11: Committee Chair's Assurance Report - RMG 30-Jan-2020.docx

4.0 10:45 - AC20/12: Governance Review Update (verbal update)

In attendance: The Assistant Director of Patient Safety and Experience

4.1 11:05 - AC20/13: Legislation Assurance Framework (LAF)

The Audit Committee is asked to:

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

AC20.13 Legislation Assurance Framework_March_2020.docx

5.0 11:25 - AC20/14: Clinical Audit Plan

The Audit Committee is asked to approve the draft 2020/21 Clinical Audit Plan

AC20/14: Clinical Audit Plan Coversheet-March 2020.docx

6.0 11:45 - AC20/15: Internal Audit Progress Report and Plan

The Audit Committee is asked to:

** Receive the progress report; and*
** Receive and discuss the limited assurance reports; Partnership Governance - Section 33 Agreements and the Quality Improvement Strategy; and*
** Approve the deferment of the Ysbyty Wrexham Maelor Hospital – Backlog maintenance risk management capital review; and*
** Approve the draft plan for 2020/21 and internal audit Charter 2020.*

AC20/15a: BCUHB Internal Audit Committee cover sheet March 2020.docx

AC20/15b: BCUHB Audit Committee Progress Report February 2020v2.docx

AC20/15c: Final Internal Audit Report Partnership Governance - Section 33 Agreements.pdf

AC20/15d: Final Internal Audit Report Quality Improvement Strategy.pdf

AC20.15e BCUHB Internal Audit Plan 2020 Committee cover sheet March 2020.docx

AC20.15f Draft BCUHB Internal Audit Plan 20-21v4.docx

7.0 12:30 - AC20/16: Wales Audit Office Update Report

The Audit Committee is requested to:

** Note the content of the audit progress update.*
** Receive and discuss the Wales Audit Office Audit Plan*
** Receive and discuss the Review of arrangements for interim staff appointments (Welsh and English)*

AC20/16a: Board and Committee Report Template - WAO.docx

AC20/16b: BCUHB_Audit_Committee_Update_March 2020.docx

AC20/16c: BCUHB_2020_Audit_Plan.pdf

AC20/16d: BCUHB_Interim_Staffing_Cy.pdf

AC20/16e: BCUHB_Interim_Staffing_Eng.pdf

8.0 13:15 - AC20/17: Agree Audit Committee Cycle of Business

The Audit Committee is asked to:

** Note the contents of this report and agree the 2020/21 Cycle of Business (CoB)*

AC20/17: Audit Committee CoB_March_20.docx

9.0 13:20 - AC20/18: Issues of Significance for reporting to Board

10.1 13:25 - AC20/19: Date of Next Meeting - 28/05/20

10.2 13:26 - AC20/20: Exclusion of Press and Public

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

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

AUDIT COMMITTEE DRAFT
Minutes of the Meeting Held on 12.12.19
In the Boardroom, Carlton Court, St Asaph

Present:

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

In Attendance:

Andrew Doughton	Performance Audit Lead, Wales Audit Office
Meilyr Emrys	Welsh Language Officer (for Minute AC19/80)
Dave Harries	Head of Internal Audit, NWSSP
Sue Hill	Acting Executive Director of Finance
Melanie Maxwell	Senior Associate Medical Director (for Minute AC19/84)
Lawrence Osgood	Associate Director of Workforce Performance & Improvement (for Minute AC19/80 and AC19/81)
Teresa Owen	Executive Director Of Public Health (for Minute AC19/80)
Justine Parry	Assistant Director of Information Governance & Risk (for Minute AC19/83)
Dawn Sharp	Acting Board Secretary
Clair Tipton	Workforce Information Systems Manager (for Minute AC19/80)
Mike Usher	Engagement Director, Wales Audit Office
Bethan Wassell	Statutory Compliance, Governance & Policy Manager

Agenda Item	Action
AC19/74 Opening Business and Apologies for Absence. A private meeting with Internal and External Auditors was held at 9.00am. Apologies were received from the Deputy Chief Executive / Executive Director of Nursing and Midwifery, the Financial Audit Manager, Wales Audit Office and Jacqueline Hughes, Independent Member.	

AC19/75: Declarations of Interest. No declarations of interest were made at the meeting.	
AC19/76: Procedural Matters. 1). The Minutes of the last meeting of the Committee held on 12/09/19 were reviewed and approved as a true and accurate record and; 2). The Summary Action Log was noted and updated accordingly and; 3). It was noted that Chair's Action has been taken on the following matters since the last meeting; • 16/10/19 – Draft Internal Audit, Continuing Health Care Review, deferment from 2019/20 plan. • 16/10/19 – Draft Internal Audit, Cluster Governance Arrangements, deferment from 2019/20 plan. • 16/10/19 – Draft Internal Audit, Compliance with Standing Financial Instructions – Procuring Goods and Services: Pharmacy Electronic Dispensing System (EDS) Review, removal from 2019/20 plan. • 16/10/19 – Approval of revised Master Scheme of Reservation and Delegation (SoRD) together with the Model Standing Orders to be presented to the October Audit Workshop prior to Board sign off in November.	
AC19/77 Revised Terms of Reference. **Recommendation**: That the Committee review and approve the following revised Terms of References (ToRs) and recommend approval to the Board: • Audit Committee and; • Digital Information Governance Committee (DIG) and; • Charitable Funds Advisory Group. An Independent Member (Chair of DIG) requested a minor amendment to the title of 'Chief Information Officer (removal of reference to 'digital'). **RESOLVED: That the ToRs be approved and recommended for approval to the Board.**	BW
AC19/78 Issues Discussed in Previous In Committee Session. The Committee formally received the report in public session of those issues discussed in the private session at the meeting held on 12.09.19, which related to: • Financial Conformance Report. • Post Payment Verification Progress Report. • Counter Fraud Services Progress Report. • Update on Internal and External Audit Actions. **RESOLVED: That the report be noted.**	
AC19/79 Amendment to Standing Orders: Scheme of Reservation and Delegation (SoRD).	

Recommendation:

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

AC19/79.1: The Acting Board Secretary presented the report outlining the amendments to the SoRD and the rationale for the changes. Members noted that following the adoption of Model Standing Orders, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) had subsequently made minor changes that were required to be recognised and incorporated within the Health Boards own Standing Orders.

RESOLVED:

- **That the Committee approve the changes to Standing orders and SoRD on behalf of the Board.**
- **That the report be noted.**

AC19/80 Internal Audit Progress Report.

Recommendation:
The Audit Committee is asked to:

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

AC19/80.1: The Head of Internal Audit proceeded to provide an overview of the progress report in Welsh and commented that overall, he considered the report to be positive. However, he did note that it was important that management ensure that any governance or Management Group detailed within relevant policies, is accurately recorded in the Health Board's organisational governance structure. Members then proceeded to discuss the following Limited Assurance Reports:

- **AC19/80.2: Patient Monies:**
  The Acting Executive Director of Finance proceeded to provide an update on the progress made against the recommendations. The updated Patient Monies Procedure had been submitted to the Executive Team for approval and a question had been raised with regards whether the Health Board's Security team had been sufficiently involved. A meeting was to be held with the Associate Director of Health, Safety and Equality to review any concerns, with the intention of resubmitting the Procedure for approval to the Executive team in Dec/Jan.
  Members queried the reasoning for setting up a Task and Finish Group and whether it had proved to be beneficial. The Acting Executive Director of Finance advised that this had proven to be a positive and useful step that ensured clinical input and operational engagement.

- **AC19/80.3: Welsh Language:**
  The Chair welcomed the Executive Director of Public Health, Associate Director of Workforce Performance & Improvement, Workforce Information Systems Manager and Welsh Language Officer to the meeting. Members and attendees proceeded with introductions in Welsh.
  The Associate Director of Workforce Performance & Improvement provided an update on the progress made against the recommendations. The findings of the report had been accepted by management and significant progress had been made to address the identified issues. An electronic portal was now in place that contained mandatory prompts and questions to accurately determine whether the position was 'Welsh essential'. For example, 'does the post have contact with the public?' The 'Welsh essential?' section in the system was set as a default to Welsh. This was to ensure the recruiting manager asked the right questions. Once completed, the information went to the Establishment Control (EC) team for quality checks. Upon receipt, if the EC team considered that the position was in fact 'Welsh essential', the original decision could be overridden. The Welsh Trac advertising system went live on the 26/11/19. The Trac advertising team then also did further quality checks on receipt. This was all evidence of a stronger level of challenge for posts that should be advertised as Welsh essential. If recruitment was not successful and a candidate was

appointed, it was possible to go back out to advert as ‘welsh desirable’. This did require approval via the Workforce Information Systems Manager who would further quality check that there were no suitable candidates originally and review the recruiting manager’s plan to cover any gaps the absence of welsh language skills may create.

The Chair queried how Welsh skills/competencies were checked and verified. The Workforce Information Systems Manager advised that the EC team were working closely with the Welsh Language team. They were conscious that candidates may categorise themselves incorrectly though noted that this was difficult to challenge as it was based on self-assessment. However, the Strategy was also under review and would seek to reinforce the importance of considering the skill set of the whole team alongside regular reminder communications to staff about levels of competency and the requirements for each. The Welsh Language Officer highlighted a useful flowchart that provided applicants with information on how to self assess (from 1-5) and suggested its inclusion in the forthcoming Strategy.

Members noted that primary points of contact were required to be Welsh essential and queried whether this also applied to clinical staff. There were concerns that this may result in further delays to difficult to recruit to clinical posts. In particular, when this necessitated recruiting from England or in some cases, outside the UK where English may not be the candidates first language. The Workforce Information Systems Manager assured Members that this had been considered. More often than not, the first point of contact would be an administrative staff member and thus the post may not fall under the ‘first point of contact’, Welsh essential requirement. This would again, be quality checked by the EC team who had specialist knowledge of areas and positions that were particularly difficult to recruit to. The Workforce Information Systems Manager further noted that EC response times had reduced and performance against targets had improved. The Executive Director of Public Health provided further assurance that the requirement was not causing delays and that there were some groups, for example Childrens Services, that were expected to be prioritised. She further added that the review had been really helpful.

The Head of Internal Audit queried whether there was still work to do with regards strengthening the recruiting manager’s knowledge of the Strategy and the requirements for compliance with the Welsh Language Standards. This would be considered and addressed via the revision of the existing Strategy which would be used as a vehicle to embed in January. The Performance Audit Lead, Wales Audit Office highlighted the longer term strategy required by the Well-Being of Future Generations (Wales) Act 2015 and the importance of working with local partners to recruit from North Wales. The Welsh Language Officer provided Members with an overview of the work being undertaken to engage with schools. This included promoting the benefits of having bilingual skills. It was noted that the overall response was positive – many students that had initially indicated that they did not consider themselves to be able to speak Welsh at the start of the session, revised their opinion and later acknowledged that they were able to speak basic phrases and greetings in Welsh. In addition, a live webinar had been given in conjunction with Careers Wales whom had indicated an interest to provide similar sessions in the future.

Members then proceeded to discuss the frequency of, and the requirement to conduct interviews in Welsh. In particular, the quality of information sourced from references and that there was a lack of structure for ensuring candidates were being tested on essential skills. The Associate Director of Workforce Performance & Improvement advised that candidates should be assessed against all essential points including Welsh language and that training was available for recruiting managers. Enquiries would be made as to the number of staff that had received training. Whilst ideally, it would be preferable to have a qualified Human Resources professional on every panel, there was insufficient resources or capacity to support this. It was further noted by the Independent Members whom were involved with Consultant interviews that example questions provided by Workforce had proven to be useful. The Workforce and Welsh Language teams concluded that whilst there was further work to do, these types of reviews were instrumental for improvement. The discussion concluded and the Chair thanked both teams for attending (the Associate Director of Workforce Performance & Improvement remained to discuss a Wales Audit Office review).	LO
AC19/80.4: The Head of Internal Audit formally requested the removal of the three reviews from the 2019/20 plan (Compliance with Standing Financial Instructions – Procuring goods and services: Pharmacy EDS, Cluster governance arrangements and Continuing Healthcare) and drew Members attention to table four of the Progress report. Members were advised that whilst the Performance Indicators remained on target, performance had dropped in terms of Management Responses, ToR agreement as well as general engagement. Though he wished to express gratitude to the Acting Board Secretary for the support given in escalating issues.	
AC19/80.5: Members expressed concern with regards the removal of the Cluster governance review. The Head of Internal Audit provided the background for the removal and assured Members that further review would be considered again in April to ensure the governance and planning for the new proposed service was correct.	
AC19/80.6: The decision to remove the Continuing Healthcare review was due to the decision to proceed with the National Commissioning Collaborative. There were five different groups that would be reviewing the structures of meetings and to proceed with the Internal Audit review would be a duplication of work. A further review would be undertaken early 2020/21 to allow for system/process changes following the external review to be embedded. The Performance Audit Lead, Wales Audit Office highlighted the potential to look across at a regional level and emphasised the importance of the quality of care as well as the general cost allocation.	
AC19/80.7: The Vice Chair enquired as to the reasoning for the pause in the review of salary overpayments (detailed at page 18 of the progress report). The Head of Internal Audit advised that this was to enable to allow management to determine the reasons for a spike before continuing with analysis which was now moving forward. The Acting Director of Finance offered to investigate and update Members further on the reasons for the spike.	SH
RESOLVED: • **That the Progress report be received.** • **The three reviews from the 2019/20 plan be removed.**	

AC19/81 Wales Audit Office (WAO) Update Report.

Recommendation:
The Audit Committee is asked to:

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

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

AC19/81.1: The Performance Audit Lead, WAO proceeded to provide an overview of the progress report. Following discussion at the Public Accounts Committee of the National Assembly for Wales, a review of Interim Directors' Appointments was to be undertaken. The Engagement Director, WAO highlighted some concerns with regards BCUHB engagement and it was agreed that the Chair would escalate to the Chairman and Chief Executive. The Executive lead for the review was the Executive Director of Workforce and Organisational Development. The Associate Director of Workforce Performance & Improvement apologised for the delay in response and advised that the requested information would be sent to WAO that day.

AC19/81.2: Members then proceeded to discuss the progress report. The Vice Chair queried the identification of the Executive Lead on page six of the Progress report. The Acting Executive Director of Finance indicated this should be the Associate Director of Quality Assurance, Nursing and the Acting Board Secretary agreed to escalate for confirmation. DS

- **AC19/81.3: Integrated Care Fund:** Members noted the size and geography of BCUHB posed a particular challenge. Due to the requirement to liaise with six different local authorities, it was a very complex landscape. Members proceeded to discuss whether there were any similarities to other Health Boards in Wales and if there was any shared learning that could be utilised. The Performance Audit Lead, WAO advised that Aneurin Bevan University Health Board was probably the most similar in terms of geography (Greater Gwent Regional Partnership Board was listed in the notable practice which other RPBs could learn from in page 15 of the report).
- **AC19/81.4: National Review of Public Service Boards**: This was a national report that highlighted some common issues. An Independent Member queried whether there were any specific example of engaging with citizens (page 17 of the report). The Engagement Director WAO directed Members to paragraph 1.9 to 1.10 (questionnaire surveys and workshops). Members concurred that there

was still ambiguity how these were communicated to members of the public and how visible this really was. The Engagement Director and Performance Audit Lead WAO agreed to feed these points back to the National Team and enquire as to any other specific examples of engagement. Members concluded that the recommendations would be monitored by the Strategy, Partnerships and Population Health (SPPH) Committee rather than be tracked via the Internal and External Tracker/system.	AD BW
• **AC19/81.5: Implementing the Well Being of Future Generations Act:** Members noted the progress made though acknowledged Health in general to be a little behind Local Authorities. Members further noted there were good examples of joint working. An Independent Member highlighted that long-term funding was an issue outside of BCUHB control. The Performance Audit Lead WAO stressed the need for prevention, supported by short term funding to meet long-term needs. The Acting Executive Director of Finance highlighted the issue about the ability to have a strategic impact when funding was often received late in the day. The Engagement Director WAO agreed and advised that the point had been raised with Welsh Government. • **AC19/81.6: Primary Care Services in Wales:** members noted that this was a National report following the previous local report received in 2018. The Vice Chair queried what the priorities were for primary care on a national basis. In particular, community pharmacists undertaking wider roles and whether this was sustainable. The Performance Audit Lead WAO agreed that clarity on the roles was required. • **AC19/81.7: Structured Assessment:** The Performance Audit Lead WAO provided an overview of the report and highlighted the issues of performance. There was evidence of a cycle of fail and recover which did not provide long-term sustainability. Members discussed the need to build cohesive and constructive relationships at Board and Committees. The Acting Executive Director of Finance assured Members that the Board was very aware of these issues which would be further discussed at a Board Workshop to look to a five year outlook as well as a detailed operational review with the top 120 managers looking at how to deliver services better. An Independent Member raised concern with regards how BCUHB move from cost saving recovery to transformation and whether there was a sufficient plan in place. However, he did note that he felt grip and control had improved which had also been evidenced at the Finance and Performance (F&P) Committee. The Vice Chair expressed gratitude for the report and cited it as being a useful roadmap though noted the temporary organisational structure, which was person dependent. It was important to focus on succession planning. The Performance Audit Lead WAO agreed and advised that the work should be program based and managed. The Engagement Director WAO concluded that the Structured Assessment was an ongoing conversation but there were signs of encouragement. • **AC19/81.8: Cwm Taf Morgannwg University Health Board Update**: The Engagement Director WAO provided an update to Members. In particular, the report had highlighted concerns around sufficient sight of issues (the gap between ward to Board). It was important for the Board to have its finger on the pulse of what was happening at an operational level as well as confidence in how to raise and escalate issues. The Vice Chair stated that it was governance that underlies all of these types of reports and members noted that the BCUHB response to the report was to be discussed at an upcoming Board workshop on the 19th December.	

AC19/81.9: The Engagement Director WAO concluded the update by advising Members that there would be a rotation of WAO staff. Dave Thomas would take over as the Engagement Director with Richard Harries to lead on the financial audit work. The Chair thanked the Engagement Director WAO for his input and wished him well in the new position. **RESOLVED:** • **The content of the audit progress update be noted.** • **Received and discussed the Integrated Care Fund report.** • **Received and discussed the National Review of Public Service Boards report with the assurance on progress against recommendations provided in the form of a narrative report to the Strategy, Partnerships and Population Health (SPPH) Committee.** • **Received and discussed the Wellbeing of Future Generations report and BCUHB response. A formal Management Response was to be received at March Audit Committee.** • **Received and discussed the Primary Care Services in Wales report, and add the applicable Recommendations to the Tracker** • **Received and discussed the Structured Assessment. The intention was that the Management Response would be finalised and approved at 9th January Board.**	BW BW BW DS

AC19/83 Corporate Risk Register and Assurance Framework Report. **Recommendation:** The Audit Committee is asked to: 1) Note, approve and recommend the Corporate Risk Register (CRR) to the Board and to gain assurance that the risks are managed in line with the Health Board`s risk management strategy. 2) To recommend two new risks which were approved by the Quality, Safety & Experience Committee (QSE) to the Board for inclusion onto the CRR. **AC19/83.1:** The Assistant Director of Information Governance & Risk presented the report to Members and advised that it was a requirement that the CRR was presented at Audit Committee twice a year. The Coversheet detailed the changes since the previous iteration and included two new risks (CRR20: Security Risk and CRR21: Health & Safety Risk). Members further noted that their previous comments on the Risk Management Strategy had been taken on board and were currently being reviewed by the Deputy Chief Executive / Executive Director of Nursing and the Associate Director of Quality Assurance, Nursing. The intention was to have the revised version to Members by the end of the week for approval via Chair's Action. Members then proceeded to review the CRR with the following comments: • **AC19/83.2: Coversheet**: The Vice Chair queried the de-escalated risks. There was a discussion with regards which risks each referred to and Members agreed that the full title should be included in future reports rather than just the ID/number. An Independent Member expressed an ongoing general concern as to the inherent scoring of risks. The Assistant Director of Information Governance & Risk informed Members that an Executive Risk Management Scrutiny Panel had been formed and would support the influence for change. • **AC19/83.3: CRR05 Learning from Patient Experience**: Controls not updated. Control 14 – Associate Director has been in post for over two years, suggest remove. General dissatisfaction in controls listed, indicates a lack of understanding in what a 'control' is. Assistant Director of Information Governance & Risk advised that the planned training program will address this though there was work to do around terminology of 'controls'. Training package to be sent to Members. Risk to be referred back to the QSE Committee in January for review. • **AC19/83.4: CRR06 Financial Stability:** Members discussed the scoring of the Risk and whether potential future costs had been taken into account. The Acting Executive Director of Finance briefed Members on a previous conversation with other Directors of Finance on Welsh Risk pool costs. The additional cost was in BCUHB forecast but needed to be considered at F&P Committee where the initial risk rating would be considered. Further discussion ensued as to whether there should be two separate risks and Members recommended an additional risk for Sustainability. • **AC19/83.5: CRR10A National Infrastructure and Products:** Issues with Controls (project governance is not a BCUHB control). Assuring Committee should state Digital and Information Governance (DIG) Committee. Point 3 of further actions to achieve target risk score (Implementation of recommendation's from Architecture and Governance Reviews due in May 19), Members queried how BCUHB engage with this – comments to go to Chair of DIG and the Executive Medical Director.	JP JP JP/SH JP

• **AC19/83.6: CRR10b Informatics - Acute and Community Health Records:** Assuring Committee should state Digital and Information Governance (DIG) Committee. Title of Risk has also changed, should just read 'Health Records'. To be picked up at DIG.	JP
• **AC19/83.7: CRR10C Informatics infrastructure capacity, resource and demand:** Assuring Committee should state Digital and Information Governance (DIG) Committee.	JP
• **AC19/83.8: CRR11a Unscheduled Care Access:** This risk was reviewed at F&P on the 2nd December but has not been updated. The Assistant Director of Information Governance & Risk advised a new lead had been identified and had met with the Head of Risk.	
• **AC19/83.9: CRR11b Planned Care Access:** This risk was reviewed at F&P on the 2nd December but has not been updated. Further comments around scoring – initial score of 20 and remains at 20 yet Risk has 17 controls in place which suggests the controls are having no effect to mitigate. Also queries whether a lot of the controls relate to previous year and should therefore be removed.	JP
• **AC19/83.10: CRR12 Estates and Environment:** Queries were raised with regards the likelihood score of '3' and whether this took into account electrical issues. Risk to be referred back to F&P.	JP
• **AC19/83.11: CRR13 Mental Health Services:** The progress graph appeared to show an anomaly (gap). Members were advised this was due a formatting issue where the current line was obscured by the target line. There was a further discussion with regards the previous unauthorised reduction in score and how this should be recorded in the progress graph. Members agreed that in order to accurately reflect previous discussions / other Committee minutes, the graph would continue to show the unauthorised reduction but would need a footnote explaining the rationale. Further work is required on controls and actions, both are out of date / not updated. The use of the term 'ongoing' is inappropriate, actions need to be able to evidence improvement. Risk to be referred back to the QSE Committee in January for review.	JP
• **AC19/83.12: CRR14 Staff Engagement:** Query with regards scoring and whether realistic. If the target score has been achieved, then the recommendation should be to de-escalate. Members also commented that there was an excessive number of controls that should be streamlined. Risk to be referred back to SPPH for review.	JP
• **AC19/83.13: CRR15 Recruitment and Retention**: Members queried the initial score and considered whether the recent Welsh Language Measure Internal Audit review should be considered against the Risk. Actions to be listed for compliance with Welsh Language standards.	JP
• **AC19/83.14: CRR16 A major safeguarding failure occurs**: Title of risk is not appropriate, requires renaming. Further actions out of date and require updating. Risk to be referred back to QSE in January for review.	JP
• **AC19/83.15: CRR20 Security**: members queried whether this was collective or site specific. Further queries on scoring (should impact/likelihood be reversed?). Risk to be referred back to the QSE Committee in January for review.	JP
• **AC19/83.16: CRR21 Health & Safety Leadership and Management**: Controls need to be revised (a Policy is not a control) as well as scoring (narrative does not match score).	JP

AC19/83.17: As a general observation, the Head of Internal Audit queried what horizon scanning was in place. The Corporate Risk Register is more in line with an issue log as opposed to risk. The Assistant Director of Information Governance & Risk indicated that this would be picked up as part of the Strategy. The Vice Chair stated that this would also need to be recognised in the Board Assurance Framework. A discussion ensued with regards the inclusion of a 'Reputational' risk. Members noted that this had previously been discussed by the Executive and agreement reached not to include. The Engagement Director WAO supported this decision and advised against its inclusion. **AC19/83.18:** The Assistant Director of Information Governance & Risk concluded by providing members with a brief overview on the planned form of the training. This included face to face training, initially with Senior Management and leads as well as e-learning. The Head of Risk had also developed a self-assessment competency framework. **RESOLVED:** • **That the CRR be noted and approved pending review and revision as detailed above.** • **To recommend two new risks for inclusion to the Board onto the CRR.**	

AC19/84 Clinical Audit Policy. **Recommendation**: • The Audit Committee is asked to approve the amended policy and procedure document. **AC19/84.1:** The Senior Associate Medical Director presented the report and the revised Policy that had been updated post review at the Joint Audit and Quality, Safety & Experience (JAQS) Committee on the 5th November 2019. Members noted that the Policy had been shared with the Executive Director of Primary and Community Services who was comfortable with the content and keen to commence implementation, it was important to get the clinical teams engaged. **AC19/84.2:** The Chair thanked the Senior Associate Medical Director as it was evident that a lot of hard work had been undertaken. However, there appeared to be some confusion as to the recommendation for the Audit Committee. The QSE Committee was the approving Committee and the Policy would need to be tabled for review in January (it was not possible for the Audit Committee to approve the Policy). It was also necessary that the Committee had sight of the EqIA post amendments since JAQS. **AC19/84.3:** Members further stated that there were still some administrative amendments required and it was agreed that the Senior Associate Medical Director would meet with the Vice Chair to review. It was also agreed for the EqIA to be reviewed by the Head of Equalities and Human Rights. The Document would then be approved via Chair's Action by Audit Committee before being final approved by the QSE Committee. **RESOLVED:** • **That the Clinical Audit Policy be tabled for review at January QSE Committee.**	MM
AC19/85 For Information Charitable Funds Accounts **Recommendation:** The Audit Committee is asked to note the Charitable Funds Annual Report and Accounts 2018/19, together with the letter from WAO and BCUHB response. **AC19/85.1:** The Acting Board Secretary presented the report and drew Members attention to a letter received from the Wales Audit Office and the BCUHB response. The Engagement Director, WAO provided Members with the background to the items and Members noted that it was disappointing the length of time it had taken to be implemented. The Vice Chair queried the evidence that this had been implemented as specific communications of the changes had not been received. The Acting Board Secretary agreed to facilitate a specific communication to inform all Independent Members of the update. **RESOLVED:** • **That the report be noted.**	DS

AC19/86 Issues of Significance for reporting to Board The Chair agreed to prepare an assurance report for the Board.	
AC19/87 Exclusion of Press and Public Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."	

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Last updated 10.03.20				
Ian Howard/ John Darlington	**AC19/30** Revenue Business Case –review management response and set clear milestones to address recommendations	August	Updated Management Response received noting this was a limited assurance report and will be subject to IA follow up.	close
Dawn Sharp/Liz Jones	**AC19/61** BAF individual action ownership sub divided where appropriate	March	Board Assurance Framework currently under revision following discussion at Audit Workshop. This will be aligned to the Annual Plan and presented to the March meeting	
Bethan Wassell / Jacqueline Hughes	AC19/61 LAF, demo for JH of electronic system	Oct	Agreed to be arranged outside of meeting subject to availability.	close
Bethan Wassell	**AC19/77** DIG ToR, Membership section: Remove reference to ‘Digital’ from the ‘Chief Information Officer’ line	Dec	Secretariat confirmed amendment and inclusion in DIG draft end of year Annual report 19/20 (to be reviewed and signed off 13/02/20).	close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Lawrence Osgood	**AC19/80.3** Information to be provided to the Committee on number of recruiting managers that have received training	March	BCU W&OD department provide Recruitment Skills Training as part of the following programmes: • ASIM (A Step into Management) Programme: 176 managers trained via this programme • Ward Managers Programme: 111 managers trained via this programme. This year the training programme for Matrons will also include Recruitment Skills Training. The W&OD recruitment team offer 1-1 advice both on an ad-hoc basis and as part of a rolling programme. In 2019/20 Q4 recruitment team have been targeting all ward managers at YMW, visiting each in turn to assess current vacancies and to give 1-1 recruitment skills training. In addition to this NWSSP are running workshops in YMW in March to specifically cover TRAC system training in more detail. This rolling programme of ward by ward training will be rolled out to the other secondary care sites and beyond in 2020/21. All recruiting managers also have access to recruitment managers guidance packs via the intranet. This guidance is due to be reviewed and refreshed 2020/21 Q1 when the new Recruitment Team manager is due to start.	Close
Sue Hill	**AC19/80.7:** Information to be provided to Committee reasons for spike in the review of salary overpayments	March	The increase in salary overpayments are mainly due to Payroll receiving the form late (top two reasons: late leaving form & late changes form). Change in hours have also doubled compared to a year ago.	Close
Dawn Sharp/Justine Parry	**AC19/81.2:** Confirmation on Executive lead for WAO review: Orthopaedic Services follow up	March	Confirmation received that Executive lead is the Deputy Chief Executive / Executive Director Nursing & Midwifery	close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Andrew Doughton	**AC19/81.4:** Feed points raised by Members re engagement back to National team and enquire as to specific examples	March	Email provided by WAO to Members 19/12/19	close
Bethan Wassell	**AC19/81.4:** PSB Review - Recommendations to be tracked via SPPH	Dec	SPPH Chair, Exec Lead and Secretariat informed. Item added to draft February agenda.	close
Bethan Wassell/Sally Baxter	**AC19/81.5:** WFG Review - Management Response to be provided to WAO	March	Update 03/03/20: Management response awaiting Executive sign off (Planning & Performance / Public Health)	March/April
Bethan Wassell	**AC19/81:** Applicable recommendations to be added to tracker / TeamMate	March	ICF and Primary Care Services review input and live tracking in TeamMate.	Close
Dawn Sharp/Justine Parry	**AC19/81.7:** Structured Assessment – Management Response to be approved at January Board	Jan	Draft response approved 23/01/20. Final to be received at March Audit Committee following approval at January Board.	Close
Justine Parry	**AC19/83.2:** CRR coversheet – include full title of risk in future reports	March	03/01/20: Template report updated to reflect this change	Close
Justine Parry	**AC19/83.3:** CRR05 / Patient Experience – RM training package to be sent to Members	March	03/01/20:Sent via email	Close
Justine Parry	**AC19/83.3:** CRR05 / Patient Experience – Review and update controls	March	03/01/20: Updates returned to leads and will be presented to QSE in January 2020	Close
Justine Parry	**AC19/83.4:** CRR06 Financial Stability – Welsh Risk Pool costs to be considered at F&P / reconsider Initial risk rating and add additional ‘Sustainability’ Risk.	March	03/01/20: Updates returned to leads and will be presented to F&P in January 2020	Close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Justine Parry	**AC19/83.5:** CRR10A National Infrastructure and Products – review and update controls. Info to be provided on BCUHB engagement with recommendation's from Architecture and Governance Reviews due in May 19 to Chair of DIG and Exec Medical Director	March	03/01/20: Updates returned to leads and will be presented to DIG in February 2020	Close
Justine Parry	**AC19/83.6:** CRR10b Informatics - Acute and Community Health Records. Update title of risk, to be picked up at DIG	March	03/01/20: Updates returned to leads and will be presented to DIG in February 2020	Close
Justine Parry	**AC19/83.7:** CRR10C Informatics infrastructure capacity, resource and demand. Assuring Committee to be updated	March	03/01/20: Updates returned to leads and will be presented to DIG in February 2020	Close
Justine Parry	**AC19/83.8:** CRR11a Unscheduled Care Access – Risk not updated post review at F&P	March	03/01/20: Updates returned to leads and will be presented to F&P in January 2020	Close
Justine Parry	**AC19/83.9:** CRR11b Planned Care Access – Risk not updated post review at F&P. Further issues around controls	March	03/01/20: Updates returned to leads and will be presented to F&P in January 2020	Close
Justine Parry	**AC19/83.10:** CRR12 Estates and Environment – review likelihood score / refer back to F&P	March	03/01/20: Updates returned to leads and will be presented to F&P in January 2020	Close
Justine Parry	**AC19/83.11:** CRR13 Mental Health Services – insert footnote to explain graph anomaly, review controls and actions, refer back to QSE	March	03/01/20: Updates returned to leads and will be presented to QSE in January 2020	Close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Justine Parry	**AC19/83.12:** CRR14 Staff Engagement – Scoring and controls to be reviewed. Refer back to SPPH	March	03/01/20: Updates returned to leads and will be presented to SPPH in February 2020	Close
Justine Parry	**AC19/83.13:** CRR15 Recruitment and Retention – Review score. Actions to be added to address compliance with Welsh Language Standards	March	03/01/20: Updates returned to leads and will be presented to SPPH in February 2020	Close
Justine Parry	**AC19/83.14:** CRR16 A major safeguarding failure occurs – Review risk title and actions. Refer back to QSE	March	03/01/20: Updates returned to leads and will be presented to QSE in January 2020	Close
Justine Parry	**AC19/83.15:** CRR20 Security – review score and refer back to QSE.	March	03/01/20: Updates returned to leads and will be presented to QSE in January 2020	Close
Justine Parry	**AC19/83.16:** CRR21 Health & Safety Leadership and Management – Revise controls and score	March	03/01/20: Updates returned to leads and will be presented to QSE in January 2020	Close
Melanie Maxwell	**AC19/84.3:** Clinical Audit Policy – MM to discuss/review with Vice Chair and EqIA to be reviewed by Equalities Team before review at January QSE	March	Approved at January QSE. Audit Committee Chair's Action for approval taken.	Close
Dawn Sharp/Justine Parry	**AC19/85.1:** Charitable Funds Accounts – specific communication to be sent to Independent Members of update	March	Email sent to IMs 10/03/20	Close

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 19/03/20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: Responsible Director:	Acting Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Acting Board Secretary
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the report.

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

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

Sefyllfa / Situation:

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

Cefndir / Background:

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

The issues listed below were considered by the Audit Committee at its private in committee meeting of: 12.12.19.

- Financial Conformance report
- Post Payment Verification Progress report
- Primary Care Dental Contracts Assurance report
- Counter Fraud Services Progress report
- Welsh Risk Pool update report
- Update on Internal and External Audit Actions

Asesiad / Assessment & Analysis

Strategy Implications

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

Financial Implications

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

Risk Analysis

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

Legal and Compliance

Compliance with Standing Order 6.5.3

Impact Assessment

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

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Joint Audit and Quality, Safety & Experience (QSE) Committees

Minutes of the Meeting Held on 5th November 2019 in the Boardroom, Ysbyty Gwynedd, Bangor

Present:

Cllr Medwyn Hughes	Independent Member (Joint Chair)
Mrs Lucy Reid	Independent Member (Joint Chair)
Mr John Cunliffe	Independent Member
Mrs Jacqueline Hughes	Independent Member
Mrs Lyn Meadows	Independent Member

In Attendance

Mrs Deborah Carter	Associate Director of Quality Assurance / Interim Director of Operations
Mr Andrew Doughton	Performance Audit Lead, Wales Audit Office
Mrs Kate Dunn	Head of Corporate Affairs
Dr David Fearnley	Executive Medical Director
Mr Dave Harries	Head of Internal Audit
Ms Sue Hill	Acting Executive Director of Finance
Dr Melanie Maxwell	Senior Associate Medical Director (part meeting)
Ms Dawn Sharp	Acting Board Secretary
Dr Chris Stockport	Executive Director of Primary and~~&~~ Community Services
Mr Adrian Thomas	Executive Director of Therapies and~~&~~ Healthcare Sciences

Agenda Item Discussed	Action By
JAQS19/1 Chairs' Welcome The Joint Chairs welcomed everyone to the meeting. It was noted that Dr Melanie Maxwell had been delayed and the agenda order would therefore be flexed.	
JAQS19/2 Declarations of Interest None made.	
JAQS19/3 Apologies for Absence Apologies were recorded for Cllr Cheryl Carlisle, Mrs Sue Green, Mrs Gill Harris, Miss Teresa Owen, Mr Mark Thornton and Mrs Amanda Hughes.	

JAQS19/4 Minutes of Meeting Held on 6.11.18 for Approval of Accuracy, Matters Arising and Review of Action Log **JAQS19/4.1** The minutes were agreed as an accurate record. **JAQS19/4.2** With regards to the action log the QSE Committee Chair was of the view that she was not prepared to accept a recommendation to close an action without sufficient evidence that the action had been addressed. Once Dr Maxwell joined the meeting the action log was reviewed in detail but given the pressures of time it was agreed that the joint chairs would review outside of the meeting and confirm their acceptance or otherwise of the RAG status of each action, and recirculate.	MH LR
JAQS19/9 Briefing on Governance Review *[Agenda item taken out of order at Chairs' discretion]* **JAQS19/9.1** The QSE Committee Chair explained that she had requested a briefing paper as whilst she was aware that discussions regarding the governance review had been held within Audit Committee workshops, she was conscious that QSE Committee members had not been directly involved. She was also aware that the review had been referred to within the public domain but there had not been a specific position update. **JAQS19/9.2** The Acting Board Secretary presented the paper which summarised the work being undertaken to undertake a review of governance and risk arrangements across the organisation with a key intention to ensure there were clear reporting lines from any management groups to ensure timely and appropriate escalation. She also highlighted that consideration was being given to ~~a proposal to~~ splitting the work of the Quality Safety Group (QSG) into three main areas of 1) quality and safety; 2) effectiveness and outcomes; 3) patient experience and co-production. The Acting Board Secretary reiterated that the proposals were still awaiting full consideration by the Executive Team. **JAQS19/9.3** The Audit Committee Vice-Chair referred to the proposal within the paper that executive led groups report into an appropriate scrutiny committee chaired by an Independent Member and noted that previously it had been widely accepted that the Board level committees were not scrutiny committees. He also was not aware of any discussion to date at the Finance and~~&~~ Performance (F&P) Committee regarding the potential need for an investment committee. He noted that whilst this may well reduce the burden on the F&P Committee it would increase the burden on Independent Members. The Acting Board Secretary indicated that the Executive Team would need to be clear what it wanted this forum/group to do, and that it may well not be a full committee. The Audit Committee Vice-Chair was also keen to ensure clarity on the role of existing and any new committees. **JAQS19/9.4** The Executive Medical Director was supportive of reducing unnecessary burden on committees whilst ensuring ~~and felt that~~ good governance ~~was a way of working~~. He also encouraged the use of digital solutions for sharing information ~~and enabling meetings~~. The QSE Committee Chair noted that the paper was a position update on the ongoing discussions and asked when the whole Board would be	

engaged in the process. The Acting Board Secretary suggested that initially there would be discussions at the Committee Business Management Group and within a future Board Workshop setting, ahead of consideration by full Board in public. **JAQS19/9.5** The Acting Executive Director of Finance enquired whether any benchmarking had been undertaken as to how other Health Boards aligned and structured their committee responsibilities. The Acting Board Secretary confirmed such benchmarking had been carried out in the past but not specific to this ongoing review. It was noted that All Wales QSE Committee Chairs had been asked to consider the matter and that the direction of travel of the BCUHB review was in line with arrangements in place elsewhere. Mr A Doughton concurred that generally Committee structures were similar across Wales although the size of BCUHB and its geography added a further challenge. He asked whether the proposal to split the QSG into three main areas of work would be replicated at divisional level. The QSE Committee Chair confirmed ~~this was not the intention~~that the principle being considered was to ensure clear lines of reporting. **JAQS19/9.6 It was resolved that** the Joint Audit and Quality, Safety & Experience Committee ~~to~~ note the context and progress of the governance review and the emerging considerations and further updates would be provided to the Board going forwards. *[Dr M Maxwell joined the meeting]*	
JAQS19/5 Draft Clinical Audit Policy & Procedure **JAQS19/5.1** The QSE Committee Chair referred to the coversheet and suggested that the purpose of the paper was not to seek approval as that was the recommendation. **JAQS19/5.2** The Audit Committee Vice-Chair set out a range of specific comments: • Para 6.4 roles and responsibilities – he was concerned that only the clinical audit lead was to review the action plan. • Para 7.1 role of Audit Committee – he felt this was rather prescriptive. The Senior Associate Medical Director indicated that agreement had previously been reached to include the Welsh Government handbook wording. The Audit Committee Vice-Chair suggested the narrative could be softened to read "the role of the Audit Committee includes……" • Para 7.5 Quality and Safety Groups – he suggested that this needed to clarify to where or whom risks should be escalated. • Para 7.6 Clinical Audit and Improvement Groups (CIAG) – he enquired why this did not related to the West area also. The Senior Associate Medical Director indicated that the CIAG function in the West was incorporated into their quality and safety site meetings. This variation was of concern. It was suggested that the policy should describe how the function was delivered, not necessarily how the groups were structured in different areas. This would be refreshed and reworded. • Para 8 registration of audits – he asked how members would get assurance that the quality and safety groups were addressing the right priorities. • He noted that the policy did not reference triggers to tier 3 audits, and did not define the Part A and Part B elements of national audits. This would be addressed.	

JAQS19/5.3 A member asked that the policy make it clearer as to the consequences of a "must do" audit not being completed, and that any that were abandoned must be escalated with the reason clearly set out. **JAQS19/5.4** The Audit Committee Chair indicated that the lack of progress around implementation of clinical audit actions including the development of the policy would again be escalated to the Board, but he did not wish this to be seen as a reflection on the work of the clinical audit team. He was disappointed that the previous concerns had not been picked up adequately by the Executive Team. He also referred to the resources available to the team and the Executive Medical Director felt that a stock-take of resources going into the audit function was needed, including the ability of clinicians to take time to undertake audit and to ensure this was appropriately reflected in job plans. The Head of Internal Audit indicated he would be more than happy to input into the approach. **JAQS19/5.5** Members queried the relevance of some of the statements within the equality impact assessment (EQIA) which accompanied the policy and whether some of the impact would actually be positive rather than neutral. It was also noted that the equality diversity and human rights section within the policy document itself had been removed in error. **JAQS19/5.6** The QSE Committee Chair noted that the Policy stated that the corporate clinical audit annual plan would be agreed by the end of February each year, however, as the QSE Committee did not meet in the month of February it was agreed this would need to be ~~undertaken~~ reviewed in March. She also noted that the policy needed to be consistent in that the narrative needed to concur with the appendices and that there were still some typographical and grammatical errors within the policy. **JAQS19/5.7 It was resolved that** the Joint Audit and Quality, Safety & Experience Committee were not in a position to approve the policy. The comments and concerns would be followed up with a revised policy being submitted to Audit Committee on the 12th December.	MH LR MM
JAQS19/6 Draft Clinical Audit Reporting Templates **JAQS19/6.1** The QSE Committee Chair felt it was unn~~'t~~ clear what the templates were to be used for. The Senior Associate Medical Director confirmed that the aim was for the templates to provide an overview of audit activity including detail of those which had been added to the original plan, any audits abandoned and detail of those which had been completed. The templates would be supported by narrative to provide contextual detail. The Audit Committee Vice-Chair noted that they would need to meet the needs of both the Audit and QSE Committees as they had different and distinct roles in terms of monitoring the clinical audit plan. **JAQS19/6.2** The QSE Committee Chair enquired why the templates were laid out as site specific whereas ~~and felt that~~ audits were generally on a pathway or specialty level. The Executive Director of Therapies and Health Sciences indicated that site level did often improve ownership. The Performance Audit Lead (Wales Audit Office) concurred that site level detail was often helpful to identify variance. He suggested that members	

needed to consider the balance of information that the Joint Committees required, ensuring it was meaningful and able to give assurance whilst not providing too vast a level of detail. He suggested that the focus should be on the exception reports and those audits given limited assurance. The Associate Director of Quality Assurance / Interim Director of Operations added that it was often difficult to decouple methodology from the national audits. **JAQS19/6.3 It was resolved that** the feedback provided by the Joint Audit and Quality, Safety & Experience Committee ~~noted~~ on the draft templates would be considered further by the clinical audit team.	
JAQS19/7 Clinical Audit Report 2019 **JAQS19/7.1** The Senior Associate Medical Director apologised that resources had notw allowed for a full-year report to have been prepared. The paper related to a number of audits delivered in the first six months of 2019-20. Members' attention was drawn to Section 2 on audit activity and that BCUHB had completed data submission for the majority of Tier 1(nationally mandated) audits. There were however resource challenges affecting participation with the following audits: • COPD / Asthma (East and West). • Fracture Liaison Service. • Vascular audit (Lower limb Angiography) **JAQS19/7.2** The Audit Committee Chair expressed concern at the lack of participation in Tier 1 audits. The Senior Associate Medical Director confirmed that the information required was available in the system and it was purely a capacity issue to extract and validate the data appropriately. The Audit Committee Vice-Chair again suggested that the Part A and B elements needed to be expanded upon to clarify and define. He also felt that the report should identify where BCUHB performance in terms of clinical audit activity differed from its peers. The QSE Committee Chair suggested that Table 2 (changes identified on Part A and B) needed to make it clear where BCUHB data was not submitted for the period but there was a recommendation or learning taken from the national report. She also ~~felt~~ noted that there were questions within the table rather than ~~that needed~~ an explanatory narrative and this needed to be addressed in order for them to make sense. **JAQS19/7.3** A member referred to the governance issues and risks set out within the coversheet and sought assurance as to whether these were significant – for example was the respiratory service itself of concern or compliance with the related audit. The Senior Associate Medical Director indicated that as there was not the resource nor capacity to take part in the respiratory audit it wasn't possible to benchmark the service. This did not necessarily mean there was a concern or problem with the service but positive assurance could not be given. The Audit Committee Vice-Chair asked whether a priority could be given to undertaking a local respiratory audit in order to provide some level of assurance. The Executive Medical Director undertook to look into this and acknowledged that appropriate risk management processes were key to mitigating this assurance gap.	MM MM DF

JAQS19/7.4 A discussion ensued around Table 1 (Tier 1- National Clinical Audit & Outcome Review Plan). The Audit Committee Chair noted that the Board's compliance with submission of data had improved since last year. The QSE Committee Chair suggested it would be helpful for the table to have a single status column and also to indicate whether recommendations of the previous year's audit had been delivered. She noted that the report was very numbers rather than outcome focussed and that she would expect the compliance rate reported to relate to compliance against the standards being audited rather than compliance with the plan. **JAQS19/7.5** It was noted that a lack of leadership was referenced within the paper and the Associate Senior Medical Director indicated this again came back to capacity but that she hoped that as job plans evolved this would be addressed. It was agreed that the joint Chairs would prepare a note to encourage participation in audit. **JAQS19/7.6 It was resolved that** the feedback provided by the Joint Audit and Quality, Safety & Experience Committee would be considered and incorporated into future reports~~acknowledge the update~~.	MM LR MH
JAQS19/8 Clinical Audit Plan Update **JAQS19/8.1** The Executive Medical Director confirmed that there was nothing significant to report, and implementation of the plan was progressing. The Head of Internal Audit added that the draft Internal Audit plan was subject to Audit Committee approval, and that he would welcome approval of the Clinical Audit policy as soon as possible. The Performance Audit Lead (Wales Audit Office) suggested that the organisation was at the forming and storming stages of clinical audit development, and that the challenges~~d~~ being made would strengthen and improve processes. He felt that the organisation was in a far more positive place than previously. **JAQS19/8.2** The Executive Medical Director wished to record his gratitude to Dr~~R~~ Melanie Maxwell for her work in developing the clinical audit agenda and for bringing ~~many of~~ the papers together.	
JAQS19/10 Date of Next Meeting To be arranged for November 2020	KD

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Structured Assessment 2019 – management response to audit recommendations

Betsi Cadwaladr University Health Board

Audit year: 2019

Date issued: December 2019

Document reference: Publishing team assigns this

Introduction

1. We have concluded our 2019 Structured Assessment of Betsi Cadwaladr University Health Board. As part of this work, we made a number of audit recommendations to the Health Board. These are set out with our findings and conclusions, in our full report which can be found on our website [will insert link once uploaded].

2. This document sets out the Health Board's response and the actions it intends to take to address our 2019 structured assessment recommendations.

3. Any enquiries regarding re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

Betsi Cadwaladr University Health Board: management response

The following table sets out the Health Board's management response to our 2019 structured assessment audit recommendations

Recommendation	Management response	Completion date	Responsible officer
Clinical strategy and service planning R1 Ensure that work to develop a clinical services strategy is delivered to planned timescales and includes a fundamental review of the shape and location of clinical services across all three main hospital sites. This work should focus on solving a number of service sustainability issues including: • Medical staffing, vacancy gaps and on-call rota management. • Service efficiency and affordability. • Ability to meet forecasted growth in service demand. • Mitigate the impact of unscheduled care on the effectiveness of wider services. • Enabling sub-specialisation of clinical services, where beneficial.	A digitally enabled clinical strategy has been proposed and extensively discussed at health board meetings in September, October and November 2019. It sets out an ambitious approach to improving population health by focussing on prevention and systems changes, specifically establishing whole-system evidence based pathways; managed professional networks; and implementing a core bundle of digital healthcare technology, e.g. a digital health record. This strategy will disrupt traditional ways of working and enable greater digital literacy. It will build a system that focusses and measures outcomes and places less and less reliance on the site of care, moving to more accessible and personalised care. The strategy will reduce unwarranted variation in practice and outcomes, enhance specialisation and opportunities to improve research partnerships.	July 2020	David Fearnley, Executive Medical Director

Recommendation	Management response	Completion date	Responsible officer
	The strategy will support prudent healthcare and improve the use of resources and maintain an affordable service that meets growth in demand. The health board is supporting the development of the strategy, with updates and the final implementation plan due by April 2020.		
Clinical engagement in service design and transformation R2 Ensure clinical engagement and leadership are integral elements as part of the development of clinical strategy and associated change programmes.	Clinical engagement has commenced, as part of a variety of initiatives including service transformation groups, cluster planning and medical and clinical staff involvement in the development of the proposed clinical services strategy. Further engagement is planned before April 2020, including a series of clinical summits, to develop the clinical leadership opportunities and formally appoint clinical leaders for the new pathways and networks, and to enhance the clinical informatics capability across the health board.	April 2020	David Fearnley, Executive Medical Director
Programme management arrangements supporting service change and transformation R3 To support effective delivery of clinical strategy, introduce clear programme management structure, change programmes and programme management methodology. This should incorporate both required central and corporate structure as well as resources to enhance division-level change management capacity.	The Health Board has agreed to establish a central improvement and portfolio management service. The aim of this service is to support the development and delivery of both an improvement system and methodology together with a portfolio management infrastructure. This recognises the need for both horizontal and vertical (strategic/tactical/operational) delivery of improvement across a complex system.	April 2020	Sue Green, Executive Director of Workforce & Organisational Development

Recommendation	Management response	Completion date	Responsible officer
Executive team structure R4 The Health Board should review the form and function of the executive team to: • ensure that there is clear responsibility for acute care services at an Executive level; • ensure that programme leadership for service transformation has clear executive director level responsibility or responsibilities; and • increase focus on strategy, organisational design and the capacity and capability within the organisation to deliver the necessary change.	Following discussion at the appropriate Board committee, agreement has been reached on a new structure to ensure there is clear responsibility for acute care services at an Executive level. Programme leadership for service transformation sits with the Executive Director of Workforce and Organisational Development. Increasing our focus on strategy, organisational design and the capacity and capability for change within the organisation will be addressed through our planning process for 2020-2023, culminating in a plan being agreed by the Board prior to April, though achieving the changes in organisational culture and approach will need to be an ongoing programme.	April 2020	Gary Doherty, Chief Executive
Reliance on temporary management staffing R5 As part of the Health Board's wider approach to workforce planning, aim to reduce reliance on external interim management by building the required senior manager capacity and capability within the	A management review is underway under the workforce optimisation structure. One of the key objectives of this review is to determine the management capacity and capability required to move the organisation forward making best use of the system architecture.	April 2020	Sue Green, Executive Director of Workforce & Organisational Development

Recommendation	Management response	Completion date	Responsible officer
organisation, especially in relation to service transformation and change.	This is also intrinsically linked with our improvement structure/system and infrastructure as referenced above.		
Acute services structure R6 Finalise and agree the management structure for acute services.	Following discussion at the appropriate Board Committee, agreement has been reached on a new structure.	April 2020	Gary Doherty, Chief Executive.
Audit recommendation tracking and sign-off R7 Ensure that senior management processes for reviewing and sign-off are strengthened so that the audit committee is assured that progress is accurately reported and that actions in response to recommendations are delivered in a timely and effective manner.	The management of the Audit Tracker Tool and associated processes has recently been strengthened through the trialling of an alternative approach to reviewing tracker recommendations. This approach includes a reformatted tracker report focusing on high risk recommendations exceeding their original implementation date, Internal Audit sampling of closed recommendations to provide added assurance on actions taken, and greater accountability for overdue actions through requiring additional managers to present at Audit Committee meetings. A recent concerted effort to sharpen the focus on priorities has seen a significant number of audit tracker actions closed. This has made the Tracker Tool more manageable and will enable resources to be targeted at enhancing the quality of status updates to ensure they fully address the recommendation, and also at the achievement of realistic implementation dates.	February 2020	Liz Jones, Acting Board Secretary

Recommendation	Management response	Completion date	Responsible officer

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee – March 2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Schedule of claims over £50,000
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Matthew Joyes, Assistant Director of Patient Safety and Experience Claims Managers, Patient Safety and Experience Department
Craffu blaenorol: Prior Scrutiny:	Review by the Assistant Director of Patient Safety and Experience and Executive Director of Nursing and Midwifery/Deputy CEO
Atodiadau Appendices:	Schedule of closed claims and financial value for quarter three of 2019/20 (over £50,000)

Argymhelliad / Recommendation:

The Committee is asked to note the contents of the report and approve the Schedule of Losses and Compensation.

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

Sefyllfa / Situation:

The Audit Committee has a responsibility to ensure the provision of effective governance which includes reviewing and approving the Schedule of Losses and Compensation (as per Standing Orders, Scheme of Reservation and Delegation, Audit Committee Terms of Reference and cross checked with the Audit Committee Handbook).

To help address this requirement, the Audit Committee is required to receive a report on all claims settled over £50,000. This report provides that information.

The Health Board's Scheme of Reservation and Delegation puts in place authorised signatories to approve payment of claims to a certain value. The Chief Executive has the highest delegated approval which is up to £1 million. Above this, the Health Board itself must approve payment.

This report is the first report of its kind and has been developed to strengthen governance and ensure compliance with the requirements detailed above following a request by the Vice Chair/Chair of the Quality, Safety and Experience (QSE) Committee. Advice from the Head of Internal Audit was also taken prior to this paper being developed.

It is important to avoid duplication of reporting to the QSE Committee which has a responsibility to ensure that a robust review has been undertaken on the cause of claims and that action has been taken to minimise any future risk of the incident happening again. This is achieved through a quarterly report to the QSE Committee (the Patient Safety Report) which is also being strengthened to provide improved analysis and assurance on learning. As such, this report to the Audit Committee focuses on providing assurance on the proper process.

In addition to this report and the process for claims management outlined below, there is an annual internal audit into claims management which provides further assurance to the Committee.

Cefndir / Background:

The Health Board has a legal duty of care towards those it provides care and treatment, together with members of the general public and its workforce. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the Health Board, either for clinical negligence claims or personal injury claims.

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

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

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

Over the next six months, the new Assistant Director of Patient Safety and Experience (who has responsibility for claims management) is planning a review of the claims management process to ensure it is effective. This will be reported to the QSE Committee. Additionally, the Health Board is part of the Datix IQ Cloud implementation programme which will see a standard electronic claims system developed and implemented across Wales (this is planned to go live in April 2021).

Asesiad / Assessment & Analysis

The attached report provides a schedule of closed claims and financial value for quarter three of 2019/20 (over £50,000). This is presented to the Audit Committee to support the discharge of its responsibility to ensure the provision of effective governance and to review and approve the Schedule of Losses and Compensation.

In all cases, the claims have been managed by the claims managers within the Patient Safety and Experience Department who are all legally trained. The correct signature for delegated authority of payment has been obtained on the standard template. Additionally, all claims have been managed with the support and involvement of the Legal and Risk Services Department of NHS Wales Shared Services Partnership (NWSSP). Additionally, a Learning from Events Report (LfER) has been prepared by the claims managers and submitted to the Welsh Risk Pool (WRP) for reimbursement and will now be considered by the WRP Committee. Case Management Reports (CMR) will be produced at the time required by the Welsh Risk Pool.

The Patient Safety Report to the QSE Committee provides details of each individual claim over £50,000 and assurance on the learning and improvement alongside analysis of themes and trends. The last report submitted to the QSE Committee was for quarter three of 2019/20.

The annual internal audit into claims management for 2019/20 is underway at the time of writing and will be submitted to the Committee when complete.

Appendix 1 - Schedule of closed claims and financial value for quarter three of 2019/20 (over £50,000)

Ref	Area	Specialty	Incident Date	Claim Opened Date	Description	Total Value
CLA18-3889	West	Emergency Department (Secondary)	10/12/2016	19/02/2019	Failure to diagnose an intra cranial bleed.	£137,892.60
W16-2423	West	Gynaecology (Secondary)	01/09/2011	16/09/2016	Patient went in for surgery for a pelvic floor repair and vaginal hysterectomy to "alleviate prolapse". Vaginal hysterectomy was not performed leaving patient in pain and discomfort and a requirement for further surgery.	£92,972.18
W12-805	West	Emergency Department (Secondary)	01/01/2003	14/09/2012	Claimant attended hospital in 2004 where an x-ray was taken of the left hand. There is a failure to diagnose the fracture.	£67,535.90
E15-1910	East	Obstetrics & Gynaecology	05/10/2013	30/04/2015	Failures in the management of Marfan syndrome and heart condition.	£659,406.40
E13-1397	East	ENT	01/01/2009	20/12/2013	Failure in investigation of a neck lump throughout March - May 2008 including failure to carry out timely MRI and concerns with how initial biopsy was performed.	£204,255.50
CLA16-2513	East	Obstetrics & Gynaecology	05/09/2016	09/12/2016	Perforation of the bowel in two places during a routine sterilisation procedure.	£65,231.34
CLA2538	Central	Urology	19/12/2014	04/01/2017	Failure to appropriately diagnose prostate and bladder cancer resulting in claimant not receiving treatment in a timely manner.	£136,901.86

Cyfarfod a dyddiad: Meeting and date:	Audit Committee 19th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Corporate Risk Register and Assurance Framework Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris – Deputy Chief Executive/Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Mrs Justine Parry, Assistant Director of Information Governance and Assurance Mr David Tita, Head of Risk Management
Craffu blaenorol: Prior Scrutiny:	The full Corporate Risk and Assurance Framework (CRAF) is scrutinised by the Health Board twice per year and is published on the Board's external facing website. Individual risks are allocated to one of the Board's Committees for regular consideration and review. This report has been approved for submission to the Committee by the Deputy Chief Executive / Executive Director of Nursing and Midwifery.
Atodiadau Appendices:	Appendix 1 – Details of Corporate Risk Register Report Appendix 2: - Details of new risks for scrutiny, approval and recommendation for inclusion onto the CRR.

Argymhelliad / Recommendation:

The Audit Committee (AC) is hereby requested to:

1. Note, approve and recommend the Corporate Risk Register (CRR) to the Board and to gain assurance that the risks articulated on it are appropriately managed in line with the Health Board`s risk management strategy and best practice.
2. Review, scrutinise, approve and recommend the five new risks which were approved by the Quality, Safety and Experience Committee (QSE) for inclusion onto the CRR.
3. Recommend to the Board for approval, changes to risks that have been requested by the various committees.

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

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

Sefyllfa / Situation:

This paper presents risks on the Health Board`s CRR and seeks to demonstrate and highlight the controls and further actions being implemented to mitigate them as well as the progress and any changes that have been made since the risks were last presented to the Audit Committee (AC). While this coversheet articulates the key highlights/progress and changes captured in each risks, appendix 1 presents details of each of the risks on the CRR and appendix 2 presents the new risks being set before the AC for review, scrutiny, approval and recommendation to the Board for inclusion on the CRR.

This paper will endeavour to provide assurance that risks which could compromise the achievement of the Health Board`s objectives and priority areas as defined in its 3 Year Plan are being robustly, efficiently and effectively mitigated and managed to expected standards and in line with best practice.

Cefndir / Background:

In preparation for the implementation of the new Risk Management Strategy and Policy, the Risk Management Team continues to hold a series of workshops and meetings with staff across the entire Health Board to keep them abreast of the impending changes and to develop their capacity and capability in risk management with particular focus on the Enterprise Risk Management model (ERM). Updates to Datix (our Electronic Risk Management System) will also be undertaken to accommodate the new changes that will come along with the implementation of ERM, especially as we shall be moving from a 5 to a 3 tier risk management model.

The launch of the new Risk Management Strategy and Policy will take place on 1st April 2020 at the Executive Management Group (EMG) in Carlton Court in the morning and at Glan Glwyd hospital in the afternoon. Other launch events have been planned for the other sites of the Health Board later that week. This enterprise-wide approach to the launch of the new strategy underlines the Health Board`s firm commitment to placing effective risk management at the heart of all what it does. Staff training and workshops to populate the new strategy have been rolled out across the Health Board over the last few weeks and will be continuing into much of 2020/21.

These changes and the implementation of ERM will have a positive impact on how the Health Board currently identifies, assesses and manages risks on the CRR, and will enable us to embed risk management into business/organisational and financial planning, priority/objective setting and in fostering a culture of safety and continuous improvements in patient care and enhanced experience.

Asesiad / Assessment & Analysis

The QSE held on the 28/01/2020 reviewed, approved and recommended six risks for inclusion onto the CRR. Following extensive discussions with Clinical Executive Directors during the Risk Management Group (RMG) on the 30/01/2020, members agreed to recommend four risks for consideration for the CRR. The RMG then de-escalated two of the risks and advised further updates were required, as these should be reviewed and managed as tier 2 risks linked to the existing Health and Safety corporate risk - CRR21. The QSE also agreed to the rewording of CRR03 which removed the Care Home element as this was risk assessed, de-escalated and will be mitigated and managed at tier 2 while the core components around CHC were upheld to constitute the updated CRR03.

The Digital and Information Governance Committee (DIGC) held on 13th February 2020 received, reviewed and scrutinised their risks on the CRR and noted and acknowledged the further updates being undertaken on their risks following discussions at the RMG. The committee also considered the accuracy of the scores as well as the effectiveness of the controls and actions as captured in each of their risks and approved the increase in the current score for CRR10b from 16 to 20 as advised by the RMG.

The Finance and Performance Committee (F&P) at its meeting held on the 23rd January 2020 recommended an increase in current score for CRR06 from 12 to 20 considering the current financial position of the Health Board. The Committee further noted that a financial sustainability risk assessment will be undertaken and presented at their next meeting on 30th April 2020.

The Strategy, Partnership and Population Health Committee (SPPH) which was held on 5th March 2020, reviewed and scrutinised their risks on the CRR and declined a request for CRR14 to be recommended for de-escalation. Members also noted the ongoing work by the Public Health team around COVID-19 which aligns with the wider national PHW COVID response agenda.

In summary, following review, scrutiny and monitoring from the relevant committees, the following changes have been made to CRR since the last report was received by the Audit Committee: -

- **CRR01 Population Health.**
  Key progress: Members at the last SPPH noted the updated risk controls in place which include working with the Regional Partnership Board to ensure population prevention focus on Building a Healthier Wales (BAHW) funding across the North Wales Region. The Public Health team has been mobilised to support the national PHW COVID response, as such, the team are expecting at least a three-month delay to the progression of work programmes aligned under CRR01.
  CRR02 Infection Prevention and Control.
  Key progress: This risk was reviewed at the QSE and members noted that it remains largely the same with no change in score as was in the previous CRR report. Infection Prevention quality visits have commenced to replace the previous "audit programme". These visits encompass observation of clinical practices, support and advice, micro teaching, safe clean care updates, hand hygiene observations, screening and any other relevant support needed by the ward staff. Scrutiny of every avoidable infection and lessons learnt are regularly shared.
- **CRR03 Continuing Health Care.**
  Key progress: As per updates in the previous report, this risk has now been split into two distinct risks i.e. CHC and the Care Home strand. Both risks were reviewed at the last QSE and after much discussions, the committee was agreed that the updated version of CRR03 which focuses on CHC should replace the current CRR03 while the new risk around Care Homes should be de-escalated and managed as a tier 2.
- **CRR05 Learning from Patient Experience.**
  Key progress: This risk was reviewed at the QSE and members noted that it remains the same as in previous CRR report. Performance and accountability reviews include concerns monitoring as Patient Advice and Support Service has been initially established in Ysbyty Glan Clwyd. There has been no change to the current risk scoring and no change to this risk since the previous updates.
- **CRR06 Financial Stability.**
  Key progress: After some discussions regarding the inappropriate initial score rating, it was agreed that the initial score of this risk should be raised from 12 to 20. Further actions to mitigate this risk so as to achieve its target risk score were also discussed, agreed and have been incorporated which includes, continuously scrutinising recovery and savings delivery as the financial year elapses, potential additional escalatory grip as well as control measures. However, despite these additional actions and given the current financial position, it was recommended that current risk score be increased from 16 to 20.
- **CRR09 Primary Care Sustainability.**
  Risk has been updated and controls strengthened. It was noted at the last SPPH that the controls in place for mitigating this risk have also been refreshed to take account of the current position and completion of sustainability Primary Care assessments for each of the management practices. Development of a Primary Care Academic is proceeding as funding has been secured for the next three years.

- **CRR10a National Infrastructure and Products**.
  Key progress: This risk was reviewed at the DIGC on 13th February 2020 as members noted that it has been reviewed including its controls and further actions following feedback from the last AC and RMG. It was noted that future discussions regarding this risk will take place within the Executive Team for scrutiny alongside Area Directors.
- **CRR10b Informatics - Health Records**
  Key progress: Member of the DIGC noted that the updated change to the risk title had been actioned and it was proposed to increase the current score to 20. The Committee further debated and suggested the name change to being solely "health records". The Assistant Director of Information Governance and Risk clarified that the scoring would be updated to reflect the likelihood scoring. The Committee agreed with the updated score.
- **CRR10c Informatics infrastructure capacity, resource and demand.**
  Key progress: Members of the DIGC noted that Controls had been updated to remove an action which was not a control, the target risk date had also been amended to reflect a realistic date to implement the further actions required to achieve the target risk score. Following an in-depth review of this risk at the RMG, it was noted that the further updates would be reflected.
- **CRR11a Unscheduled Care Access.**
  Key progress: Members of the F&P noted that the current score of this risk has been increased from 12 to 16 to reflect the current position of the Health Board. Risk controls have also been strengthened to include reporting arrangements and further actions identified and added to support the achievement of the target risk score.
- **CRR11b Planned Care Access.**
  Key progress: Members of the F&P noted that this risk has been updated alongside its controls and further actions. The target risk date was amended to take into account the implementation of further actions to support the achievement of the target risk score.
- **CRR12 Estates and Environment.**
  Key progress: members of the F&P recognised and noted that the current score of this risk has increased from 12 to 16 to reflect the current position of the Health Board. Risk controls had been strengthened to include reporting arrangements and further actions had been identified to support the achievement of the target risk score. Increase in score of risk was agreed.
- **CRR13 Mental Health Services.**
  Key progress: Risk was discussed at the QSE and it was noted it has been updated and controls and further actions refreshed and strengthened. Recommendation to reduce the score of this risk was declined at the last QSE.
- **CRR14 Staff Engagement**
  Key progress: The controls in place for reducing this risk have been strengthened and updated to include implementation of all the 2016 Engagement Strategy as initiatives within the strategy have been mainstreamed into ongoing organisational development. Mechanisms currently in place to measure staff engagement on regular basis via the BeProud organisational survey and NHS Wales Staff Survey were highlighted amongst others. A request to recommend this risk for de-escalation as it has met and sustained its target score was declined as the Committee was not convinced with the robustness of the evidence that was presented to them.
- **CRR15 Recruitment and Retention.**
  Key progress: Key controls have been strengthened and updated with further actions identified to support achieving the target risk score. There has been no change to the current risk scoring.
- **CRR16 Safeguarding.**
  Key progress: This risk was reviewed at the QSE and it was noted that its controls have been strengthened to include business planning, a refreshed reporting framework and the introduction

of a senior management tier in the safeguarding structure. It was also noted that further actions have also been updated to support achieving the target risk score. There has been no change to the current risk scoring.

- **CRR17 Development of Integrated Medium Term Plan.**
  Key progress:
  Whilst there were no further updates to this risk, members of the SPPH noted that an updated paper will be presented to the Board to which will include the next steps of the 3 Year Outlook for 2020/21. This risk would therefore be updated following further discussions at the Board and the SPPH appropriately notified. It was agreed that the score of this risk requires further review which will be done to align with the 2020/21 operational plan that is being finalised
- **CRR18 EU Exit - Transition Arrangements.**
  Key progress: This risk remains unchanged from the previous report as controls have been strengthened. Following exit from the EU on 31 Jan 2020 and progress of the Withdrawal Agreement Bill (WAB) through parliament, planning and preparations have now been stood down by WG until further notice. The national leadership Group will continue to meet on a monthly basis but SRO meetings have been stood down. Position will be reviewed by WG in July 2020 and response arrangements may be stood up if required, dependent on an evaluation of political situation.
  CRR20 Security Risk
  Key progress: Risk was reviewed at last QSE and scored agreed at 20 with the target score set at 10. A comprehensive action plan is being developed to further support and ensure the achievement of target score. It was noted that significant investment will be required in order to fully and timely mitigate this risk.
  CRR21 Health & Safety Leadership and Management
  After some extensive discussion, review and scrutiny at the QSE, members agreed that the current score should of this risk stay at 20 as this is underpinned by evidence from the gap analysis. The target risk score was also agreed at 10. Progress on the implemenation of the H&S Gap Analysis will be aligned in informing and shaping future reviews and updates of this risk.

NB: Details of the full CRR are captured in appendix 1.

The Audit Committee are requested to note the following risks which had been de-escalated in the past.

- CRR04 was de-escalated in July 2019 following review by the Maternity SMT.
- CRR08 was de-escalated in July 2018 by the Board.
- CRR19 was de-escalated in June 2019 by the F&P Committee.
- CRR14 Staff Engagement in January 2020 by the Audit Committee.

Closed Risk:

The following risk has been closed since the last CRR report was presented to the Board:

- CRR07 - Capital Systems on the 25^{the} June 2019 by the F&P Committee.

New risks

The following five risks are being presented to the AC for review, scrutiny, approval and recommendation for inclusion onto the CRR: -

- **Risk ID 2956 (Potential to comprise patient safety due to large backlog and lack of follow-up capacity):** Approved and recommended for inclusion onto the CRR. Updates have been included which comprise some information from Informatics following a paper that was

done around resourcing a permanent validation team for the Health Board as the cost of independent or external validation is very high. This will be important in informing and shaping how this risk is mitigated and managed going forward.

- **Risk ID 3019 (Asbestos Management and Control)**: Discussed, approved and recommended for inclusion onto the CRR. Target score needs re-considering as it sits outside the Health Board's risk appetite.
- **Risk ID 3020 (Contractor Management and Control):** Although the QSE recommended this risk for inclusion onto the CRR, members at the RMG requested for some further work to be done in strengthening the controls and further actions in place and for the title to be refreshed to focus on the potential risk and not the issue.
- **Risk ID 3023 (Legionella Management and Control – "My CAD"):** Members at the RMG reviewed this risk and recommended that the current score should be changed to 16 to reflect the controls in place. Target score needs re-considering as it sits outside the Health Board's risk appetite.
- **Risk ID 3924 (Non-compliance of Fire Safety Systems):** Members at the RMG reviewed these risks and requested for some further work to be done in strengthening its controls and further actions. Target score needs re-considering as it sits outside the Health Board's risk appetite.

After further discussion, extensive scrutiny and review, members at the RMG agreed that the following two risks should be de-escalated and managed at tier 2 as linked risks to CRR21 (Health & Safety Leadership and Management) that is already on the CRR.

- **Risk ID 3021** - Vibration Control
- **Risk ID 3022** – Electrocution at Work

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5			CRR03	CRR10a CRR11a CRR11b CRR17	
	Likely - 4			CRR05	CRR01 CRR06 CRR09 CRR10b CRR10c CRR15 CRR16 CRR13 CRR12	CRR20 CRR21
	Possible - 3				CRR18	CRR02
	Unlikely - 2				CRR14	
	Rare - 1					

Strategy Implications
This CRR report is strategically important as it evidences, confirms and provides assurance to the Audit Committee that the Health Board is effectively and efficiently identifying, assessing, mitigating and managing high/extreme risk risks to the achievement of its Priority Areas and Objectives as defined in its 3 Year Plan in line with best practice and its risk management strategy.

Financial Implications
The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.

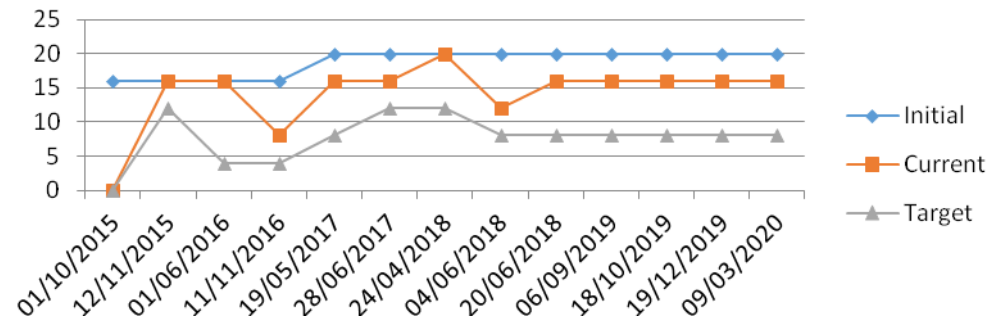
Risk Analysis
No risks have been identified from crafting this report as the risk of inaction is far greater than that of positive engagement with its content.

Legal and Compliance
This CRR report which will be periodically shared with the Board is intended to provide assurance.

Impact Assessment
Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Appendix 1: Details of the Corporate Risk Register

CRR01	**Director Lead:** Executive Director of Public Health	**Date Opened:** 1 October 2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 09 March 2020
	Risk: Population Health	**Target Risk Date:** 31 March 2021
There is a risk that the Health Board fails to deliver improvements in population Health in North Wales. This is due to a failure to focus on prevention and early intervention. This will lead to higher levels of non communicable diseases such as obesity, hypertension, coronary heart disease, stroke, diabetes, and some cancers. This will lead to an increase in demand on primary and secondary care, and increase levels of health inequalities between our most and least deprived communities.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

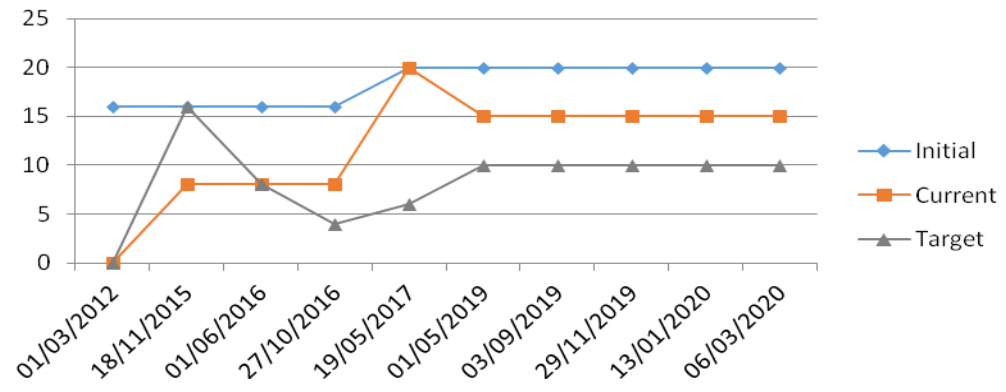
Controls in place	**Further action to achieve target risk score**
1. Population health intelligence updated on a continuing basis ensuring that information is available to support planning for and monitoring of health status. 2. Approved Population assessment to inform Social Services and Wellbeing Act developed in partnership, and now informing implementation of North Wales Regional Plan for 2018-2023.	1. Further exploration and identification of new opportunities for Health Board to secure population health improvement through leadership role in strategic partnerships utilising new structures - Regional Partnership Board and Public Service Boards.

3. Review of Board cycle of business completed to enable focus on population health issues. 4. Wellbeing Assessments completed and approved. 5. Wellbeing Objectives and Plans approved / to be approved in the 4 PSBs. 6. Strategic Partnerships in place providing opportunities for advocacy for improving population health with partners. 7. Approved HB Strategy Living Healthier, Staying Well confirms emphasis on improving population health through more focus on prevention. 8. Baseline Assessment informing LHSW completed, underpinned by WG Public Health Outcomes Framework. 9. Improved data on Primary care available to Area Teams and Contractors via PH Directorate website. 10. Organisational objectives have now been revised and redefined as our Wellbeing Objectives. 11. BCUHB Operational Plan aligned with key actions for improving health identified in Public Health Wales IMTP. 12. DPH / Public Health Consultants attend all PSBs and Part 9 Board to advise and influence on prevention / early intervention agenda. 13. Delivery of Public Health Team workplan is aligned with operational Area Teams. 14. Public Service Boards Wellbeing Plans developed. 15. Health Improvement and Reducing Inequalities Group (HIRIG) established and working to ensure that population health and prevention initiatives are developed in Health Board Planning. 16. Continued engagement with the Live Lab work with Office of Future Generations Commissioner and Public Health Wales. Focusing on Healthy Weight in Pregnancy and Children.	2. Health Improvement and Inequalities Transformation (HIIT) Group lead the development of relevant section of 2019/22 IMTP submission, and ensure co-ordination with other aspects of the Plan which are interdependent. 3. Identify substantive PMO support for this programme. 4. Participate in Live Lab work with Office of Future Generations Commissioner and Public Health Wales to provide a new focus for prevention within the delivery of community services, and generate learning which can be shared across Wales. 5. Review of all other public health risks underway which will inform the existing risk mitigation measures for this overarching risk. 6. Grant funding available for Prevention and Early Intervention from Welsh Government (Building a Healthier Wales) has been made available via Health Board and spend allocation over three years.

17. BCUHB working with Regional Partnership Board to ensure population prevention focus for Building a Healthier Wales (BAHW) funding across the North Wales Region.	

Assurances	**Links to**		
1. Oversight by Public Service Boards and Local Authority Scrutiny Committees. 2. WG Review Meetings (JET). 3. Public Health Observatory reports and reviews. 4. WG Review and feedback on needs assessment.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 5 6 7	PR8	Strategic and Service Planning

CRR02	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 6 March 2020
	Risk: Infection Prevention & Control	**Target Risk Date:** 30 September 2020
There is a risk that patients will suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.		



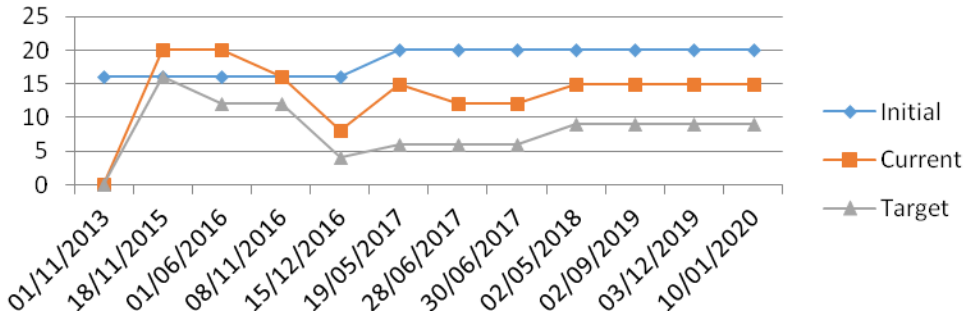
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Infection Prevention Sub-Group scrutinise trajactories and performance through the regular cycle of business, quarterly and annual reports to Quality and Safety Group. 2. Surveillance systems and policies/SOPs in place for key infections, with data presented through the governance route to Board. 3. Areas and Secondary Care sites governance arrangements are in place.	1. Continue the implementation of SCC and IP via annual work programmes. 2. Consider aligning SCC with IP Annual Work Prgramme. 3. Implement the other actions identified in the 2019-20 annual infection prevention programme. 4. Implement actions in response to Welsh Government Antimicrobial Delivery Plan, relevant Welsh Health Circulars and in

4. 6 weekly Executive-led scrutiny meetings to review infections and learning from each site in place. 5. Continued progress on ANTT staff training, with key trainers in place, increased focus on medical staff supported by MDs, competencies held by individuals managers. 6. External review performed August 2017; report on further actions presented to Board. Second review report received in August 2019 shows improvement, as does the internal audit on Safe Clean Care (SCC) assurance in June 2019. 7. SCC Programme launched 29-01-18. 8. CAUTI snapshot carried out in September 2019. 9. Deep dive considers every 6 organisms under WG scrutiny.	response to multi-drug resistant organisms. Part of the ARK study and rollout. 5. Continue to progress key actions from Duerden and Jan Stevens reports 2016, 2017, 2019 in relation to Variation, Consultant Microbiologist staffing and capacity, Antimicrobial Stewardship, Estates and Facilities, policies and procedures and Safe Clean Care. 6. Scrutinise every avoidable infection and lessons learnt from these are shared formally from Post Infection Reviews and Deep Dives. 7. Continue work on influenza preparedness and response for Winter 19-20 and review Pandemic policy and procedures. 8. 12 Key action points carried out HB wide in November 2019 which showed a decrease in 5 of the 6 trajactories. 9. Educational event and Link practitioners in place December 2019. 10. Canula devices and documents approved for distribution. 11. Collaberative work with Continence, Tissue Viability and pharmacy to address unwarrented variation. 12. Improved visability across the HB from IP service. 13. Review of all IP policies and SOPs. 14. Development of IP team 2020. 15. Working alongside Tissue Viability, Pharmacy and Continence service in relation to HCAIs.

Assurances	**Links to**		
1. Professor Duerden report 2016. 2. WG review of decontamination. 3. Demonstrable improvement in line with National Benchmarks. 4. CHC Bug watch visits. 5. HSE reviews. 6. Internal Audits of Governance Arrangements.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Leadership

CRR03	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 1 November 2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 January 2020
	Risk: Continuing Health Care	**Target Risk Date:** 31 March 2021
There is a risk that the CHC National Framework is not complied with. This is due to limited understanding of the framework and inconsistent application. This could lead to poor patient experience, outcomes and value for money.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

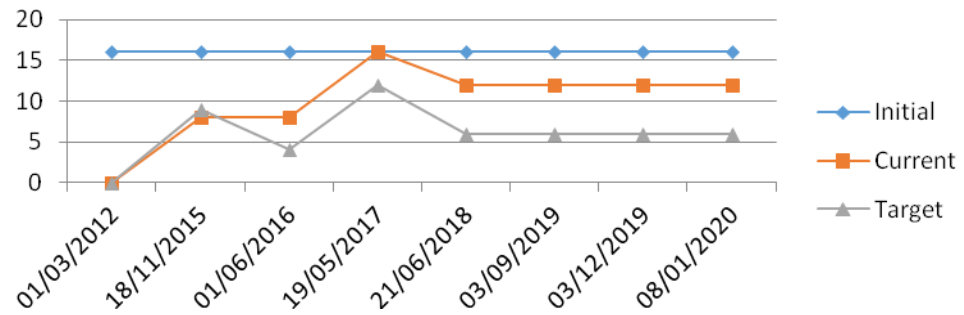
Controls in place	**Further action to achieve target risk score**
1. National CHC Framework. (2014). 2. Area and divisional CHC team with local accountability. 3. Revised BCUHB CHC Improvement Group and CHC operational Group Reporting and Governance Framework agreed. 4. Annual WG self assessment. 5. Contracts and contract monitoring team in place. 6. CHC Contracts in place for all placements.	1. Progress programme of CHC support with NCCU, to include focus on training and development, data and performance management, standard operating proceedures, stakeholder engagement and realignment of CHC within the Health Board. 2. Development of dashboard KPI's for CHC with Broadcare. 3. Monthly exception reporting. 4. Develop CHC commissioning strategy. 5. Develop and finalise the joint contracting process for providers in formal escalation.

7. Partnership established with the National Commisioning Collaborative Unit to oversee overarching strategy development improving quality, experience and value.	

Assurances	**Links to**		
1. Regular meetings with Regulators (CSSIW). 2.Inter-agency processes in place to review escalated concerns. 3. FNC Judicial Reviews of NHS Wales fee setting methodology implemented. 4. National reporting on CHC placements.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 6 7	PR1	Strategic and Service Planning

CRR05	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 08 January 2020
	Risk: Potential inability to learn from patient safety and experience concerns	**Target Risk Date:** 31 December 2020

There is a risk that the Health Board does not listen and learn from patient safety and experience due to the untimely management, investigation and subsequent improvement actions from concerns (incidents, complaints, claims, inquests). This could lead to repeated failures in quality and safety of care, poor patient experience, loss of organisational memory and reputational damage to the Health Board.



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	3	4	12
Target Risk Score	2	3	6
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Processes in place to manage concerns (incidents, complaints, claims, inquests) in accordance with PTR Regulations. 2. Corporate and divisional meetings to manage processes and cascade learning including daily reviews within divisions, weekly reviews within divisions and a weekly pan Health Board Incident and Complaint Review Meeting. 3. Reporting to share learning and monitor performance at divisional and pan Health Board levels; including divisional quality and safety	1. Concerns processes (incidents, complaints, claims, inquests) being fully reviewed following appointment of the new Assistant Director of Patient Safety and Experience – full process re-design will take place throughout 2020 in co-production with stakeholders, building on national best practice.

reports, divisional patient experience reports and a Health Board monthly and quarterly Patient Safety Report and quarterly Patient Experience Report. 4. Harm Dashboards available for local clinical leaders to identify opportunities for learning and improvement. 5. Pan Health Board quality improvement collaborative programmes commenced based on identified risks including a Falls Collaborative, Sepsis Collaborative and a Healthcare Acquired Pressure Ulcer (HAPU) Collaborative. 5. Patient Safety and Experience Department in place to develop and manage processes and systems and offer advice and assurance – supported by divisional governance teams and linked to the BCU Quality Improvement Hub. 6. New Patient Advice and Liaison Service (PALS) fully resourced and launched in 2019. 7. Learning from Event (LfE) Reports prepared for all claims and redress cases. 8. The Head of Patient Safety is part of, and chairs, the All-Wales Redress Case Review Group enabling learning from across the country to be identified. The Patient Safety and Experience Department is represented at, and fully engaged in, each All-Wales concerns related network. 9. Training programme in place to support continued learning, delivered by the Patient Safety and Experience Department. 10. Patient Safety Alerts process in place to cascade learning across the Health Board. 11. Quality and Safety Group in place to oversee patient safety and to cascade learning from patient safety issues, and a Patient Experience Group in place to undertake the same for patient experience (divisions provide reports to both groups).	2. Patent Safety Alert process to be moved to the Patient Safety and Experience Department allowing for greater integration of data/insight and activity. 3. Development of a Patient Safety and Experience Learning Library on the intranet to further promote learning. 4. Development of a Patient Safety and Experience Bulletin to further promote learning. 5. Review and update of training and development with a particular emphasis on developing and embedding human factors and systems thinking. 6. Implementation of new "Once for Wales" RLDatix concerns management system to aid learning across the Health Board and Wales. 7. Review of the weekly incident and complaint review meeting and development into a weekly Patient Safety Summit. 8. Structure review within the Patient Safety and Experience Department to improve the focus and profile of patient safety and to integrate complaints with patient experience/PALS. 9. Enhancement of the mortality review process to implement the new national Medical Examiner programme. 10. Workshop to be held with the Community Health Council to develop partnership working.

12 Joint protocol in place between Health Boards and Welsh Ambulance Service Trust to undertake joint investigations when appropriate. 13. Mortality review process in place to support learning from deaths. 14. Site audits by the Community Health Council (CHC) received through a single point of contact within the Health Board. 15. Inspections by Health Inspectorate Wales (HIW) received and coordinated through a single point of contact within the Health Board along with regular meetings with the HIW relationship manager.	

Assurances	**Links to**		
1. Welsh Risk Pool Reports. 2. Monthly review by Delivery Unit. 3. Public Service Ombudsman Annual Report, Section 16 and feedback from cases. 4. Regulation 28 Reports from the Coroner.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 4 5 6	PR9 PR7 PR1	Leadership

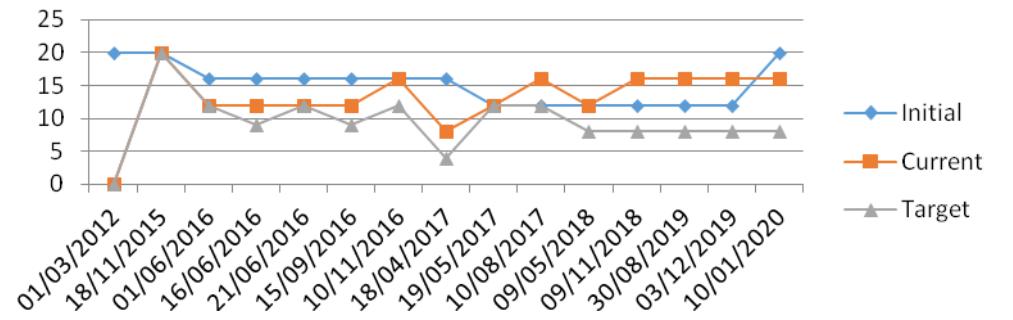
CRR06	**Director Lead:** Executive Director of Finance	**Date Opened:** 1 March 2012
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 10 January 2020
	Risk: Financial Stability - Health Board Financial achievement of the control total agreed with Welsh Government	**Target Risk Date:** 31 March 2020

There is a risk that the Health Board will fail to achieve the deficit that meets the control total set by Welsh Government.

This is due to:
1. Savings plans that are not fully identified and may not be fully delivered.
2. Expenditure exceeding plan in both pay and non-pay areas.
3. The use of non-recurrent measures to support the in-year position risking the Health Board's longer term sustainability and continued failure to achive its financial duty.
4. Failure to identify and progress transformational schemes that will position the Health Board for the longer-term.

The impact of this could increase the in-year deficit to 31 March 2020 and fail to progress towards the Control Total of £25m, and impact on the ability of the Health Board to improve its financial position in out-years.

The Health Board will remain in Special Measures until the financial position improves and will fail to attract necessary investment.



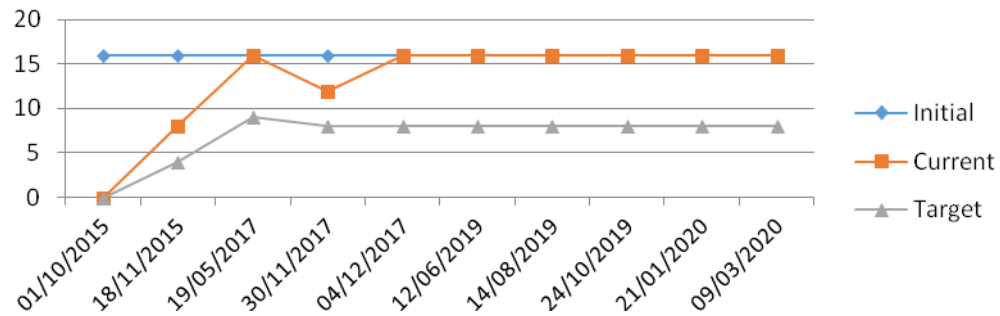
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	Further action to achieve target risk score
1. Appointment of Recovery Director and establishment of a multi-faceted Recovery Programme, including recovery challenge meetings across all business areas and improvement themes, deployment of detailed grip and control, and active management if savings opportunity pipeline. 2. Scheme of Financial Delegation and Accountability Agreements in place covering all devolved budgets. 3. Additional stretch targets issued across all business areas. 4. Dedicated Chief Finance Officer embedded in the management team of each Division (and hospital/area team). 5. Focused additional recovery support provided by PwC and Finance in key areas of budgetary pressure. 6. Programme Management software used to track and monitor the delivery of savings. 7. Reporting through Financial Recovery Group and Finance and Performance Committee.	1. Further work to identify and convert recovery opportunities, including ongoing review by Improvement Groups of the All Wales Efficiency Framework for further opportunities. 2. Ongoing communications to continuously embed financial goals across the organisation and all devolved budget areas including Better Care, Spending Well initiative. 3. Potential F&P Committee requesting attendance of divisions with recovery shortfalls to seek assurances regarding further progress. 4. Improved Financial Recovery Reporting to support oversight and decision-making. 5. Recovery and savings delivery are under continuous and progressive scrutiny as the financial year elapses. 6. Executives are discussing and agreeing potential additional escalatory grip and control measures.

Assurances	Links to		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
1. Monthly financial position reported to the F&P Committee and Board. 2. Finance Delivery Unit (FDU) view at the WG Special Measures meeting.	7	PR2	SM4 SM1

CRR09	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 1 October 2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 09 March 2020
	Risk: Primary Care Sustainability	**Target Risk Date:** 31 March 2021

There is a risk that the Health Board may be unable to meet its statutory responsibilities to provide a primary care service to the population of North Wales. This may be due to the significant number of GPs who are able to retire within the next 5 years and the supply of GPs in training may not meet the demand created by the turnover. This could lead to delayed access for some patients to the appropriate primary care service.



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. 5 Domain Sustainability risk assessment metric developed by PCUS used pan-BCUHB and by Areas to RAG rate and identify highest risk requiring support. Last assessment undertaken January 2020. 2. Each Area has developed a regular practice review process to prioritise support.	1. Evaluation and integration of new service models into primary care to ascertain their success. 2. New governance models of primary care need to be assessed to identify their reliability and assurance. 3. Care closer to home strategy to be evaluated. 4. Establish primary care academy and further develop primary care training, including mentorship.

3. Area Teams have developed support infrastructure to those practices experiencing significant challenges/pressures in terms of sustainability. 4. National Sustainability assessment process allows practices to request support from the Health Board. 5. Clinical advice available from Area Medical Directors and Cluster leads to provide support and development advice to practices. 6. Salaried GPs employed by Areas, working in managed practices and also GMS practices in difficulty. Further GPs employed since August 2019. 7. Agreement to employ clinical leads in managed practices to provide leadership and oversight. Clinical lead appointed for Blaenau Ffestiniog, Criccieth/Porthmadog, Cambria/Longford other practices progressing recruitment at present. 8. Recruitment and retention plan to recruit new GPs into North Wales under development. Project Management for recruitment and retention appointed. Attendance at recruitment fairs and other conferences being co-ordinated to promote careers and share current vacancies in North Wales. 9. Schemes for retaining and recruiting staff e.g. Outstanding GP scheme and the GP with experience scheme in place. 10. Developed Multi-Disciplinary Teams within GP practices eg physiotherapists, ANPs, audiologist, pharmacists and this team takes on patients that were previously seen by the PG. 11. Developing new models of delivery of care within GP practices. 12. Primary care funding is supporting the way that services are delivered within community and primary care setting to take pressure off GPs.	5. Recruit to GP schemes being adopted by Clusters and supported by new project manager for recruitment and retention. 6. Primary care workforce plan to be developed and fully implemented. 7. Further engagement with primary care and partner organisations. 8. Demand management scheme – establishing ways to release GP capacity and shift services out of hospital settings – new roles, new models, and new services. 9. Work with Deanery to increase the number of GP training places in N Wales. 10. Lobby WG for review of national DDRB pay scales and recommendations to increase the rates to better reflect the different roles of salaried GPs. 11. Accelerated role out of advanced practice training. 12. Promote practice mergers and federating. 13. Project to establish a Primary & Community Care Academy in place to deliver a sustainable, fit for purpose workforce within primary and community services through the allocation resources and development of new models. 14. Further development of clusters/localities with partners to strengthen primary/community/social care. 15. Accelerate estates improvements to ensure fit for purpose buildings for care in community settings.

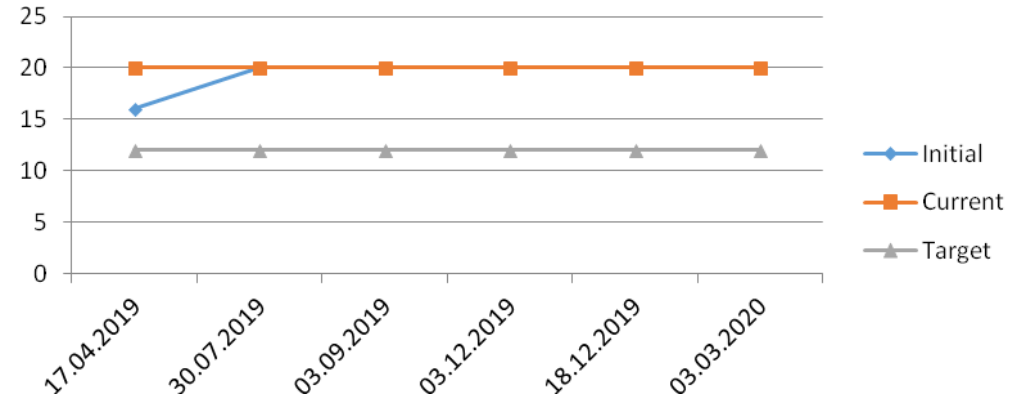
13. Emerging schemes that will further support the way that services are delivered from Primary care eg Occupational therapy, advanced practice paramedics and GP sustainability and innovation unit have been allocated funding from Primary Care Investment funds in 2019/20 continuing into 20/21. 14. Cluster plans and funded schemes are focusing on areas such as pathways and supporting the way that care is delivered at local level. 15. ANPs focusing activity within Care/Nursing homes to improve patient care and reduce demand on GP visits. 16. Running 24/7 DN service to reduce out of hours call out and unnecessary ED admissions. 17. Navigators working within GP practices signposting patients to the right healthcare. 18. Workflow optimisation training available to practices. 19. Intermediate care funded schemes supporting primary care. 20. 16 BCUHB managed practices in place that are providing opportunities to trial new models of working and develop new areas of clinical care. 21. BCUHB has approved a 'Care Closer to Home' strategy that provides a vision of the way that care will be provided within community and primary care setting in the future. A CCtH transformation board has been established to oversee progress, with the first meeting held on 20 July 2018. 22. Care closer to home themes set out in annual operational plan. Priority for cluster development, service model, workforce development, digital healthcare and technology and estates. 23. Governance and accountability of managed practices group in place; performance indicators established, project	

management work books published, governance framework for nurses and pharmacists agreed. 24. Premises issues being addressed with a number of practices, including approval to assign some premises head leases from partners to BCUHB. 25. Programme for recruiting and training practice nurses funded by PC funds in place with 6 nurses being recruited per annum. 26. Director of Primary and Community Health Services appointed and in post. 27. Plans to progress CCtH built into IMTP 2019-20, identified leads for progressing 4 themes (CRTS, Clusters, Health and Worksforce/service model) Centres. 28. Project to establish a Primary & Community Care Academy in place to deliver a sustainable, fit for purpose workforce within primary and community services through the allocation resources and drvelopment of new models. Project Manager appointed August 2019 and additional pacesetter proposal funding secured. 29. Changes to GP contract include partnership premium to support and encourage GPs becoming partners going forward.	

Assurances	**Links to**		
1. Oversight by Board and WG as part of Special Measures. 2. CHC visits to Primary Care. 3. GP council Wales Reviews. 4. Progress reporting to Community Health Council Joint Services Planning Committee.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR6	Primary Care

CRR10A	**Director Lead:** Executive Medical Director	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 03 March 2020
	Risk: National Infrastructure and Products	**Target Risk Date:** 28 December 2020

There is a risk that the national infrastructure, technical architecture and products are not fit for purpose and do not allow the organisation to deliver benefits when planned. This may be caused by
a) a one size fits all approach.
b) products which are not delivered as specified (e.g. time, functionality and quality).
c) the approach of the National Programme to mandate/design systems rather than standards.
d) poor resilience and a "lack of focus on routine maintenance".
e) Supplier capacity leading to commitment or delivery delays.
f) Historic pricing models that are difficult to influence / may not be equitable.
This could result in negative impacts in several key areas including:- Patient outcomes. An inability to support the strategic direction of the Health Board. Delays to delivery of transformational change. Inefficient work flows, poor system usage. Increased costs as we maintain multiple systems / pay inequitable prices. Delays with the delivery of cost saving schemes.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12

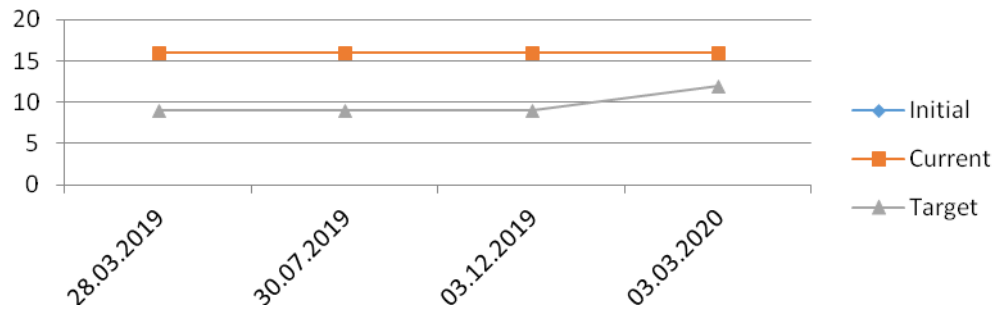
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺

Controls in place	**Further action to achieve target risk score**

1. Scrutiny of NWIS by DIGC. 2. Project Governance.	1. Viable SLA. 2. Development and approval of local Digital Record. 3. Implementation of recommendation's from Architecture and Governance Reviews (due in May 19).

Assurances	**Links to**		
1. Public Accounts Committee Review of NWIS. 2. Assurance Reports from Informatics to DIGC / EMG. 3. WAO - review. 4. National Architecture and Informatics Governance Reviews.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	7	PR6	Not Applicable

CRR10b	**Director Lead:** Executive Medical Director	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 03 March 2020
	Risk: Informatics - Patient Records pan BCU	**Target Risk Date:** 1 April 2022
There is a risk that patient information is not available when and where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This could result in substandard care, patient harm and an inability to meet our legislative duties.		



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Corporate and Health Records Management policies and procedures are in place pan-BCUHB. 2. iFIT RFID casenote tracking software and asset register in place to govern the management and movement of patient records. 3. Escalation via appropriate committee reporting. 4. Key performance indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group).	1. Enable actions to meet the regulatory recommendations from the ICO, HASCAS/Ockenden and Internal Audit reports. UPDATE MARCH 2020 - Last ICO review was positive with good feedback on the progress to date. A full review of all outstanding regulatory recommendations across all regulators is planned for Q1 of 2020/21. 2. (Project) Development of a local Digital Health Records system to digitise the 'acute general' patient record. UPDATE MARCH 2020 - The OJEU tender is closed and the evaluation findings will be ready to present to the DHR Steering Group for ratification of

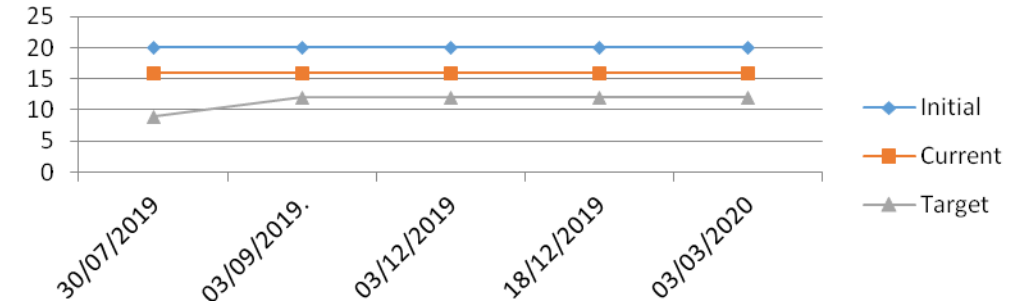
	the preferred supplier on 6th March. The work on the FBC will commence next week and the project remains on track to present to the F&P Committee end of April and then the Health Board in May. 3. (Project) Improve the assurance of Results Management (stop printing results). UPDATE MARCH 2020 - The project is making good progress under the SRO of the Secondary Care Medical Director. Requirements in the WCP to action record (enable stopping printing) are planned for release v3.12 expected end July/August. Work is underway in partnership with NWIS to increase ETR (test requesting in WCP) by Sept 2020, with a new e-test requesting form being developed for Cytology/Histology. The NDR national project remains sighted as a priority to enabling access to our results data locally to feed an assurance report of results not viewed/actioned. 4. (Project) Digitise the clinic letters for outpatients through implementation of Digital Dictation, and as appropriate Speech Recognition software. UPDATE MARCH 2020 - The options appraisal was undertaken to appraise the subsequent ITT responses against the incumbent supplier, to evaluate the best approach for BCUHB and its patients, demonstrating value for money and minimising recurring revenue costs. The findings from the options appraisal concluded that the incumbent supplier is the preferred choice in both technical and commercial elements, with the best chance of mitigating the migration off the PIMS to WPAS at greater pace. Progress is with Procurement to advise on the extended contract. In the meantime the preparation for the upgrades to the product in use by the pilot users is underway. 5. (Project) Digitise nursing documentation through engaging in the WNCR - Adults National Nursing systems. UPDATE MARCH

	2020 - The WNCR product has been through UAT and with all showstoppers addressed, enters pilot on one live ward 02/03/20 for 4 weeks. There are a number of enhancements to be addressed which will be reviewed again by NWIS alongside any pilot findings. A local business case will need to be written to consider the evaluation and any future roll out. 6. (Project) Baseline the; storage, processes, management arrangements and standards compliance, and present the recommendations and funding requirements to work towards PAN-BCUHB Patient Records Compliance with legislation and standards in patient records management across all casenote types. UPDATE MARCH 2020 - The Project Manager post funding has been secured and interviews planned for March. Records standards will be assessed pan-BCU against the new IG Toolkit to inform the ensuing recommendations. 7. Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records. UPDATE MARCH 2020 - In order to ensure the YGC File Library development is fit for purpose and value for money in the wider context of evolving estates and Service plans, a full review of need is being undertaken across all schemes and Service growth demands, with an update due at the next meeting of the YGC File Library Programme Board in April.

Assurances	**Links to**		
1.Chairs reports from Patient Record Group. 2.ICO Audit. 3.HASCAS Audit.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	7	PR1	Not Applicable

CRR10C	**Director Lead:** Executive Medical Director	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 03 March 2020
	Risk: Informatics infrastructure capacity, resource and demand.	**Target Risk Date:** 15 December 2021

There is a risk that digital services within the Health Board are not fit for purpose. This may be due to:
(a) A lack of capacity and resource to deliver services / guide the organisation.
(b) Increasing demand (internally from users e.g. for devices/ training and externally from the public, government and regulators e.g. growing need for digital services).
(c) the moving pace of technology.
This could lead to failures in clinical and management systems, and a failure to support the delivery of the Health boards strategy / plans impacting negatively on patient safety/outcomes. It may also pose a greater risk to the Health board of infrastructure failures and cyber attack.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

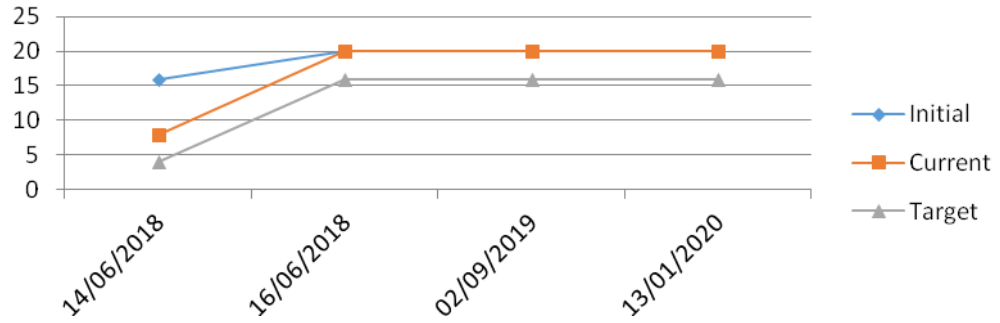
Controls in place	**Further action to achieve target risk score**
1. Governance structures in place to approve and monitor plans. Monitoring of approved plans for 2019 2020 (Capital, IMTP and Operational. Approved and established process for reviewing requests for services. 2. Integrated planning process and agreed timescales with BCU and third party suppliers.	1. Develop associated business cases and secure funding for resource required based upon risks and opportunities e.g. Digital Health Record. 2. Review workforce plans and establish future proof informatics/digital capability and capacity.

3. Key performance metrics to monitor service delivery and increasing demand. 4. Risk based approach to decision making e.g. Local hosting v's National hosting for WPAS etc.	3. Review governance arrangements e.g. DTG whose remit includes review of resource conflicts has not been replaced (April 2020).

Assurances	**Links to**		
1. Annual Internal Audit Plan. 2. WAO reviews and reports e.g. structured assessments and data quality. 3. Scrutiny of Clinical Data Quality by CHKS. 4. Auditor General Report - Informatics Systems in NHS Wales. 5. Regular reporting to DIGC (for Governance).	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 6 7	PR6 PR5 PR2	Not Applicable

CRR11a	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 June 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 13 January 2020
	Risk: Unscheduled Care Access	**Target Risk Date:** 30 April 2020

There is a risk that systematic harm may be caused to patients needing access to unscheduled care services due to failures to be able to respond to demand in accordance with expected national targets.
This may be caused by mismatches between resources available across the unscheduled care system to demands placed on the system for prolonged periods of time or inappropriate allocation of resources available to meet the demand.
This could lead to an impact/effect on patient experience and outcomes, organisational reputation, delivery of national targets and recognised standards of care.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	4	16
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Multi-agency Unscheduled Care (USC) Transformation Board refreshed to USC improvement group, chaired by the Executive Director of Nursing. 2. Continued cycles of improvement with 3 specific work streams: Demand, Flow and Discharge. 3. Program manager appointed to oversee production and implementation of action plans. 4. Daily National Conference Calls with WG to address daily position.	1. 3 EC managers substantively recruited and engaged with building better care plans (was previously 90 day improvement plan). 2. Building better care plan consisting of 3 streams of work: a. Demand - SICAT established and demonstrating reduction in transfers to ED (~30% of calls - assumption that ALL calls previously would have resulted in transfer). b. Flow - Multiple substreams including:

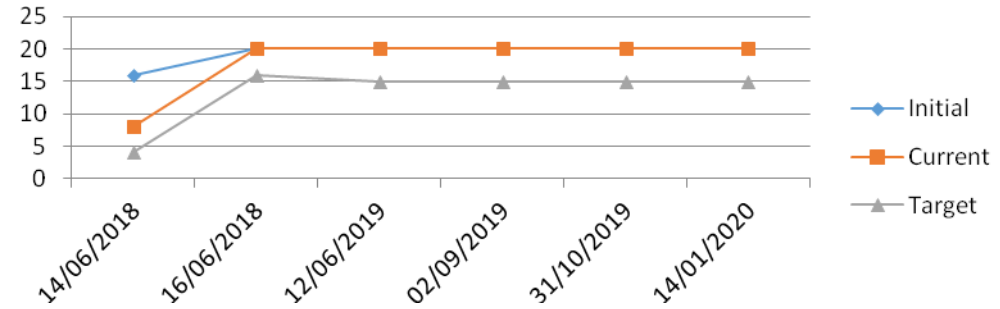
5. Daily Safety Huddles in place on 3 acute sites. 6. Daily BCU system calls to support flow between divisions. 7. Daily Board rounds on acute sites to support continuity of care and early discharge planning. 8. Weekly MDT stranded patient review meetings to identify reasons for lack of progress to facilitate more complex discharges across the Health Economies. 9. Development of USC dashboard with live and daily performance information to support decision making. 10. Weekly teleconference with DU to report performance and concerns and track improvement plans. 11. Sitrep reporting 3 times a day including SAPhTE for ED risk assessment. 12. Mental Health support located within site Police Control. 13. Frequent attenders WEDFANs group regularly review vulnerable patients who frequently access services to support implementation of care plans. 14. Escalation process and structure in place to provide 24/7 escalation from site management through bronze, silver and gold. 15. Development of internal clinical standards to highlight best practice and support teams to consider ways of working to achieve standards. 16. Discharge information provided to patients on admission via new discharge leaflet. 17. Use of SHINE tool to ensure that patient safety is monitored and intentional rounding complete for all patients including those waiting for offload from ambulances. 18. EDQDF early adopter site with focus on improving KPI's, patient feedback and experience and staff feedback and	-ambulance handover - WMH lost improved with consistent reduction in time taken for handover. -proactive triage - promoting use of alternative resources and early decision-making to reduce time in ED (Overall average time in ED is reducing). -early senior decision-making - recognition of senior medical staffing issues especially at WMH - requiring workforce and roster review. -escalation and capacity management review - test of 'grip and control' at YGC site de-escalated from sitrep 4 to 2 without associated reduction in overall time in ED - further work on-going to review process and pilot at other sites. -implementation of SAFER - ongoing - small increase in numbers of earlier discharges. -stranded & super-stranded patient review - to launch across sites. -review of acute assessment/ambulatory models with pilots to be launched later this month at YGC & WMH. -review of specialty reviews for inpatients - to enable earlier discharge. -review of imaging pathways to support early outpatient scans and avoid longer inpatient stay. c. discharge planning - work continues to reduce delays in transfers of care and decision-making. Letter shared re. patient choice and working with staff to encourage proactive discussions with families and patients. 3. Review of site escalation and management to support site responsibility during normal working hours.

experience as key pieces of work within this programme and specific work to improve ambulance handover. 19. Active engagement in Every Day Counts programme to support key pathways of discharge. 20. Remodelling of urgent care processes in place across all 3 sites.	4. Associate Director for unscheduled care replaced with programme manager with additional interim support at area level to oversee progress against building better care plan. 5. Engagement with National ED Quality & delivery framework. 6. Workforce review - supported by Kendall Bluck.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
1. Seasonal Plan. 2. RTT Plan. 3. Twice Yearly JET meetings with WG. 4. Monthly meetings with Delivery Unit. 5. National Patient Flow Collaborative. 6. OOHs review (both National and Internal Audit). 7. Subject specific internal audit reviews. 8. Orthopaedic Plan development. 9.Transformation groups reporting. 10. WPAS implementation group reporting and daily tracking.	1 2 3 6 7	PR3	Leadership

CRR11b	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 June 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 14 January 2020
	Risk: Planned Care Access	**Target Risk Date:** 31 July 2021

There is a risk that the BCUHB is not able to provide access to planned care in accordance with the national standards. This may result in not being able to meet the timely clinical needs and expectations of patients. BCUHB will need to provide assurance to partner organisations on the management of clinical safety and treatment of the backlog.
This is caused by capacity shortfalls or mismatch between allocation of available capacity and demand including booking of patients in chronological order following clinical urgency, a lack of effective utilisation of resources, conflicting pressures (management of Unscheduled Care pressures and elective delivery), equipment failure and availability of suitable facilities, workforce issues.
This could lead to adverse outcomes for patients, prolonged waiting periods, an inability to meet national targets (RTT, diagnostics, cancer, clinically due review time, and impact on the financial stability and the reputation of the Health Board.



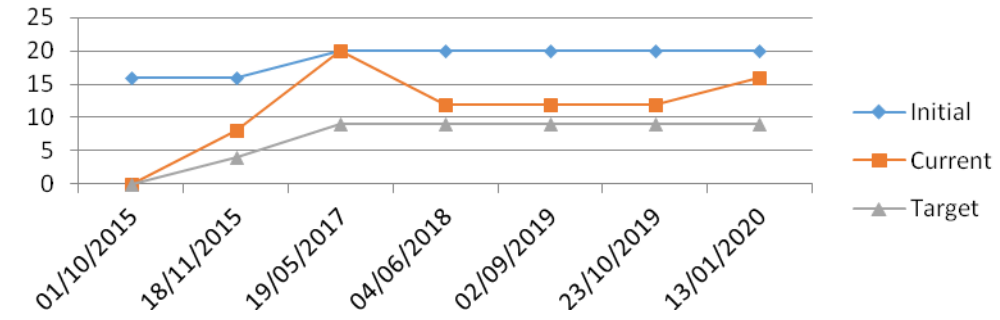
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	5	15
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Weekly PTL and Daily waiting times information in place for RTT, diagnostics and Cancer. 2. Performance team and trackers in Cancer utilising escalation processes with operational teams. 3. Demand and Capacity plan agreed per specialty and site confirming extent of sustainable service gap.	1. Developing Capacity plan for 2020/21 ongoing, which includes outpatients follow up, non-planned care, diagnostics and Endoscopy. 2. Sustainable service plans for 5 specialties are being further developed for 2020/21 including feedback from the national planned care programme (Orthopedics, Ophthalmology, Urology, Maxio facial and General Surgery).

4. Weekly Access meeting extended to include RTT, Diagnostics and Cancer. 5. Interim Planned Care leadership in place responsible for leadership across the HB providing oversight of RTT. 6. Leadership in place responsible Cancer, Endoscopy and Diagnostics remedial action plans. 7. Weekly Performance management meetings at Hospital and Area Level. 8. Weekly outsourcing meeting in place. 9. Elective patient pathway and outpatient improvement cells in place with clear targets for efficiency improvement. 10. Engaged with National Planned Care, National Outpatient and Cancer Implementation Groups. 11. Single Cancer Pathway demand and capacity submission completed and shadow reporting to monthly to WG. 12. Elective and Seasonal plan assumes only daycase and urgent/cancer surgery is scheduled for winter 2019/20 to support unscheduled care capacity (except at Abergele). 13. Implemented additional eye care resource to undertake measure reporting and activity. 14. Insourcing and outsourcing of Endoscopy being undertaken till March 2021. 15. Additional contracts in place to maintain non-obstetric Ultrasound 8 week waits till March 2021. 16. Programme of work in place to reduce follow up backlog monitored via QSE.	3. Review Endoscopy management and governance structure. 4. Matrix working and responsibilities of clinical and operational leaders to be confirmed to strengthen governance. 5. Enhanced governance structure and responsibilities are being put in place for 2020/21. 6. Outpatient Programme Group established and commencing in February 2020.

Assurances	Links to		
1. Seasonal Plan. 2. RTT Plan. 3. Twice Yearly JET meetings with WG. 4. Monthly meetings with Delivery Unit. 5. National Patient Flow Collaborative. 6. OOHs review (both National and Internal Audit). 7. Subject specific internal audit reviews. 8. Orthopaedic Plan development. 9.Transformation groups reporting. 10. WPAS implementation group reporting and daily tracking.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 6 7	PR3	Leadership

CRR12	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 1 October 2015
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** 13 January 2020
	Risk: Estates and Environment	**Target Risk Date:** 30 April 2023
There is a risk that the Health Board fails to provide a safe and compliant built environment. This may be due to insufficient financial investment and estates rationalisation. This could result in avoidable harm to patient, staff, public, reputational damage and litigation.		



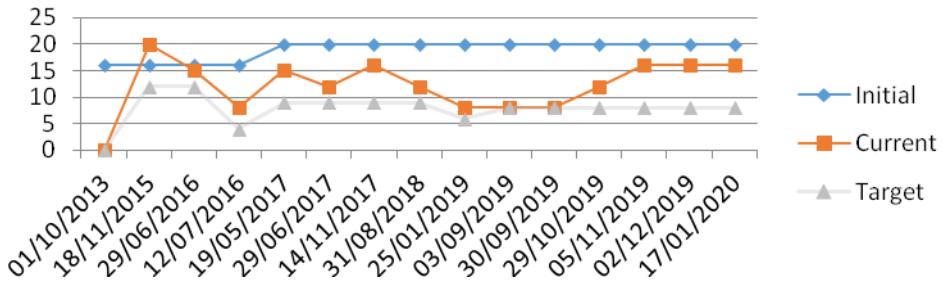
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in November 2019	**Increased** ⇧		

Controls in place	Further action to achieve target risk score
1. Three Year Outlook 2020-2023 and 2020-21 Annual Plan - Living Healthier Staying Well in place and reporting to the Board and Committees. 2. Three Year Outlook 2020-2023 and 2020-21 Annual Plan - Living Healthier Staying Well - Sec 5.4 High Quality Estates and work programme priorities 2020-2023 in place and reporting to the Finance and Performance (F&P) Committee, Board and other appropriate Committees. 3. Estates Strategy - 3 yr (2019 - 2022)in place and reporting to F&P Committee. 4. Annual Estates Performance Reporting (EFPMS) to QSG and QSE.	1. Annually agreed programme of estates rationalisation and selective demolition (2019-20). 2. Annually agreed programme of Disc and All-Wales capital investment across the Estate. 3. Development of Estates Compliance PBC and SOC for Ysbyty Wrexham Maelor, Ystyty Gwynedd and Ysbyty Glam Clwyd Hospitals. 4. Undertake six facets condition survey of the Estates for Acute and Community premises to inform capital investment plans (2020/23). 5. Implement MICAD Property Management IT System to manage estate data and drawings. (2020-2023).

5. Annual Capital Investment Programme 2019-20 Disc and All-Wales Projects ongoing with reporting to F&P Committee and the Board. 6. 2020-2023 - Annual Plan Work Programmes Deliverables for High Quality Estates (Investment schemes listed within plan)in place and reporting to appropriate Committees and the Board. 7. Estates Health and Safety Compliance Audit and Action Plans 2019-20 in place and reporting to SOH&SG, QSE and the Board. 8. Estates Improvement Group (EIG) established based on Health Economy Groups processing Estate rationalisation and disposals, capital investment, corporate accommodation and review of Leased premises. Reporting to the Finance Recovery Group (which reports to Executive Team), F&P and the Board.	6. Implement actions required following Estates Health and Safety Compliance Audit (2019/20) including assessing additional revenue investment required for 2020-21 budget setting process. 7. Update Estates and Facilities Tier 5-4-3 risk registers to reflect current status of Estates and Facilities risks and mitigation required.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
1. Independent authorising engineer appointments. 2. Internal Audit Programme. 3. HSE Statutory Reviews and Reports. 4. EFPMS Portal Data used by WG for Annual All Wales Report. 5. Local Authority Trading Standing. 6. Food Safety Assessment. 7. Annual Reports (HSE, Fire, V&A and sustainability).	1 2 3 4 5 7	PR5	Strategic and Service Planning

CRR13	**Director Lead:** Director of Mental Health and Learning Disabilities	**Date Opened:** 1 October 2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 17 January 2020
	Risk: Mental Health Services	**Target Risk Date:** 31 March 2020
There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance within the Division which could result in poor quality outcomes for patients.		



Between August 2018 and October 2019 a reduction in score was unauthorised, this has been reverted to correct score.

	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

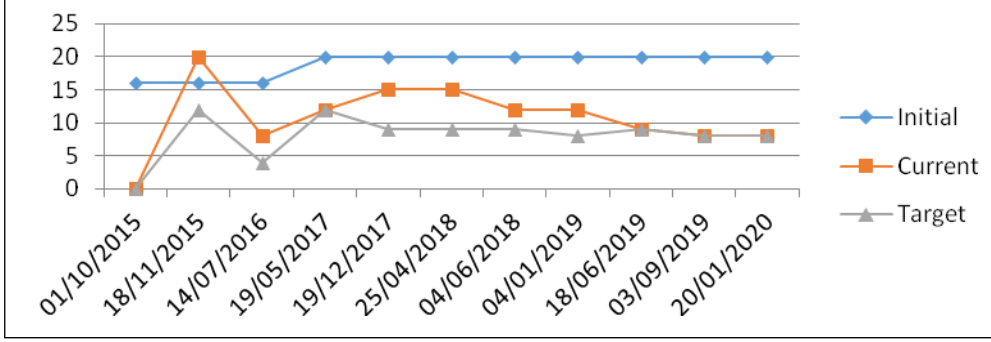
Controls in place	**Further action to achieve target risk score**
1. Board assurance provided at all levels of MHLD governance framework – local, divisional and directors, MHLD presents weekly at Corporate complaints and concerns meeting, monthly at QSG, bi monthly to QSE, Board as required/requested and F&P. 2. More focussed monitoring on progress at Board level agreed and implemented. 3. Achieved and implemented renewed focus and escalation arrangements for dealing with operational issues: weekly	1. Review of Tier 7 & 8 in leadership structure underway. 2. Improve the use of patient experience and real time feedback intelligence to inform service improvements. 3. Further embed learning culture across the division. 4. Systematic implementation of Quality Improvement Methodology across the division at all levels. 5. Implementation of actions following skill mix review on inpatients wards to inform our future staffing levels linked to the All Wales Staffing Principles.

operations meeting in each area, daily safety huddles, weekly leadership review, MHLD QSG and MHLD F&P. 4. Governance Framework developed and fully embedded – review of committee names being undertaken to ensure consistency with BCUHB framework. 5. Recommendations from Internal Audit Review (2019) implemented. 6. Mental Health Strategy approved by the Board and now in implementation phase with areas sustaining strategy change and new developments evidenced with new initiatives that are being modelled across MH services as good practice. 7. Senior Management and Clinical Leadership is no longer a holding structure but implemented with a permanent structure of leadership established, including to Tier 5 & 6. 8. External reviews and visits including positive HIW inspections detailed to QSE and Board. 9. MHLD provides Quality and Performance assurance to Executive accountability meetings in two forms of scrutiny i) Divisional presentation and ii) with each area health economy and is not in escalation as a result of current progress. 10. Monitoring continues via SMIF. 11. Implementation of HASCAS investigation and wider governance review including completion of HASCAS recommendation specific to MHLD has been successfully achieved. This is monitored through corporate governance processes and QSE Committee. 12. Ward accreditation embedded. 13. Improved scrutiny at local and divisional level in relation to PTR has resulted in improved KPIs across all of PTR. MHLD is	6. Delivery Unit have undertaken demand and capacity review with the Community Mental Health Teams, which will inform BCUHB and Local Authority future plans for staffing. 7. Additional actions to address Sickness across MHLD includes the development of Wellness strategy developed for MHLD – wellness, work and you!

the only division to have 0 complaints overdue. This is monitored via QSEEL. 14. Implementation of Listening Leads and BE PROUD OD Programme across the division with full engagement at Director level.	

Assurances	**Links to**		
1. Board and WG oversight as part of Special Measures. 2. External reviews and investigations commissioned (Ockenden and HASCAS). 3. HIW Reviews. 4. Internal objective accreditation. 5. External Accreditation. 6. Delivery Unit oversight of CTP. 7. Caniad coproduction and objective day to day review of services. 8. Enhanced WG support has now concluded following intense scrutiny and input due to assurances provided by MHLD, including PAC report as submitted evidence.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Mental Health

CRR14	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 1 October 2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 20 January 2020
	Risk: Staff Engagement	**Target Risk Date:** 31 March 2020
There is a risk that the Health Board does not maintain a culture which promotes excellence and engagement of staff in order to transform services. This may be caused by a disconnect between stated values and actual behaviours. This could lead to poor quality services, damage to the organisations reputation, long term sustainability and low levels of workforce satisfaction and well being.		



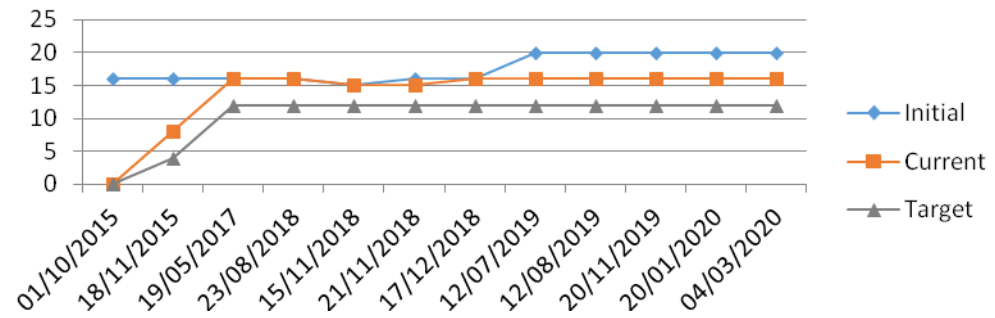
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	2	8
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	Further action to achieve target risk score
1. All the requirements of the Engagement Strategy 2016 have been met. All the initiatives within the strategy have been mainstreamed into ongoing organisational development work. 2. Workforce & Organisational Development Strategy 2019-22 in place. 3. Workforce Objectives 2019-20 to meet the Workforce Strategy in place and monitored through the Annual Plan Progress Monitoring mechanism.	1. Implement HEIW talent management framework to retain and develop staff at Tiers 1-3. 2. Develop Workforce Objectives 2020-21 to continue to meet the Workforce Strategy. 3. Implement Pay Progression Policy to drive improvements in PADR.

4. Mechanism in place to measure staff engagement on a regular basis via the BeProud organisational survey. 5. Mechanism in place to measure team level staff engagement through the BeProud Pioneer programme. 6. NHS Wales Staff Survey Organisational Improvement Plan and Divisional Improvement Plans monitored through the Workforce Improvement Group. 7. Retention Improvement plan in place. 8. PADR Improvement plan in place.	

Assurances	**Links to**		
1. Board and WG monitoring as part special measures. 2. Staff survey benchmarked across Wales. 3.Corporate Health Award. 4. Implmentation of I Want Great Care.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR9	Engagement

CRR15	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 1 October 2015
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 04 March 2020
	Risk: Recruitment and Retention	**Target Risk Date:** 27 March 2020
There is a risk that the Health Board will have difficulty recruiting and retaining high quality staff in certain areas. This may be due to UK shortages for certain staff groups and the rurality of certain areas of the health board. This could lead to poor patient experience and outcomes, low morale and well being and attendance of staff.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

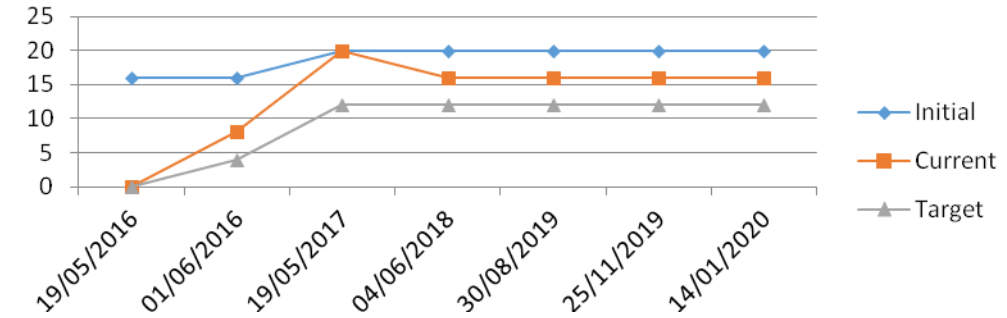
Controls in place	**Further action to achieve target risk score**
1.Embedded Medical & Dental (M&D) recruitment panel that oversees the fast tracking of medical vacancies from authorisation to offer accepted. This is having a positive effect on M&D vacancy rates and time to hire (TTH) . 2.This also includes fast tracking the EC posts for hard to fill vacancies, reports submitted to the Board. 3. WOD currently reviewing options to increase admin support for M&D recruitment by placing adverts on Trac on behalf of the lead recruiters. This is anticipated to further reduce TTH KPIs by ensuring adverts are ready to go live as soon as EC has been approved.	1. Improve digital media marketing via social media the train work live north wales brand now has its own facebook. 2. Identification of recruitment co-ordinators in each secondary care high vacancy areas. Continue with student recruitment and promotion of nurse vacancies to Manchester, Chester and Staffordshire Universities. 3. Contribution to Medical Training Initiatives (MTI) Bapio Scheme. 4. Source recruitment marketing funding to support further digital marketing. Further work on recruitment pipelines

4. Promotion of the employment brand "Train Work Live North Wales" through digital media and marketing through key publications such as RCN careers brochures, BMJ on line and hard copy. The Tender for international nursing recruitment is nearing completion; bidder presentations took place in February with anticipated contract award in March. First cohort of Nurses could be arriving in July 2020 with planned numbers of circa 25 per month. 5.New calendar of recruitment events being organised for 2020. This will include planning and attendance at local and national job fairs for nurses in particular. 6.Deeper analysis of the time to hire showing more specifically where the hot-spots and delays are in the process, leading to improvements. Implemented a new process to review all posts to ensure that the BCUHB is compliant with the Welsh Language Standards - work led by the Workforce Information Systems Manager, compliance of existing process reported to the Welsh Language Forum on a quarterly basis, and will be included in Annual Report for Welsh Language. 7.Identification of top 10 priority areas for nurse recruitment is in place, the team are focusing on adverts out versus vacancies and then using enabling techniques to improve the time to hire. Streamlined process for internal vacancies in place, which also allows a focus to be placed on these. 8.Recruitment lead for BCUHB working with Corporate Nursing on a number of recruitment pipelines such as fast track of HCA band 4 to adult nurse course at Bangor University (2 year course will provide 12 nurses in 2020). Positive changes to bursary system on degree nursing courses at Welsh Universities will commit graduates to 2 years working in the Welsh NHS. 9.A focus on retention with appraisal compliance and mandatory training monitored.	such as trainees, graduates return to practice, cadet scheme and overseas candidates. 5. Finalise and implement the all Wales approach to Student Streamlining Process which will ensure that the HB complies with the national agreed process and manage the Bursary Schemes in conjunction with NWSSP. 6. Finalise tendering process for an international recruitment campaign to bring 200+ RN into BCU form overseas, this is due to complete in March 2021. 7. Implement a new process to embed Welsh Language Standards as part of the Establishment Control process. This will be achieved by reviewing the Portal, the aim is to enable the HB to report on all posts and triangulate data back to appointees in the HB. 8. Work is currently underway to review the Exit Questionnaire process to encourage further feedback on our leavers. 9. Further work to develop our retention strategy being led by the Head of OD. 10. Implement a return to practice campaign later in 2019 - although challenges raised in November 2018 to Bangor University on lack of places for BCU RTP nurses. Corporate Nursing taking forward.

10.National KPI's Time to Hire focus on recruitment timescales monitoring both within BCUHB and NWSSP. 11.TRAC system in place which ensures standardised processes, this is monitored through the Workforce Monthly Reports including time to hire which enables Managers, HR and the Board to understand on a monthly basis where the recruitment difficulties are. Summary of monthly dashboard reported to F&P Committee Quarterly. 12. Implementation and promotion of flexible working: part time working, job share, compressed hours, annualised hours, flexi, career breaks, personalised annual leave etc. 13.Staff benefits such as cycle to work schemes and other non-pay benefits in place. 14. HR and Recruitment Team continue to promote best practice through times of organisational change, redeployment and secondments and through flexible working arrangements. 15. An agency cap for medical and dental staff in place, with tight controls in place to reduce agency expenditure. National reporting is conducted monthly, which will be reviewed regularly. 16. BCU HB contributes to the All-Wales Recruitment campaigns - 'train, work, live' brand. BCU Recruitment Team now has the SPOC which is promoted nationally and locally. Student nurse recruitment is the most successful pipeline and BCU have worked with WG/SSP to introduce a more robust method of recruiting our nurse graduates resulting in 130 nurses joining in September 2019 and a further 75 planned to join in March 2020.Resource implications	

Assurances	**Links to**		
1. Staff surveys. 2. WG reporting (e.g. sickness absence and long term disciplinary cases). 3. NMC Royal College and Deanery Reviews and Reports. 4. Review of NWSSP recruitment timescales	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR4	Leadership

CRR16	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 19 May 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 January 2020
	Risk: A Failure To Discharge Statutory and Legislative Safeguarding Responsibilties	**Target Risk Date:** 31 March 2020
There is a risk that the Health Board does not discharge its statutory and moral duties in respect of Safeguarding. This may be caused by a failure to develop and implement suitable and sufficient safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resources to manage the undertaking. This could impact on those persons at risk of harm to whom BCUHB has a duty of care.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

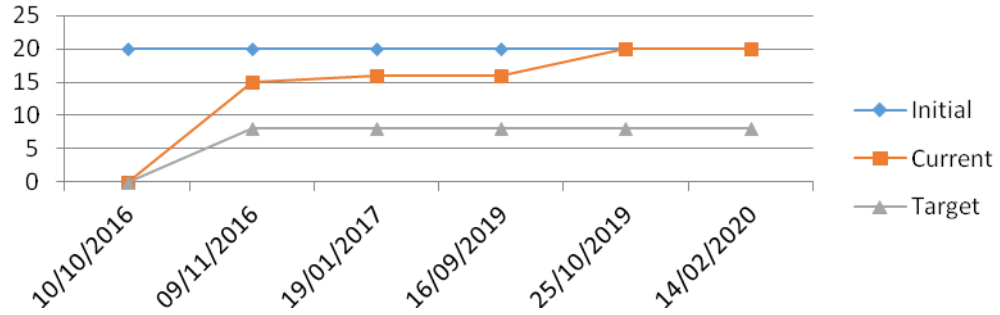
Controls in place	**Further action to achieve target risk score**
1. A cycle of Business Planning meetings have been implemented within the Nursing and Midwifery Directorate which scrutinises and reviews Level 1 and 2 Risks and is attended by the Associate Director of Safeguarding. 2. A refreshed Safeguarding Reporting Framework has been implemented which sets out clear lines of accountability and is underpinned by a Cycle of Business.	1. The third and final phase of the review of all Safeguarding JDs will be submitted to A4C January 2020. 2. Vacant posts continue to be progressed through the establishment control approval process to maintain a fully funded Safeguarding Team. 3. Further structural activity is planned to ensure business continuity and stability within the Corporate Safeguarding Team.

3. A standardised data report on key areas including Adult at Risk, Child at Risk and DoLS is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 4.Risk Management has been embedded into the processes of the Reporting Framework by being included as a standing item on the Safeguarding Governance and Performance and Safeguarding Forum[s] Agendas. Issues of Significance reports require risks to be identified and reported on in terms of mitigating action. 5. The new Senior Management tier has been appointed to within the Safeguarding Structure. This will strengthen strategic oversight in key areas. 6. A paper has been presented to QSG on the 10.1.20, in line with HASCAS / DO recommendation Numbers 8 and 6 and 11 and 9. This is relating to the review and effectiveness of the Safeguarding structure and progress report relating to the DoLS 2017-2018 action plan. Key controls have been implemented by increasing the number of DoLS Signatories, development of a Signatories Governance Framework and Specialist training. Bespoke DoLS Training and reporting of compliance and activity at Safeguarding Forums in accordance with the Safeguarding Reporting Framework has been put in place. See Risk 2548. 7. Bespoke training continues to be delivered to key high priority areas with responsibilities for 16/17 yr olds who may be / or experience a deprivation of their liberty as a result of a Supreme Court Judgement 26.9.19.	This includes the provision of a 7 day on call, flexible working service. This was incorporated into the Structure Report at QSG 10th January 2020. 4. In line with the HASCAS Recommendation / DO Recommendation 8, 6, 11 and 9. A Business Case is to be presented to the Finance and performance Group. 5. The legal framework and organisational accountability for Deprivation of Liberty Safeguards [DoLS] continues to place increased demands upon the organisation. In addition DoLS will be replaced by the Liberty Protection Safeguards [LPS] in 2020/2021 and will have a greater impact upon activity. The recent Supreme Court Judgement relating to 16/17 yr olds, came into force on the 26.9.19. A National Task and Finish Group and a BCU implementation group is to be convened to support the review and identify the impact the new legislation will have on organisations. 6. The programme of work to support the implementation of the Supreme Court Judgement and the increased activity is to be driven by a Task & Finish Group as agreed by QSG and completed by 31.3.20 (see Risk 2548. 7. A review of the DoLS structure and service provision is a priority activity for 2019-20 and a key requirement from HASCAS. An options paper which sets out options for the DoLS Team will be presented to QSG in January 2020. See Risk 2548. 8. The appointment of a Named Doctor, Adult at Risk remains outstanding however positive discussions have taken place with the Office of the Executive Medical Director. The business case to be presented at Finance and Performance Group is to include the financial requirements to support the appointment of a Named Doctor Adult at Risk and additional clinical support.

	9. Fully engage with the Corporate Safeguarding Governance Audit and Deprivation of Liberty Safeguarding [DoLS] Audit, conducted by the NHS Wales Shared Services Partnership Audit and Assurance Service. Engage with any actions identified.

Assurances	**Links to**		
1. Strengthened Governance and Reporting arrangements. 2. Enhanced engagement with partner agencies. 3. Safe and effective data collection and triangulation of organisational data to identify risk. 4. Improved compliance against recognised omissions relating to the review and development of Safeguarding policies and Training materials. 5. Regional Safeguarding Boards.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 7	PR9	Governance

CRR17	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 10 October 2016
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 14 February 2020
	Risk: Development of IMTP (Integrated Medium Term Plan)	**Target Risk Date:** 31 March 2020
There is a risk that the Health Board cannot deliver safe and sustainable services to the population of North Wales which may be because there is not an agreed plan for the next 3 years. This could lead to an inability to address and improve health and healthcare services.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

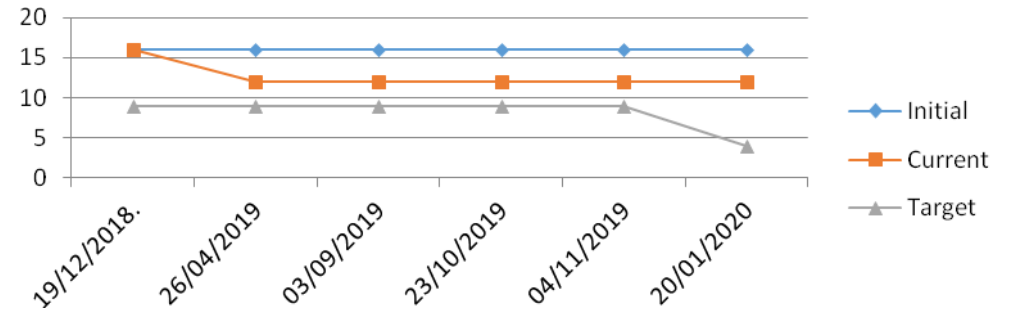
Controls in place	**Further action to achieve target risk score**
1. The timetable to develop the 2019/22 IMTP was discussed and agreed by SPPH Committee on 9th August 2018. 2. The Health Board approved approach for developing the 2019/22 IMTP on 6th September 2018. 3. Unscheduled Care - 90 day plan launched and measures and trajectories agreed for inclusion in the AOP for 2018/19. 4. Transformation fund proposals developed with RPB partners Proposals for Community Services, children, mental health and learning disabilities submitted to Welsh Government. 5. Workplan established to develop 2019/22 IMTP with 3 CEO sponsored workshops held on 4th October, 8th November and 13th December 2018.	1. Revised Plan to SPPH Committee on 5th March 2020. 2. On 12th March, there will be a full board workshop. The intention is to make the focus of the day the plan, and associated aspects. 3. Final version of the plan to the executive team on 18th March 2020. 4. Plan presented to Board on 26th March 2020.

6. Care closer to home service transformation plan and approach reviewed and re-profiled under the leadership of the Director of Primary and Community Services. 7. Board resolved to develop a 3 year plan for 2019/22 and WG notified. 8. Board received draft 2019/22 3 year plan in January 2019. 9. Planned care delivery group established in January 2019. Work programme under development including; RTT, diagnostics, cancer and outpatient plans, infrastructure/support, Strategic/tactical change - Acute hospital care programme schemes, Policy/national programmes - National delivery plans, Enablers - PMO turnaround schemes with a focus short term productivity and efficiency improvements and processes i.e. transactional rather than transformational. 10. Feedback from WG received around ensuring a clear work programme for 2019/20 to deliver improvements in RTT and Unscheduled care. 11. Three Year outlook and 2019/20 Annual plan presented to Board in March 2019. Plan approved with further work identified and agreed around elective care in the specialties set out on page 40 of the paper. 12. The Board received an updated plan in July 2019 and recommended that further work be undertaken led by F&P Committee to scrutinise underpinning planning profiles, specifically RTT, (including diagnostics), unscheduled care alongside the financial plan for 2019/20. 13. Completed profiles at BCU level and submitted to F&P Committee on 22nd August 2019. 14. Site and speciality core activity profiles developed. 15. Draft 2020/23 Cluster plans developed to feed into health economy plans. 16. Key deliverables for 2020/23 developed in September 2019.	

17. Health economy planning arrangements established to support development of 2020/23 plan with linked support from corporate planning team. 18. 2020/23 Planning principles and timetable prepared and presented to EMG, F&P and SPPH Committees. Identified plan development actions to be implemented September - December. 19. Plan updates provided to SPPH Committee meetings and workshops from October. Following our financial review, our aim is to develop a refreshed Three Year Outlook for 2020/23 alongside a Work Programme for 2020/21 in the context of our statutory duty to produce a three-year IMTP. 20. Draft health economy plans for 2020/23 developed in November 2019 for initial review by Improvement Groups. 21. F&P Committee received on 19th December 2019 the draft Three Year Outlook and Annual Plan for 2020/21 (v.0.02)together with draft 2020/21 Work Programme incorporating North Wales wide actions and specific health Economy Actions. 22. Draft 2020/23 plan presented to Board in committee in January 2020. Principles to further inform strategy and plan development identified. The annual plan guidance for 2020/21 provided by WG was presented together with our local assessment of progress and where further work is required and the route map and timetable to complete the outstanding work, specifically around Planned Care and our Financial Plan.	

Assurances	**Links to**		
1. Board and WG oversight as part of Special Measures. 2. Oversight of plan development through the SPPH Committee. 3. All Wales peer review system in place. 4. Joint Services Planning Committee of Community Health Council.5. Regular links to advisory for a - LPF, SRG, HPF.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7 8	PR5	Strategic and Service Planning

CRR18	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 19 December 2018
	Assuring Committee: Strategy, Partnerships and Population Health Committee	**Date Last Reviewed:** 20 January 2020
	Risk: EU Exit - Transition Arrangements	**Target Risk Date:** 31 December 2020
There is a risk that the Health Board (HB) will fail to maintain a safe and effective healthcare service. This may be caused by a lack of clarity and understanding at UK level in respect of the impact of withdrawal from the European Union (EU), and a subsequent failure by the HB to develop robust withdrawal contingency plans. This could lead to a disruption of service delivery and thereby adversely impact on outcomes for patients in terms of safety and access to services.		



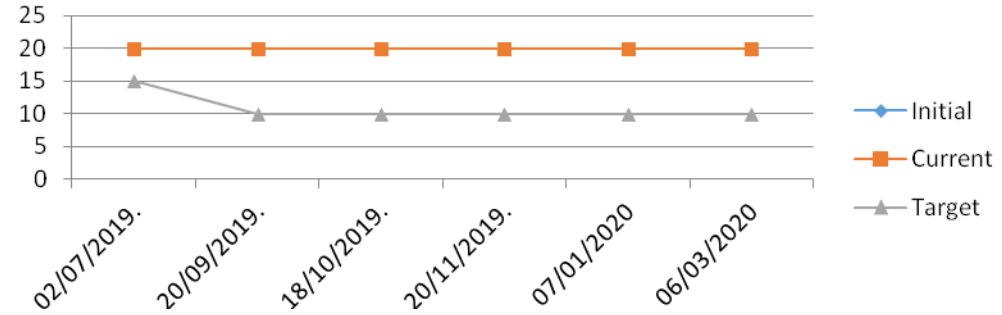
	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Score	4	1	4
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	Further action to achieve target risk score
1. BCUHB Task & Finish Group established, currently paused. 2. Potential risks and issues identified for no deal Brexit, will be further updated as implementation period progresses. 3. Participation with regional and national co-ordinating groups will re-commence as required. 4. Engagement with Executive Team will continue as required to ensure cascade of any necessary actions. 5. Update briefings will continue to staff via Bulletin, and webpages will be updated, as the situation develops.	Following extension to date of exit to 31 Jan 2020 and progress of the Withdrawal Agreement Bill through parliament, planning and preparations have been stood down by WG until further notice. The national leadership Group will continue to meet on a monthly basis but SRO meetings have been stood down. Position will be reviewed by WG in July 2020 and response arrangements may be stood up if required, dependent on evaluation of political situation; however, currently the risk of

6. Lower level risks entered onto Datix and linked to CRR18 will be updated as required.	leaving on 31 January 2020 without the passing of the WAB is significantly reduced.

Assurances	**Links to**		
1. Reporting to Executive Team and SPPH Committee 2. WAO audit of preparedness 3. WG oversight through national work streams	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Not Applicable

CRR20	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 2 July 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 March 2020
	Risk: Security Risk	**Target Risk Date:** 1 November 2020
There is a risk the Health Board fails to ensure that a suitable systems are in place to protect staff, patients and stakeholders from security, violence and aggression incidents arising out of our work activity. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed.		



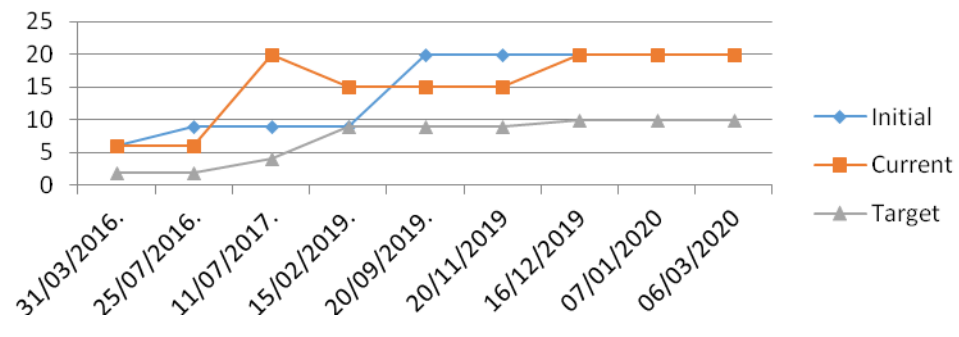
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	Further action to achieve target risk score
1) There is a system in place for a contractor (Samsun) to manage the physical/people aspects of Security for the organisation. 2) A V&A Case manager is in place to support individuals who have been exposed to violence and aggression incidents. 3) An external contractor is supporting the Head of H&S to review all aspects of Security across the Board. 4) An external Police Support Officer is in place part time to support the organisation and staff.	A systematic approach is required to both physical and people aspects of the risks identified. This includes: 1. A complete review of CCTV and recording systems. 2. Finalise and implement the CCTV Policy. 3. Clear lines of communication with the contractor, review of the contract in relation to key holding responsibilities and reporting on activities to be implemented. 4. Responsibilities of Security roles within BCUHB to be clearly defined. 5. Lone worker procedures and risk assessments further established.

	6. Reducing numbers of violence incidents to staff through clear markers and systems for monitoring violent patients. 7. Comprehensive review of Security on gaps in system which was provided to the Strategic OHS group.

Assurances	**Links to**		
1.Health and Safety Leads Group 2.Strategic Occupational Health and Safety Group 3.QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3		SM4 SM1

CRR21	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 31 March 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 March 2020
	Risk: Health & Safety Leadership and Management	**Target Risk Date:** 1 November 2020
There is a risk that the Health Board fails to achieve compliance with Health and Safety Legislation due to insufficient leadership and general management. This could have a negative impact on patient and staff safety, including organisational reputation and prosecution.		



	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

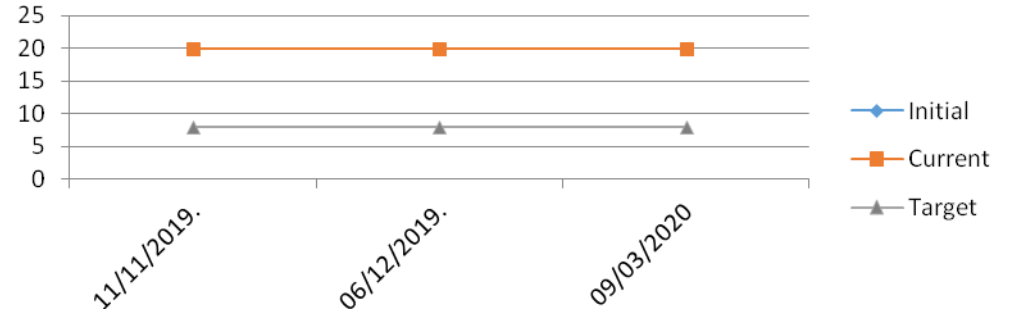
Controls in place	Further action to achieve target risk score
1. Health and Safety risk assessment systems are in place in some service areas to protect staff, patients and others from hazards. 2. Health and Safety Management arrangements further developed. 3. Strategic Health and Safety Group in place meeting regularly (3 times in 3 months). 4. Risk Assessments and safe systems of work in place. 5. Mandatory Training in place. 6. Clinical and Corporate Health and Safety Teams established. 7. Corporate Health and Safety Team established. 8. Programme of Annual Self-Assessment Audits.	1. Undertaken gap analysis of 31 pieces of legislation. Completed within specified time frame (117 inspections in 7 weeks). 2. Action plan developed based on non compliance with legislation. 3. Develop a programme of intervention and training through TNA Review. 4. Identified RIDDOR reports and scrutiny of process, looking at improved RCA system. 5. 12 Month action plan developed and 3 year strategy, that is owned by Divisions and Senior Leaders. 6. Further develop individual risk register for items of none. compliance identified through gap analysis 8-10 specific items.

9. Gap analysis in place. 10. Health and Safety Walkabouts. 11. Health and Safety Report to QSE and Board. 12. Health and Safety Improvement Project Plan.	7. Review Divisional governance arrangements so that they marry with H&S governance system and reporting to Strategic OHS Group. 8. Implement findings of internal audit review of process of inspection and governance.

Assurances	**Links to**		
1. and Safety Leads Group 2.The Strategic Occupational Health and Safety Group 3. QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM1 SM4

Appendix 2: Details of new risks for approval and recommendation for inclusion onto the Corporate Risk Register

2956	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 11 November 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 09 March 2020
	Risk: Potential to compromise patient safety due to large backlog and lack of follow-up capacity.	**Target Risk Date:** 31 December 2020
The is a risk that patient safety and experience may be comprised due to the Health Board's lack of follow-up capacity especially in outpatients specialities within Secondary across all three sites. This could lead to claims, poor patient experience, harm, reputational damage and deterioration in patient conditions who might have missed their 100% follow-up target.		



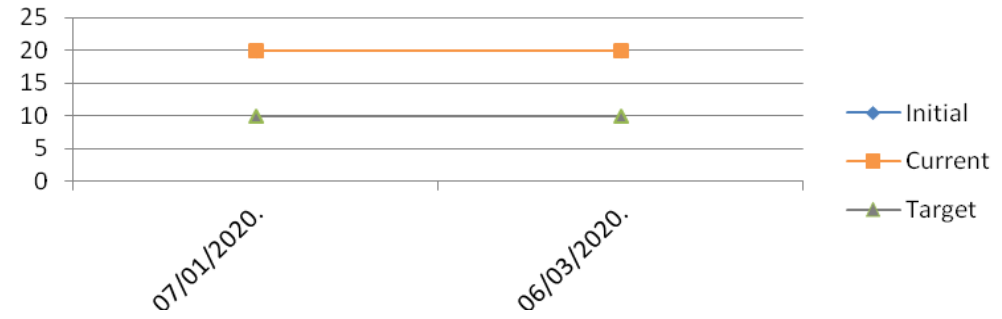
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	Further action to achieve target risk score
1. Ophthalmology and Cancer services have been validated and patients who might have come to harm due to missing their follow-up have been prioritised and seen in clinics. 2. Monitoring of follow-up numbers at weekly meetings. 3. Tendering completed for an external company to validate all follow-ups in OPD. 4. Close links with all services to ensure appropriate care planning for patients are in place.	The current reported number of backlog patients who have exceeded their follow up time by a 100% stands at 57,187 as of the end of December, of which 6,332 are booked and 50,855 are un-booked. 1. Continue the work to date outlined in the previous action plan following the best practice methodology but support with the best practice methodology outlined above.

5. Strong clinical engagement and project management support established. 6. Prioritisation of patients at clinical risk and harm reviews being undertaken for all patients who have missed their 100% follow-up.	2. Focus on the highest risk specialities for the immediate implementation of harm reviews with agreed trajectories for reduction by: - Urology - Cardiology - General surgery - Ophthalmology 3. Work on the trajectory of 15% reduction of the backlog by March 2020 and monitor these on a weekly basis through the local PTL meeting. 4. Establish a process that will allow the Health Board to contact all patients who are over 52 weeks and currently un-booked to establish if they still require an appointment in the larger specialties. 5. Review any new patient breaching 52 weeks or over 100% beyond their follow-up appointment will have a harm review to prevent growth of the backlog. 6. Agree monitoring and governance arrangements. 7. Discussion on resourcing a sustained in-house validation team ongoing as procuring indepndent validation is expensive.

Assurances	**Links to**		
1.Monitoring and governance arrangements for this risk in place. 2.Review of Ophthalmology and Cancer patients now completed. 3.Risk is now regularly reviewed at QSE with potential of adding onto the CRR.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 7	NA	Strategic and Service Planning

3019	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 6 March 2020
	Risk: Asbestos Management and Control	**Target Risk Date:** 2 November 2020
There is a significant risk that BCUHB is none compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, resulting in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.		



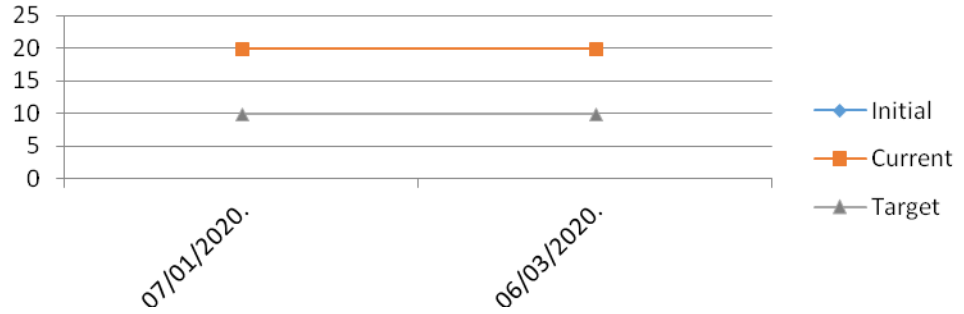
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	Further action to achieve target risk score
1. Asbestos Policy in place and partially implemented due to lack of complete asbestos registers on all sites. 2. A number of surveys undertaken, quality not determined. 3. Asbestos management plan in place. 4. Asbestos register available on some sites, generally held centrally. 5. Targeted surveys were capital work is planned or decommissioning work undertaken. 6. Training for operatives in Estates.	1. Undertaking a re-survey of 10-15 premises to determine if the original surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors. 2. Update and review the Asbestos Policy and Management Plan. 3. Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.

7. Air monitoring undertaken in some premises where there is limited clarity on asbestos condition.	4. Ensure priority assessments are undertaken and highest risk escalated. 5. Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored. 6. Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises. 7. Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks. 8. Update intranet pages and raise awareness with staff who may be affected by asbestos. 9. QR Code identification to be provided on all areas of work with identified asbestos signage in non public areas. 10. Lack complete asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.

Assurances	**Links to**		
1.Health and Safety Leads Group 2.Strategic Occupational Health and Safety Group 3.QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM4 SM1

3020	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 6 March 2020
	Risk: Contractor Management and Control	**Target Risk Date:** 1 December 2020
There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.		



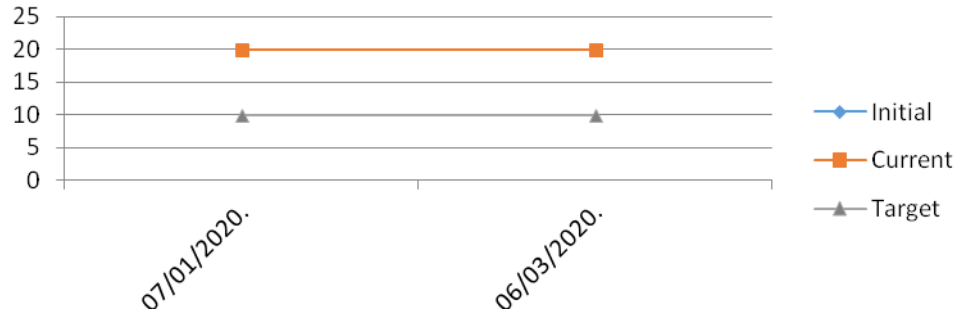
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	Further action to achieve target risk score
1. Control of contractors procedure in place and partially implemented due to lack of consistency and standardisation. 2. Evaluation of standing orders and assessment under Construction Design and Management Regulations. 3. Induction provided to some contractors but not all. Not all come through operational Estates such as IT. 4. There are a number of permit to work paper systems in place.	1. Identify current guidance documents and ensure they are fit for purpose. 2. Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy). 3. Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises. 4. Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum

	H&S are implemented and externally checked prior to coming top site. 5. Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust? 6. Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base. 7. Identify level of Local Induction and who carry it out and to what standard. 8. Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.). 9. Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis. 10. Lack of consistency and standisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.

Assurances	**Links to**		
1.Health and Safety Leads Group 2.Strategic Occupational Health and Safety Group 3.QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM4 SM1

3023	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 6 March 2020
	Risk: Legionella Management and Control.	**Target Risk Date:** 30 November 2020
There is a significant risk that the BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.		



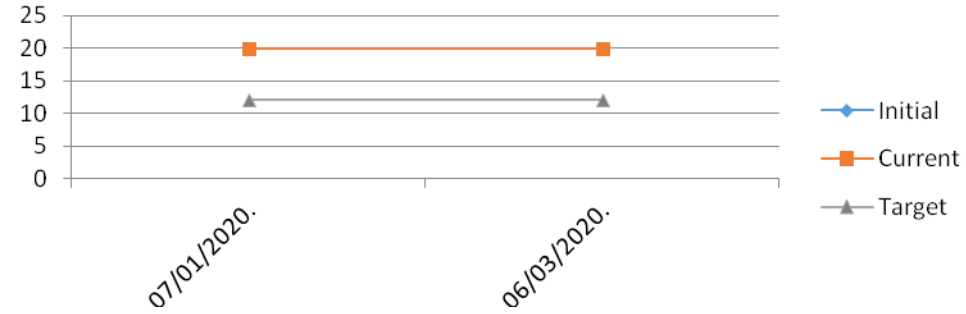
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	Further action to achieve target risk score
1. Legionella and Water Safety Policy in place and being partially impemented due to lack of consistency and standardisation. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis.	1. Update Corporate H&S Review template and H&S Self Assessment Template to ensure that actions are completed by all wards and Departments to ensure systems are in place. 2. Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified. 3. Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.

6. Authorising Engineer water safety in place who provides annual report.	4. Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person. 5. Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales). 6. Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting. 7. Awareness and training programme in place to ensure all staff aware? Departmental Induction Checklist. 8. BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets. 9. Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective. 10. Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.

Assurances	**Links to**		
1.Health and Safety Leads Group 2.Strategic Occupational Health and Safety Group 3.QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM4 SM1

3024	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 6 March 2020
	Risk: Non-Compliance of Fire Safety Systems	**Target Risk Date:** 1 November 2020
There is a risk that the Health Board's is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks, lack of relevant operational Risks Assessments. This may lead to major Fire, breach in Legislation and ultimately prosecution against BCUHB.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	4	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	Further action to achieve target risk score
1. Fire risk assessments in place in a number of service areas. 2. A number of areas have evacuations. 3. There is a fire safety group established. 4. There is a fire Policy in place. 5. The Fire Authority regularly inspect BCUHB premises and provide reports on their findings which have action plans in place. 6. Appointed fire engineer in place who oversees fire safety system in place. 7. Commission independent shared services audits.	1. BCUHB required to comply with all elements of the Fire Safety Order 2005. 2. Review Internal Audit Fire findings and ensure all actions are taken. 3. Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented. 4. Identify how site specific fire information and training is conducted and recorded. 5. Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved?

8. Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process.	6. How is evacuation training delivered / monitored? 7. How is fire safety advice provided to contractors, define when this happens? 8. AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved. 9. Ensure actions from the fire authority findings are escalated and actions completed reporting back to the Strategic OHS Group.

Assurances	**Links to**		
1.Health and Safety Leads Group 2.Strategic Occupational Health and Safety Group 3.QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM4 SM1

Audit Committee

19th March 2020

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Chair's Report

Name of Group:	Risk Management Group (RMG)
Meeting date:	30th January 2020
Name of Chair:	Gill Harris, Deputy Chief Executive Officer / Executive Director of Nursing and Midwifery
Responsible Director:	Gill Harris, Deputy Chief Executive Officer / Executive Director of Nursing and Midwifery

Summary of business discussed:	The RMG Members noted:
	• The updates to the Terms of Reference which included additional representatives to the membership and formalising the reporting arrangement to the Audit Committee. The RMG approved the updates and these are presented for information.
	• The Risk Management Improvement Plan was submitted, noting the requirement to update for the next year. 1 action remained outstanding and this would be addressed when the Board endorse the Risk Management Strategy and Policy for implementation.
	• Following a comprehensive and detailed review of the risks presented to the QSE Committee for escalation, the RMG proposed the following amendments:
	  ○ A further review and update of the risk description, controls and scoring to be undertaken for ID2956, ID3019, ID3023 and ID3024.
	  ○ De-escalation of ID3021 and ID3022 as these were closely linked to the existing CRR21 Health and Safety Risk. However members noted that both risks could be escalated at any point should they be required. Leads were requested to work with Estates to strengthen mitigating controls in place.
	• Members agreed with the request to deescalate ID2950 – Potential inability of Care Homes to provide safe quality care (split from CRR03).
	• The extensive review of the Tier 2 risks being undertaken, including the detailed oversight by the Executive Risk Scrutiny Panel.
	• The formal approval by the Audit Committee members of the updated Risk Management Strategy and Policy in January 2020, and that it would be presented to the Board in March for endorsement. Members were also informed that supporting procedures would be updated and ready for the launch of the updated Strategy by the 1st April 2020.

	• Members were presented with the Risk Management Gap and Training Needs analysis noting that outstanding actions were to be incorporated into next year's Risk Management Improvement Plan. • The progress with the Once for Wales Integrated Risk Management Project and local issues to be addressed. • The requirement to increase the reporting of the Corporate Risks to the Board Committees, noting the impact on resources required to undertake this. A further report on options would be considered, including the current template format.
Key assurances provided at this meeting:	• Progress with the Risk Management improvement plan including the implementation of the updated Risk Management Strategy and Policy. • Follow up of outstanding actions to be incorporated into future improvement plans. • Completion of the comprehensive training needs and gap analysis to influence the Risk Management Training Programme for delivery in 2020/21.
Key risks including mitigating actions and milestones	Compliance with the Risk Management Strategy and Policy
Special Measures Improvement Framework Theme/Expectation addressed	Area: Leadership and Improvement Capability
Issues to be referred to another Committee	None of note
Matters requiring escalation to the Board:	None of note
Well-being of Future Generations Act Sustainable Development Principle	The work of the Risk Management Group will help to underpin the delivery of the sustainable development principles by: • Fully embedding Enterprise Risk Management to proactively manage risk to the delivery of the Health Board's planning and risk assessment processes. • Working collaboratively across Wales to deliver solutions with partners to improve planning and system delivery.
Planned business for the next meeting:	Range of regular reports plus • Review of Corporate Risks • Review of Tier 2 Directorate and Divisional Risks • Update on Once for Wales Integrated Risk Management Project • 2020/21 Risk Management Improvement Plan
Date of next meeting:	30th March 2020

Risk Management Group Terms of Reference

INTRODUCTION

The Health Board has a responsibility to ensure robust risk management systems and processes are in place. The Risk Management Group will seek assurance that risk management system is fit for purpose in line with the Risk Management Strategy and is embedded across all areas of the Health Board.

PURPOSE

The Risk Management Group (RMG) is established to oversee the implementation of the Risk Management Strategy to drive through consistency and coordination of improvements in risk management practices across all areas of the Health Board.

The Group will seek assurance on the effectiveness of risk management systems and processes in place across all areas of the Health Board. This will include ensuring that robust systems are in place to identify risks that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the organisation.

The Group will seek assurances from sub groups ensuring there is evidence of learning from patient and staff experience.

FUNCTIONS

- To provide leadership and oversight of the risk management system and process consistent with the Risk Management Policy, Procedure and Training Plan;
- To support the Board with the development and coordination of the Board's Risk Appetite Statement and Board Assurance Framework;
- To ensure that the principle risks to the achievement of the Health Board's objectives are anticipated and proactively identified and monitored;
- To ensure systems are in place to review and monitor implementation of the Risk Management Policy across all areas of the Health Board including RM04 Module Risk Management Procedure;
- To receive key performance indicator reports detailing divisional compliance with expected standards taking action to address areas of non-compliance;
- To oversee and maintain the system for the regular review of corporate risks to be presented at the Board and appropriate committees;
- To review on a cyclical basis all Corporate (Tier1) risks alongside the Directorate/Divisional (Tier 2) risks;
- To review any operational risks brought to RMG by the Head of Risk Management which should be considered for further discussion and/or escalation;
- To receive assurance reports relating to risk management from external and internal audit;
- To oversee compliance with the agreed risk management training programme;

- To receive issues of significance from the Datix User Group, Strategic Occupational Health and Safety Group and the Quality and Safety Group including the management of safety alerts;
- To receive updates from and provide input to the Once for Wales Risk Management Project.

DELEGATED POWERS AND DUTIES OF THE DEPUTY CHIEF EXECUTIVE/EXECUTIVE DIRECTOR OF NURSING AND MIDWIFERY

The Deputy Chief Executive/Executive Director of Nursing and Midwifery has lead responsibility for the Management of Risk within the Health Board. The specific powers, duties and responsibilities delegated to the Deputy Chief Executive/Executive Director of Nursing and Midwifery from the Chief Executive are:-

- To chair the Risk Management Group.
- To make recommendations and improvements for management of risk across the Health Board.
- To ensure the implementation of relevant policies, procedures and other written control.
- Ensure competent risk management advice and guidance is available.
- Submit regular assurance reports to the Health Board through the Audit Committee via the RMG Chairs Assurance Report.
- Submit regular performance reports to the Executive Management Group.

AUTHORITY

The Risk Management Group is directly accountable to the Audit Committee through the Executive Management Group and is empowered with the responsibility for:-

- Implement and review annually the Health Board's Risk Management Strategy.
- The development and implementation of a risk management improvement plan.
- Providing Board assurance that risk is being managed effectively and make recommendations for improvements to the risk management systems.
- To monitor the performance of the Health Board in respect of the management of risk.
- Establishing Sub-Groups to address issues of significance such as but not restricted to, the development of procedures and guidance for the management of risk e.g. Risk Management Leads Group and Datix User Group.
- To ratify procedures and guidance in support of the Risk Management Strategy.
- To review all risks across the Health Board to ensure compliance and consistency with the risk management strategy.
- Maintain effective partnership working arrangements within the Health Board in relation to the management of risk.
- Develop risk management performance indicators through the self - assessment and internal audit processes.
- To receive and review updates from the Quality and Safety Group, Strategic Occupational Health and Safety Group and the Once for Wales Risk Management Project and other topics defined by the Group.

MEMBERSHIP

Chair	Deputy Chief Executive/Executive Director of Nursing and Midwifery (Chair)
Vice Chair	Executive Medical Director (Vice Chair) Executive Director of Workforce and Organisational Development Executive Director of Planning and Performance Executive Director Primary and Community Services Executive Director of Finance Associate Director of Quality and Assurance Director of Acute Care Director of Mental Health and Learning Disabilities Director of Midwifery and Women's Services Board Secretary Assistant Director: Information Governance and Risk Head of Risk Management Associate Director: Health and Safety and Equality Chief Information Officer Director of Estates and Facilities
Secretary	As determined by the Deputy Chief Executive/Executive of Nursing and Midwifery.
In attendance	Other attendees maybe requested to attend to address specific topics or issues with the agreement of the Chair.
Deputies	Should any Member be unavailable to attend, they may nominate a deputy with the agreement of the Chair, but these deputies will not count towards the quorum and will be shown as "in attendance" for the purposes of the minutes.

MEETINGS

Quorum
The quorum for the Group shall be four members, including the Chair or Vice-Chair, Health and Safety Lead, one Clinical Executive Lead and one Non-Clinical Executive Lead.

Frequency of Meetings
Meetings shall be held bi-monthly or otherwise as the Chair of the Group deems necessary.

AGENDA AND PAPERS

RMG will be supported administratively as determined by the Deputy Chief Executive/Executive of Nursing and Midwifery. Support will also be provided via the Corporate Risk Management Team.

Duties in this respect will include:

- Agreement of agenda with the Chair and attendees
- Collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward within an action log
- Advising the Executive Team on pertinent issues/area.

The timeline for submission of papers will be in accordance with the annual schedule for corporate meetings as agreed by the Executive Team.

All papers submitted to RMG must be approved by the Deputy Chief Executive/Executive Director of Nursing and Midwifery.

REPORTING ARRANGEMENTS

The RMG Group reports to the Executive Team, chaired by the Chief Executive. The Group also provides assurance reports to the Audit Committee.

- Bring to the Executive Team's specific attention any significant performance / compliance matter under consideration by the RMG;
- Bring to the attention of the Audit Committee any significant assurance issues regarding the effectiveness of the Health Board's risk management processes;
- Bring to the attention of the Quality, Safety and Experience Committee any significant risk or assurance issues regarding health and safety or clinical risk management processes which could compromise patient care.

First review date: January 2019 (version 0.11)

Next review date: January 2021

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 19/03/20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Legislation Assurance Framework (LAF)
Cyfarwyddwr Cyfrifol: Responsible Director:	Acting Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Acting Board Secretary
Atodiadau Appendices:	Appendix 1: Legislative Developments Appendix 2: Areas of Limited Assurance

Argymhelliad / Recommendation:

The Audit Committee is asked to:

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

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

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

Sefyllfa / Situation:

This paper details a summary of the work undertaken in the development of the BCUHB Legislation Assurance Framework (LAF). Including:

- Operational engagement in developing the LAF and the collation of assurances.
- Legislative developments (legislation enacted since the previous report)
- Specific items of no or limited assurance.

Cefndir / Background:

Work undertaken between the All Wales Audit Committee Chairs and Board Secretaries Network previously acknowledged that it was essential that Boards had an effective system in place in which identifying and managing risk was a continuous thought process for the Board in order to satisfy the Audit Committee that risks were being managed well. It was acknowledged that the approach in Wales would be to produce three distinct products (whilst acknowledging the need for local variation), namely:

- A narrative BAF document
- The Assurance framework map
- The Corporate Risk Register

Part B of the Assurance map comprises the Legislation Assurance Framework (LAF). NHS bodies in Wales must operate within the law in relation to all aspects of their business. The Health Board has developed a system to capture compliance and assurance information on a centralised register and management system. The Audit Committee reviews the LAF bi-annually. The system provides the Board with an oversight of legislative obligations/liabilities, the assurance level, the impact of non-compliance and the control measures in place for each.

- **Operational engagement in developing the LAF and the collation of assurances.**

Due to significant staffing issues within the Office of the Board Secretary (OBS), the LAF development has been generally limited to basic monitoring and updates. This means that all newly enacted legislation and/or amendments are reviewed for applicability and impact, disseminated to governance leads for information and input/updated in the main database where applicable. Members can be assured that the master database is continuously updated though engagement with the relevant leads to confirm allocation and complete the assurance criteria has been limited overall.

An initial review of Estates & Facilities legislation has been undertaken with the Director of Estates and a baseline of assurance completed. This is a substantial piece of work / self-assessment covering approximately 100 pieces of legislation. The data now needs to be quality checked (for example, where allocation is queried / incorrectly assigned) by the Statutory Compliance, Governance & Policy Manager. Feedback will then be provided to the Director of Estates & Facilities before the allocated legislation assurance is finalised. Areas of limited assurance will be reported to Audit Committee via the next iteration of the LAF. Pharmacy & Medicines Management are similarly at the same stage (awaiting allocation review by the Statutory Compliance, Governance & Policy Manager).

Members are also asked to note that the LAF has proven to be a useful tool for supporting the review and implementation of the Policy on Policies (as per the HASCAS and Ockenden external review recommendations), acting as a reference point to ensure any legislation cited is correct (for example devolved or national).

- **Legislative developments (legislation enacted since the previous report)**

Members should note that the report does not detail new legislation that has been enacted in order to address failures of retained EU law to operate effectively arising from the withdrawal of the United Kingdom from the European Union. The majority of amendments have no practical application and generally remove EU references that are no longer appropriate. For example 'The Planning (Hazardous Substances and Miscellaneous Amendments) (EU Exit) Regulations 2018 amended the Planning (Hazardous Substances) Regulations 2015 and would not be included unless the amendment introduced changes in the legislation's application to BCUHB. Similarly, the Health Protection (Notification) (Wales) (Amendment) Regulations 2020 which place obligations on various persons for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination have been enacted to amend/include Coronavirus Disease 2019 (COVID-19) into Schedule 1 of the existing 2010 Regulations and would therefore not be incorporated into the LAF.

Due to the political landscape (general election, Brexit preparation), the volume of legislation enacted has been reduced. Detailed at Appendix 1 is a summary of relevant legislation enacted since the previous report.

- **Specific items of no or limited assurance.**

Areas of no or limited assurance are detailed in Appendix 2. Items have been reviewed and updated where applicable by the relevant leads. Items that reported substantial or reasonable assurance in the previous report have been removed as previously agreed. Items detailed that are now showing as substantial or reasonable will be removed from the next iteration of the report unless Members direct otherwise.

Asesiad / Assessment & Analysis

Strategy Implications

The LAF contains approximately 600 pieces of legislation. These include items that impact on strategic goals and plans. For example, Well-being of Future Generations (Wales) Act 2015 or specific environmental obligations to improve air quality / reduce waste etc. or general sustainability such as Public Services (Social Value) Act 2012.

Financial Implications

The LAF contains approximately 600 pieces of legislation. These include items that impact on financial regulation or operational finance requirements, for example – Bribery/Money Laundering/Modern Slavery, Charities, Consumer Credit, Late Payment of Commercial Debts Regulations/Public Contracts Regulations, Incidental lotteries, Government financial reporting manuals, tax and pensions and the National Health Service Finance (Wales) Act 2014 etc.

Risk Analysis

Where there is evidence of limited or no assurance, items are included in appendix 2. Directorate Governance Leads / Owners are directed that areas of non-compliance should be reflected in the appropriate risk register. This supports triangulation of data analysis. The LAF also details mitigating controls in place. The Health Board has committed to ensuring that there is a managed system in place to capture compliance information in accordance with the Board's Risk Appetite. This includes risks which could be identified from the Health Board's inability to comply with legislation, regulation, policies and procedures including professional standards.

Legal and Compliance

NHS bodies in Wales must operate within the law in relation to all aspects of their business. The Health Board has a responsibility to ensure that its governance arrangements encompass an assessment of compliance with all applicable legislative obligations. These will include, but not be restricted to the following categories:

- Accreditation, registration or licensing requirements
- Reporting requirements (the provision of statistics or information)
- Complying with timeframes for performing activities
- A requirement to provide a specified service or range of services
- Restrictions or limitations on how these services can be offered
- Financial obligations
- Employer duties
- Powers of inspection or review
- Data protection
- Professional regulation
- Other key pieces of legislation

Impact Assessment

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

Appendix 1: Legislative Developments

Title	Explanatory Note	Divisional Assignment	Additional info
The Parental Bereavement (Leave and Pay) Act 2018 (Commencement) Regulations 2020	The Regulations bring into force the substantive provisions of the Parental Bereavement (Leave and Pay) Act 2018, including Schedule 1 which introduces a new Chapter 4 (Parental Bereavement Leave) in Part 8 of the Employment Rights Act 1996 and a new Part 12ZD (Statutory Parental Bereavement Pay) in the Social Security Contributions and Benefits Act 1992.	Workforce & Organisational Development	Workforce have completed an initial review of all assigned legislation and provided assurances for each. A bi-annual review was arranged though postponed due to staffing/capacity within Office of the Board Secretary. This item will be addressed during the next review.
The Parental Bereavement Leave Regulations 2020	These Regulations introduce a new statutory entitlement for bereaved parents who are employees to take up to two weeks' leave from their job called parental bereavement leave in the 56 weeks following the death of a child. These Regulations are made in exercise of the powers inserted into the Employment Rights Act 1996 by the Parental Bereavement (Leave and Pay Act) 2018	Workforce & Organisational Development	Workforce have completed an initial review of all assigned legislation and provided assurances for each. A bi-annual review was arranged though postponed due to staffing/capacity within Office of the Board Secretary. This item will be addressed during the next review.

Appendix 2: Areas of Limited Assurance

Keys:

⬆	**Compliance Level Increased.**
⟷	**Compliance Level no change.**
⬇	**Compliance Level Declined.**

- The **type** of assurance (verbal, written reports, licences or certificates)
- The **level** of assurance (where the type of assurance is overseen: operational, oversight/Committee, independent/third party verification
- The **compliance level** (as per Internal Audit Assurance Ratings: substantial, reasonable, limited, no assurance)
- The **compliance impact** rating (as per the RM01, Risk Scoring Matrix)
- The **key controls** and/or assurances in place (policy & procedures, staff training, annual reports, key performance indicators, etc.)
- **Third Party Assurance** – whether compliance has been subject to an external or independent review

Legislation	Explanatory note	Assurance Type	Assurance Level	Responsible Division	Compliance Impact	Compliance Impact Rating	Key Controls	Third Party Assurance	Comments
National Health Service Finance (Wales) Act 2014	This Act amends the National Health Service (Wales) Act 2006 so that the existing duty on each Local Health Board in Wales to secure that its expenditure does not exceed its funding in a financial year instead becomes a duty to secure that its expenditure does not exceed its funding over a period of three financial years; and may be subject to a margin of tolerance permitted by the Welsh Ministers. The Welsh Ministers must give directions to a Local Health Board requiring it— (a) to prepare a plan which sets out its strategy for securing that it complies with the duty under subsection (1) while improving— (i) the health of the people for whom it is responsible, and (ii) the provision of health care to such people; (b) to do such other things as appear to be requisite to secure that it complies with that duty.	Written	Oversight	Finance	No Assurance ⟷	High (15-20)	Reporting of compliance forms part of the Statutory Annual Accounts	Wales Audit Office	The Health Board has not achieved these Statutory Targets and this is reported by Finance to the F&P and Health Board. It is also comprehensively addressed in the Corporate Risk Register (CRR07). The Health Board developed a £35m deficit plan for 2019/20. Welsh Government set a control total of £25m. The Health Board is currently forecasting to achieve a deficit of £41m, and a Recovery Programme, led by the interim Recovery Director was implemented in July 2019.
Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013	These regulations maintain requirements that the responsible person must notify, and subsequently send a report to, the relevant enforcing authority by an approved means in relation to fatal and certain non-fatal work-related accidents, specified diseases contracted by persons at work and certain specified dangerous occurrences.	Written	Oversight	Workforce & OD	Limited ⟷	Low (5-10)	Policy & Procedure. Staff training. Dedicated Corporate H&S leads.	Internal Audit	The Health & Safety Executive will be visiting the Health Board on the 20th April to review procedures. This is as a result of a late reported incident. A plan is in place to have a RIDDOR serious incident scrutiny group lead by the Executive Director WOD.

Legislation	Explanatory note	Assurance Type	Assurance Level	Responsible Division	Compliance Impact	Compliance Impact Rating	Key Controls	Third Party Assurance	Comments
Safety Representatives and Safety Committees Regulations 1977	These Regulations give effect with modifications to proposals of the Health and Safety Commission submitted to the Secretary of State:— (a) providing for the appointment of safety representatives and prescribing their functions in relation to the employees they represent and their workplaces; (b) providing for time off with pay for safety representatives in order that they may perform their functions and undergo training in aspects of those functions; and (c) providing the cases in which it is the duty of employers to establish safety committees in accordance with the Regulations.	Verbal	Operational	Workforce & OD	Reasonable ⬆	Very Low (1-5)	Bi monthly meeting	Internal Audit	Newly reformed Strategic Occupational H&S Group meets bi monthly basis and well represented, including Trade Union Partner. The Terms of Reference (ToR) includes Trade Union partner for attendance. Further work to improve representation and involvement will continue as the Gap Analysis Action progresses / is completed (as part of 3 year strategy) and is monitored at Quality, Safety & Experience Committee (QSE).
The Information and Consultation with Employees Regulations 1996 / 2004	These Regulations require employers to consult either their employees directly or representatives elected by their employees where there are employees not represented by safety representatives appointed by trade unions under the 1977 Regulations. A duty is imposed on employers to consult and provide information with regards H&S matters at work	Verbal	Operational	Workforce & OD	Reasonable ⬆	Very Low (1-5)	Bi monthly meeting	Internal Audit	Newly reformed Strategic Occupational H&S Group meets bi monthly basis and is well represented, including nominated safety representatives from each Division/speciality etc. Further work to improve representation and involvement will continue as the Gap Analysis Action Plan progresses / is completed (as part of 3 year strategy) and is monitored at QSE
Public Health (Wales) 2017 Act	An Act of the National Assembly for Wales to make provision for a national strategy on tackling obesity; smoking; about the performance of certain procedures for aesthetic or therapeutic purposes; about intimate piercing of children; about health impact assessments; about assessing the local need for pharmaceutical services; about pharmaceutical lists; about assessing the local need for public toilets; about fixed penalty receipts for food hygiene rating offences.	Verbal	Operational	Public Health	Limited ⟷	Low (5-10)	None	None	Further work will be required to clarify HB responsibilities under the Act - some of this will come from publication of the Regulations supporting the Act which are not yet published. These are delayed due to capacity issues surrounding legal support which is currently aligned to Brexit. Draft regulations for smoke free sites have been consulted on and it is anticipated that the Regs will be laid in Autumn 2020 with a 3-4 month lead time to come into force (est. Dec 2020-Feb 21 for Health Board). As it currently stands, Hospital Managers will have a duty to take 'reasonable steps' to prevent smoking on hospital grounds. Welsh Government (WG) have established a working group looking at enforcement of the ban and are working with enforcement colleagues to develop implementation plans and guidance. The Task and Finish Group will be reconvened when new details surface. Background work, where possible, continues including planning for smoke free signage.

Legislation	Explanatory note	Assurance Type	Assurance Level	Responsible Division	Compliance Impact	Compliance Impact Rating	Key Controls	Third Party Assurance	Comments
The Functions of Local Health Boards (Dental Public Health) (Wales) Regulations 2006	These Regulations set out the functions to be exercised by Local Health Boards in Wales in relation to oral health. Those functions relate to oral health promotion programmes, dental inspection of pupils in schools maintained by local education authorities and oral health surveys.	Written	Oversight	Public Health	Limited ⟷	Low (5-10)	Action Plan	None	Local Oral Health Action Plan in place - response to WG National Oral Health Plan. Further work needed to clarify responsibilities between Health Board and Public Health Wales in respect of Dental and Oral Health surveys

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 19/03/20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Draft 2020/21 Clinical Audit Plan.
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr David Fearnley (Executive Medical Director).
Awdur yr Adroddiad Report Author:	Trevor Smith (Head of Clinical Audit & Effectiveness).
Craffu blaenorol: Prior Scrutiny:	QSG and QSE (March 2020)
Atodiadau Appendices:	1. Draft 2020/21 Clinical Audit Plan.

Argymhelliad / Recommendation:

The Committee is asked to please approve this draft ***2020/21 Clinical Audit Plan*** for BCUHB.

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

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

Sefyllfa / Situation:

The draft BCUHB Clinical Audit Plan 2020/21 includes the prioritised projects to be conducted within the Health Board in 2020/21.This consists of those projects included within the Welsh Government's National Clinical Audit & Outcome Review Plan 2020/21 (Tier 1) and those prioritised by Executive Directors in relation to service areas falling within their remit (Tier 2).

Cefndir / Background:

National Clinical Audit & Outcome Review Plan (NCAORP) projects are those that have been annually prioritised by Welsh Government and mandated for Welsh Health Board participation. These mandated audits are referred to within BCUHB as 'Tier 1'. All are included in the Tier 1 element of the BCUHB Clinical Audit Plan for 2020/21, other than the following which are not applicable within our Health Board:

- National Adult Cardiac Surgery Audit.
- National Audit of Congenital Heart Disease (*due to care provided in Manchester*).
- Paediatric Intensive Care (PICaNet).

Also within the plan are the 'Tier 2' Corporate projects which have been prioritised by Executive leads for the services within their remit. Clear identification was requested regarding:

- BCUHB priority that the project will support.
- A specified accountable lead.
- The responsible Corporate Group.
- An assessment of risk (*based upon specified criteria*).

Asesiad / Assessment & Analysis

Strategy Implications

The draft document closely relates to the breadth of topics embraced by the Welsh Government's NCAORP Plan. Also in terms of the implications for BCUHB planning and use of resources, governance, monitoring and reporting:

- Leadership and governance.
- Strategic and service planning.
- Mental health.
- Primary Care, including out of hours services.

Financial Implications

The financial considerations that relate to this document are broad in terms of direct impact upon service delivery or a number of support departments such as Clinical Audit & Effectiveness (CA&E), Medical Records or Clinical Informatics. Clinical Audit enables the measurement of care delivery against evidence-based standards; facilitating optimum use of limited resources and identification of additional resource needs for improvement. These are identified within the individual context of each project.

Also, there is the indirect cost of support services that contribute to successful participation of the projects identified as priorities by each team. These support functions need to be resourced if clinicians are to be able to participate and focus upon improvement activity.

Risk Analysis

The Tier 1 element of the 2020/21 Clinical Audit Plan relates to mandatory projects as prioritised by Welsh Government within their NCAORP. Tier 2 includes some projects which are required for accreditation, regulation and licensing; along with management of risk, quality, safety and patient experience. Resourcing to support activity corporately is currently under review and is recorded within the Risk Register (reference: 2961) at with a current tier 2 risk rating of 12.

In relation to Tier 1, there are risks associated with potential non-participation with NCAORP projects. These have related to resource challenges (such as data collection support) and lack of identification of project leads within BCUHB.

Participation in respiratory audits remained a challenge throughout last year. The Executive Medical Director is exploring this issue with the Respiratory Consultants to identify a lead. There remains concern about the data collection support required for this audit and this will need to be addressed. In relation to NACAP projects:

- *Children and Young People Asthma*: Data collection scheduled in-year. However; they have not been participating in Central and East. Partial data collection only has been occurring in West.
- *Adult Asthma*: Data collection scheduled in-year. However; data currently has been collected for Central only (no data for East or West).
- *COPD*: Data collection scheduled in-year. However; data currently has been collected for Central only (no data for East and low data capture for West).

There has been no participation within BCUHB for the *Falls & Fragility Fractures Audit Programme* (*FFFAP*): **Fracture Liaison Service (NCAORP/2019/22**). The project lead (Dr Swapna Alexander, Consultant: Care of the Elderly) has escalated to request administration support; however, still currently there is no resolution. Discussions with Clinical Lead and Area Managers has been occurring.

Data collection is partial for **NCAORP/2019/30**: **National Vascular Registry Audit** (*including Carotid Endarterectomy Audit*). Data submission is partial in relation to Interventional Radiology. Response from Mr Soroush Sohrabi (Vascular Consultant Surgeon) identified that he is taking this action forward with the Vascular Interventional Radiology Department.

Legal and Compliance
The Tier 1 element of the 2020/21 Clinical Audit Plan relates to mandatory projects as prioritised by Welsh Government within their NCAORP. Reporting on progress will be scheduled for the Clinical Effectiveness & Audit sub Group (CEAsG) on a quarterly basis leading to a full annual report in Quarter 1 2021/22.

Impact Assessment
An Equality Impact Assessment (EqIA) has been completed for the recently approved BCUHB Clinical Audit Policy which relates closely to participation with the Tier 1 and Tier 2 elements of the 2020/21 Clinical Audit Plan.
The premise of clinical audit is to establish the extent to which evidence-based standards are evidenced in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all. The policy would:

- Promote good practice as outlined above and encourages adherence to National guidance and standards.
- Promote standardisation and equality of access to good practice.
- Encourage patient and public involvement in clinical audit activity.

Appendix 1:

Tier 1 Plan:

Reference:	Title of National Audit	BCUHB Lead	East area Lead	Central Area Lead	West Area Lead	In year Data Submission	In year Report
NCAORP/2020/01	National Joint Registry	No BCUHB lead at present	Mr Stephen Phillips (Consultant Orthopaedic Surgeon)	Mr Ian Smith (Consultant Orthopaedic Surgeon)	Mr Koldo Azurza (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2020/02	National Emergency Laparotomy Audit	Dr Stephan Clements (Consultant Anaesthetist)	Mr Duncan Stewart (Consultant Surgeon) / Dr Sianedd Elliott / Dr Kiran Dasi (Consultant Anaesthetists)	Mr Richard Morgan (Consultant Surgeon) / Dr Magdy Khater (Consultant Anaesthetist)	Dr Stephan Clements (Consultant Anaesthetist) / Mr. Nik Abdullah (Consultant Surgeon)	Yes	Yes
NCAORP/2020/03	Comparative audit of critical care unit adult patient outcomes (casemix) ICNARC	No BCUHB lead at present	Dr Sam Sandow (Consultant Anaesthetist)	Dr Richard Pugh (Consultant Anaesthetist)	Dr Karen Mottart/Alison Ingham, (Consultant Anaesthetists)	Yes	Yes
NCAORP/2020/04	Trauma Audit & Research Network (TARN)	No BCUHB lead at present	Dr Ash Basu (Consultant : Emergency Department)	Mr Mark Anderton (Emergency Medicine Consultant)	Dr Leesa Parkinson / Dr Rob Perry (Consultants: Emergency Department)	Yes	Yes
NCAORP/2020/05	National Diabetes Foot care Audit	Gareth Lloyd Hughes (Head Of Podiatry & Orthotics - East Area)	Dr Anthony Dixon (Consultant Physician) & Nicola Joyce (Podiatrist)	Dr Aye Nyunt (Consultant Physician) & Lorna Hicks (Principal Podiatrist)	Prof Dean Williams (Consultant Vascular Surgeon) & Jamie O'Malley/Iola Roberts (Diabetic Podiatrists)	Yes	Yes
NCAORP/2020/06	Diabetes Inpatient Audit (NaDia)	No BCUHB lead at present	Dr Stephen Stanaway (Consultant Physician) / Cheryl Griffiths (Diabetes Specialist Nurse)	Dr Stephen Wong (Consultant Physician) / Kirstin Clark (Diabetes Specialist Nurse)	Dr Muhammed Murtaza (Consultant Physician) / Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2020/07	Pregnancy in Diabetes Audit Programme	No BCUHB lead at present	Dr Stuart Lee (Consultant Physician), Lynda Vergheese (Locum Physician) , Gill Davies (Diabetes Specialist Nurse), Rao Bondugulapati (Consultant Physician)	Dr Steven Wong (Consultant Physician), Miss Maggie Armstrong (O&G Consultant), Kirstin Clark (Diabetes Specialist Nurse)	Dr Leela Ramesh (Consultant Physician), Dr Noreen Haque (Registrar),Dr Tony Wilton (Consultant Physician), Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2020/08	National Core Diabetes Audit: (Primary / Secondary Care & Insulin Pump elements)	No BCUHB lead at present	**Primary Care element**: Dr Gareth Bowdler (Area Medical Director)	**Primary Care element**: Dr Liz Bowen (Area Medical Director). **Insulin Pump element:** Julie Roberts (Lead Diabetes Specialist Nurse), Dr Minesh Shah (Associate Specialist)	**Primary Care element:** Dr Bethan Jones (Area Medical Director)	Yes	Yes
NCAORP/2020/09	National Paediatric Diabetes Audit (NPDA)	Dr Michael Cronin (Consultant Paediatrician)	Dr Kamal Weerasinghe (Consultant Paediatrician), Karen Czerniak (Paediatric Community Nursing Team Leader)	Dr Pramod Bhardwaj (Consultant Paediatrician), Teresa Jones (Paediatric Diabetes Specialist Nurse)	Dr Michael Cronin (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/10	National Asthma & COPD Audit Programme (NACAP): Children and Young People Asthma	No BCUHB lead at present	Dr Nick Nelhans (Consultant Paediatrician)	Dr Lee Wisby (Consultant Paediatrician)	Dr Mair Parry (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/11	NACAP: Adult Asthma	No BCUHB lead at present	No lead at present	Dr Daniel Menzies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2020/12	NACAP: COPD	No BCUHB lead at present	No lead at present	Dr Sarah Davies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2020/13	NACAP - Pulmonary Rehabilitation workstream	Dr Daniel Menzies (Consultant Physician)	Michelle Owen (Clinical Specialist Physiotherapist / Pulmonary Rehab Coordinator)	Ann Ellis (Respiratory Occupational Therapist)	Ffion Edwards (Occupational Therapist) & Caerwyn Roberts (Physiotherapist)	Yes	Yes

Reference:	Title of National Audit	BCUHB Lead	East area Lead	Central Area Lead	West Area Lead	In year Data Submission	In year Report
NCAORP/2020/14	Renal Registry	No BCUHB lead at present	Dr Stuart Robertson (Consultant Physician)	Dr Mick Kumwenda (Consultant Physician)	Dr Mahdi Jibani (Consultant Physician)	Yes	Yes
NCAORP/2020/15	National Early Inflamatory Arthritis Audit (NEIAA)	No BCUHB lead at present	No lead at present	Dr Bjaya Roychoudhry, (Consultant Physician)	Dr Yasmeen Ahmed (Consultant Physician)	Yes	Yes
NCAORP/2020/16	All Wales Audiology Audit	Paediatrics: Dafydd Hughes-Griffiths (Head of Paediatric Audiology) & Georgina Parry (Paediatric Audiology Operational Lead) Adult Rehabilitation: Susannah Goggins, Head of Adult Rehabilitation and Balance, Audiology, BCU	Adult Rehabilitation: Anna Powell, Head of Adult Rehabilitation (East)	Adult Rehabilitation: Suzanne Tyson, Head of Adult Rehabilitation (Central)	Adult Rehabilitation: Heidi Jones, Head of Adult Rehabilitation (West)	Yes	Yes
NCAORP/2020/17	Stroke Audit (SSNAP)	Dr Walee Sayed (Consultant Physician)	Dr Walee Sayed (Consultant Physician)	Dr Krishnamurthy Ganeshram (Consultant Physician)	Dr Salah Elghenzai (Consultant Physician)	Yes	Yes
NCAORP/2020/18	Falls & Fragility Fractures Audit Programme: National Hip Fracture database	No BCUHB lead at present	Mr Ian Starkes (Consultant Orthopaedic Surgeon)	Mr Amir Hanna (Consultant Orthopaedic Surgeon)	Mr Ashok Goel (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2020/19	Falls & Fragility Fractures Audit Programme: In-patient Falls Audit	No BCUHB lead at present	Dr Sara Gerrie & Dr Cameron Abbott (Consultant Physicians)	Dr Geralt Owen (Consultant Physician)	Eleri Evans (Interim Head Of Nursing For Medicine - YG)	Yes	Yes
NCAORP2020/20	Falls & Fragility Fractures Audit Programme: Fracture Liaison Service	No BCUHB lead at present	No FLS Service	Dr Swapna Alexander (Consultant Physician: Care of the Elderly)	Dr Swapna Alexander (Consultant Physician: Care of the Elderly)	Yes	Yes
NCAORP/2020/21	National Dementia Audit	Dr Sean Page (Consultant Nurse)	Prof Anthony White / Dr Sam Abraham (Consultant Physicians)	Dr Indrajit Chatterjee (Consultant Physician)	Dr Conor Martin (SPR) / Delyth Thomas (Clinical Nurse Specialist)	Yes	Yes
NCAORP/2020/22	National Audit of Breast Cancer in Older Patients (NABCOP)	Mr Walid Samra (Consultant Surgeon)	Mr Tim Gate (Consultant Breast Surgeon)	Miss Mandana Pennick, (Consultant Breast Surgeon)	Mr Ilyas Khattak (Consultant Breast Surgeon)	Yes	Yes
NCAORP/2020/23	National Audit of Care at the End of Life (NACEL)	Dr Helen Mitchell (Consultant Palliative Medicine)	Mrs Geeta Kumar (Deputy Hospital Medical Director - Q&S)	Dr Tania Bugelli (Deputy Hospital Medical Director - Q&S)	Dr Karen Mottart (Hospital Medical Director - West)	Yes	Yes
NCAORP/2020/24	National Heart Failure Audit	Dr Richard Cowell (Consultant Cardiologist)	Fiona Willcocks (Heart Failure Specialist Nurse)	Dr Mohammad Aldwaik (Consultant Cardiologist) / Andy Bennett (Heart Failure Specialist Nurse)	Dr Mark Payne (Consultant Cardiologist) / Nia Coster (Heart Failure Nurse)	Yes	Yes
NCAORP/2020/25	Cardiac Rhythm Management	Dr Richard Cowell (Consultant Cardiologist)	Dr Rajesh Thaman (Consultant Cardiologist)	Dr Mohammad Aldwaik (Consultant Cardiologist)	Dr Mark Payne (Consultant Cardiologist)	Yes	Yes
NCAORP/2020/26	PCI Audit (previously Coronary Angioplasty Audit)	Dr Paul Das	N/A	Dr Paul Das	N/A	Yes	Yes
NCAORP/2020/27	MINAP	Dr Richard Cowell	Dr Richard Cowell / Lucy Trent	Dr Paul Das	Dr Mark Payne	Yes	Yes
NCAORP/2020/28	National Vascular Registry Audit (inc. Carotid Endarterectomy Audit)	Mr Soroush Sohrabi (Clinical Director – North Wales Vascular Network) & Joanne Garzoni (North Wales Vascular Network Manager)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Yes	Yes

Reference:	Title of National Audit	BCUHB Lead	East area Lead	Central Area Lead	West Area Lead	In year Data Submission	In year Report
NCAORP/2020/29	Cardiac Rehabilitation	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Jacqueline Cliff (Cardiac Rehabilitation Nurse Lead)	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Dale Macey (Cardiology Rehab Lead Specialist Nurse) / Iorwerth Jones (Exercise Physiologist- Cardiac Rehab)	Yes	Yes
NCAORP/2020/30	National Lung Cancer Audit	Dr Ali Thahseen (Consultant Respiratory Physician)	No lead at present	Dr Sakkarai Ambalavanan (Consultant Physician)	Dr Ali Thahseen (Consultant Respiratory Physician)	Yes	Yes
NCAORP/2020/31	National Prostate Cancer Audit	Mr Kyriacos Alexandrou (Consultant Urologist)	Mr. Iqbal Shergill (Consultant Urologist)	Mr. Kingsley Ekwueme (Consultant Urologist)	Mr Kyriacos Alexandrou (Consultant Urologist)	Yes	Yes
NCAORP/2020/32	National Gastrointestinal Cancer Audit Programme	**Bowel**: Mr Andrew Maw (Consultant Surgeon) **Oesophago-gastric** Mr Andrew Baker (Consultant Surgeon)	**Bowel:** Mr Micheal Thornton (Consultant Surgeon) **Oesophago-gastric:** Mr Andrew Baker (Consultant Surgeon) / Dr Thiriloganathan Mathialahan (Consultant Gastroenterologist)	**Bowel:** Mr Andrew Maw (Consultant Surgeon) **Oesophago-gastric:** Mr Richard Morgan (Consultant Surgeon)	**Bowel:** Dr Claire Fuller, (Consultant Oncologist) & Mr Anil Lala (Consultant Surgeon) **Oesophago-gastric:** Dr Rachel Williams (Associate Specialist, Oncology)	Yes	Yes
NCAORP/2020/33	National Neonatal Audit Programme (NNAP)	Mandy Cooke (Neonatal Services Manager)	Dr Brendan Harrington (Consultant Paediatrician)	Dr Geedi Farah (Consultant Paediatrician), Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Shakir Saeed (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/34	National Maternity & Perinatal Audit	Fiona Giraud (Director of Midwifery and Women's Services)	Maureen Wolfe (Matron)	Dr Niladri Sengupta (O&G Consultant)	Fiona Giraud (Director of Midwifery and Women's Services)	Yes	Yes
NCAORP/2020/35	Epilepsy 12 - Clinical	Dr Kathryn Foster (Consultant Paediatrician)	Dr Praveen Jauhari (Consultant Paediatrician)	Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Kathryn Foster (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/36	National Clinical Audit of Psychosis	Dr Mike Jackson (Consultant Psychologist)	Dr Mike Jackson (Consultant Psychologist)	Dr Mike Jackson (Consultant Psychologist)	Dr Mike Jackson (Consultant Psychologist)	Yes	Yes

NCAORP projects not applicable to BCUHB: (due to commissioned services elsewhere):

NCAORP/2020/37: National Adult Cardiac Surgery Audit

NCAORP/2020/38: National Congenital Heart Disease Audit

NCAORP/2020/39: Paediatric Intensive Care Audit (PICaNet)

Tier 2 Plan

Project Ref Number	Project Title	Int/ext guidance	Corporate policy	External review	Reaudit / continuous	Risk Register	Which BCUHB priority does this support?	Accountable Lead(s)	Responsible Corporate Group	In year Data Collection	In-year Report	Risk Assessment *(see key below)*
Acute/20/01	Ward Manager Weekly Audit			Y	Y	Y	Highly reliable clinical care	Site Directors of Nursing	Secondary Care Quality Group	Yes	Yes	Critical
Acute/20/02	Shine Tool (Emergency Department Safety Checklist)	Y		Y		Y	Reduce patient harms	Emergency Quadrant Heads of Nursing	Secondary Care Quality Group	Yes	Yes	Critical
Acute/20/03	Outlier Matrix		Y			Y	Reduce patient harms	Site Matrons / CSM's	Secondary Care Quality Group	Yes	Yes	High
Acute/20/04	Oxygen Competencies	Y	Y			Y	Highly reliable clinical care. Reduce patient harms	Julie Smith (Associate Nurse Director: Quality Improvement - Secondary Care)	Medical Gases Committee	Yes	Yes	High
Acute/20/05	IV Morphine (compliance against guidelines and record keeping)		Y		Y	Y	Highly reliable clinical care. Reduce patient harms	Julie Smith (Associate Nurse Director: Quality Improvement - Secondary Care)	Professional Advisory Group (PAG) / Safe Medication Steering Group	Yes	Yes	High
Acute/20/06	Enhanced Care	Y		Y		Y	Highly reliable clinical care	Site Directors of Nursing	Secondary Care Quality Group	Yes	Yes	Medium
CORP/04/20	Ward Accreditation Monthly Metrics	Y		Y			Highly reliable clinical care. Reduce patient harms	Deborah Carter (Associate Director Of Quality Assurance)	Senior Nursing Team	Yes	Yes	Critical
IP&C/20/01	Hand Hygiene audits	Y	Y	Y	Y		Quality and Safety. Reduction in healthcare associated infections	Amanda Miskell, Assistant Nurse Director: Infection Prevention & Control (IP&C)	Local IPG. Infection Prevention Strategic Group (IPSG)	Yes	Yes	High
IP&C/20/02	Decontamination Audits	Y	Y	Y	Y	Y	Quality & Safety. Reduction in healthcare associated infections	Amanda Miskell, Assistant Nurse Director: Infection Prevention & Control (IP&C)	Exceptions to Strategic Decontamination Group then IPSG	Yes	Yes	Critical
CORP/01/20	Record Keeping	Y	Y		Y		Highly reliable clinical care. Reduce patient harms	Site Medical Directors; Dr Steve Stanaway, Dr Emma Hosking, Dr Karen Mottart reporting to the Secondary Care Quality Committee and thereafter QSG	Secondary Care Quality Group	Yes	Yes	Critical

Project Ref Number	Project Title	Int/ext guidance	Corporate policy	External review	Reaudit / continuous	Risk Register	Which BCUHB priority does this support?	Accountable Lead(s)	Responsible Corporate Group	In year Data Collection	In-year Report	Risk Assessment *(see key below)*
Corp/OMD /Consent/20/01	Informed Consent within Secondary Care – A Retrospective Re-audit of Consent forms.	Y	Y		Y	Y	Highly reliable clinical care. Reduce patient harms	Site Medical Directors; Dr Steve Stanaway, Dr Emma Hosking, Dr Karen Mottart reporting to the Secondary Care Quality Committee and thereafter QSG	Consent and Capacity Strategic Working Group	Yes	Yes	Critical
RES/20/01	2222 Audit	Y	Y	Y	Y	Y	Highly reliable clinical care. Reduce patient harms. Quality and Safety	Christopher Shirley (Professional Development Lead : Resuscitation) Sarah Bellis Hollway (Resuscitation Services Manager)	BCUHB Resuscitation Committee, & Rapid Response to Acute Illness Learning Set (RRAILS), sepsis and Acute Kidney Injury (AKI) Steering Board	Yes	Yes	High
HTA/HA/2020	Auditing compliance with the Human Tissue Act - Human application	Y		Y	Y		Highly reliable clinical care.	Enid Lloyd Jones (Stem Cell Specialist Service Manager)	Pathology Management and Stem Cell Service	Yes	Yes	Critical
HTA/PM/2020	Auditing compliance with the Human Tissue Act - Post Mortem Sector	Y		Y	Y		Highly reliable clinical care.	Dr Huyam Abdelsalam (Consultant Histopathologist)	North Wales Managed Clinical Services (NWMCS) Quality Committee	Yes	Yes	Critical
BSQR/2020	Auditing compliance with the Blood Safety and Quality Regulations	Y		Y	Y		Highly reliable clinical care. Reduce patient harms	Blood Bank Managers - Joe Leung (YG), Nicola Polley (YGC) and Tony Coates (WMH)	NWMCS Quality Committee	Yes	Yes	Critical
ISO15189/ 2020	Annual audit calendar (minimum 12 audits per site/service) Auditing compliance with ISO 15189. Blood Science service on 3 sites, and Cellular Pathology service on one site.	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Bernadette Astbury (Head of Pathology Quality and Governance)	NWMCS Quality Committee	Yes	Yes	Critical
MedPhys/2020	Accreditation and on-going compliance with ISO9001:2015 Quality Management System. External accreditation on 36 month cycle, each section has tailored internal audit schedule.	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Mel Lewis, (Medical Physics Quality Lead)	NWMCS Quality Committee	Yes	Yes	Medium
IRR/2020	BCU Ionising Radiation Protection Regulations compliance audits (Minimum 2 a year performed by Head of Quality & Governance and Medical physics expert at any site or department in BCUHB where imaging takes place)	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	Overarching Radiation Protection Committee	Yes	Yes	Critical
IRMER/PI/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Patient Identification completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical

Project Ref Number	Project Title	Int/ext guidance	Corporate policy	External review	Reaudit / continuous	Risk Register	Which BCUHB priority does this support?	Accountable Lead(s)	Responsible Corporate Group	In year Data Collection	In-year Report	Risk Assessment *(see key below)*
IRMER/RPD /2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Patient Dose completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/PS/ 2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Pregnancy Status completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/RP/ 2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Practitioner completed annually for each Radiology service	y	y	y	y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
QSI/2020	Annual audit calendar (minimum 6 audits per site) Auditing compliance with Ionising Radiation (Medical Exposure) Regulations, Ionising Radiation Regulations, requirements for clinical audit and audits of the service as part of the requirements for Quality Standards in Imaging Accreditation	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
P&MM/20/ 01	Antimicrobial Point Prevalence Audit (Inpatients)	Y		Y	Y	Y	Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Charlotte Makanga (Consultant Antimicrobial Pharmacist)	Antimicrobial Steering Group	Nov-19	May 2020 (by Public Health Wales)	High
P&MM/20/ 02	Antibiotic Review Kit (ARK)/Start Smart then Focus audit via Public Health Wales tool	Y		Y		Y	Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Charlotte Makanga (Consultant Antimicrobial Pharmacist)	Antimicrobial Steering Group	April 2020 provided PHW tool available	Awaiting report scheduling from PHW (May 2021 suggested)	High
P&MM/20/ 03	All Wales Inpatient Medication Safety Audit	Y		Y	Y	Y	Keeping People Safe from Avoidable Harm	Assistant Directors of Pharmacy and Medicines Management (Susan Murphy, Bill Duffield, Louise Howard-Baker)	Safer Medicines Steering Group	Ongoing monthly audit	Ongoing monthly audit	High
P&MM/20/ 04	Safe and Secure Handling of Medicines in Clinical Areas	Y	Y	Y	Y	Y	Keeping People Safe from Avoidable Harm	Julie Smith (Associate Nurse Director: Quality Improvement - Secondary Care)	Safer Medicines Steering Group	Ongoing	Yes	High
P&MM/20/ 05	Controlled Drugs: storage, handling and record keeping in pharmacies and clinical areas	Y	Y		Y		Keeping People Safe from Avoidable Harm	Dr Berwyn Owen (Chief Pharmacist)	Controlled Drugs Local Intelligence Network	Ongoing quarterly audit	Quarterly	Critical

Project Ref Number	Project Title	Int/ext guidance	Corporate policy	External review	Reaudit / continuous	Risk Register	Which BCUHB priority does this support?	Accountable Lead(s)	Responsible Corporate Group	In year Data Collection	In-year Report	Risk Assessment *(see key below)*
P&MM/20/06	Compliance with the BCUHB Unlicensed Medicines Policy (MM42)	Y	Y		Y		Keeping People Safe from Avoidable Harm	Teena Grenier (Medicines Governance Lead Pharmacist)	Drug & Therapeutics Group	Yes	Yes	High
P&MM/20/07	Best value biologic - audit of Adalimumab biosimilar uptake	Y		Y			Value-Based healthcare	Teena Grenier (Medicines Governance Lead Pharmacist)	Drug & Therapeutics Group	Mar-20	Yes	Medium
P&MM/20/08	Audit of Prescribing Standards within Cancer Services	Y	Y				Keeping People Safe from Avoidable Harm	Bill Duffield (Assistant Director For Pharmacy-Central)	Pharmacy Cancer Services group	Yes	Yes	High
Research 20/01	Audit and monitoring of hosted studies (for high and medium risk categorised studies) following Assess, Arrange, Confirm process	Y			Y		Highly reliable clinical care. Reduce patient harm	Research Manager	Research senior management team group	Yes	Yes	Low
Research 20/02	Audit and monitoring of sponsored studies	Y			Y		Highly reliable clinical care. Reduce patient harms	Research Manager	Research senior management team group	Yes	Yes	Low
Research 20/03	Research policies and Standard Operating Procedures (SOPS)	Y			Y		Reduce patient harms	Research Manager	Research senior management team group	Yes	Yes	Low

Risk classification criteria:	
Critical	Control weakness could have a significant impact on the system, function or process and achievement of organisational objectives in relation to compliance with laws and regulations or the efficient and effective use of resources.
High	Control weakness could have a significant impact on the system, function or process but does not have an impact on the achievement of organisational objectives (as above)
Medium	Control weakness has a low impact on the achievement of the key system, function or process or a low degree of risk associated with exposure.
Low	Control weakness has no impact on the achievement of the key system, function or process objectives; however, improved compliance would improve overall control.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 19th March 2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Internal Audit Progress Report - 1st December 2019 to 29th February 2020**
Cyfarwyddwr Cyfrifol: Responsible Director:	Justine Parry – Acting Board Secretary
Awdur yr Adroddiad Report Author:	Dave Harries – Head of Internal Audit
Craffu blaenorol: Prior Scrutiny:	The progress report has been discussed with and agreed by the Acting Board Secretary and details the individual opinions issued by internal audit.
Atodiadau Appendices:	• Appendix 1: Progress Report • Appendix 2: Partnership governance - Section 33 Agreements Limited Assurance Report • Appendix 3: Quality Improvement Strategy Limited Assurance Report

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive the progress report; and
- Approve the deferment of the Ysbyty Wrexham Maelor Hospital – Backlog maintenance risk management capital review.

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

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

Sefyllfa / Situation:

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

Cefndir / Background:

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

- Substantial assurance (green) – one;
- Reasonable assurance (yellow) – one; and

- Limited assurance (amber) – two.

The report also details:

- Reviews issued at draft reporting stage as well as work in progress;
- Follow-up status of thirteen recommendations subject to follow-up review in the period.

Asesiad / Assessment & Analysis

Strategy Implications

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

Financial Implications

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

Risk Analysis

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

Legal and Compliance

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

Impact Assessment

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

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

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

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Internal Audit Progress Report

1st December 2019 to 29th February 2020

Audit Committee 2019/2020

Betsi Cadwaladr University Local Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

Contents

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

Please note:

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

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

Introduction

1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues and progress against the Internal Audit (IA) Plan for 2019/20 which have been finalised since the last Committee meeting. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Acting Board Secretary.

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

Reports Issued

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

Table 1 – Summary of assurance reviews issued as final

Title	Assurance Level	High	Medium	Low	Key Messages
Follow-up of the 2017/18 Safeguarding report Review completed January 2020 with Executive approval February 2020 *All recommendations have been implemented.*	Substantial	-	-	-	The review identified that management had implemented all recommendations from the limited assurance review in 2017/18. However, whilst Corporate Safeguarding have progressed all areas within their control, we wish to highlight two areas that require support: • Cleansing of the BCUHB old intranet site to remove access to outdated policies and procedures; • Health Board wide training compliance needs further improvement to build on the upward trend.
Non-emergency patient transport service (NEPTS) Review completed December 2019 with Executive approval February 2020 *There is a lack of performance management in relation to contract*	Reasonable	1	1	-	Governance and accountability arrangements for the management of NEPTS The Health Board commissioned an external advisor in 2017 to review NEPTS arrangements. The report to the Executive Management Group, advised that a single directorate be responsible and accountable for both the commissioning and management of NEPTS within the Health Board. We are unclear whether this recommendation was accepted by the Health Board. *NEPTS contract* The Health Board historically had a NEPTS SLA with Welsh Ambulance Service Trust (WAST) for

Title	Assurance Level	High	Medium	Low	Key Messages
monitoring of NEPTS. In addition, the introduction of an all-Wales NEPTS contract, by WAST, has slipped.					the provision of NEPTS (outpatients, discharge and transfer service) at a value of £4.7M. In addition the Health Board was commissioning transport providers outside the contract, at a value of over £0.5M. In October 2018, the Director of Estates and Facilities presented a paper to the Executive Team which advised the following: *"The NEPTS Service Level Agreement (SLA) in place with the Welsh Ambulance Service Trust (WAST) was outdated, therefore did not meet the needs of the Health Board (HB).* *- Minimal scrutiny relating to the performance and quality of service provision. Basically, we were accepting what WAST wanted to, or were able to deliver."* *Third party contracts* There were no contracts in place with any third party transport providers, until this was addressed via the referral of providers into the '365 Response' framework, and a draft contract has been awaiting approval by the Contracting Team since September 2018. However, WAST have asked that the Health Board not issue their own provider contract, as they will be issuing their own version with each of the providers. The first contract novation meeting was held on July 2018. There was a further novation meeting held in June 2019, following which WAST produced NEPTS Novation proposal - the current target is January 2020. *Governance of providers & Standing Financial Instructions (SFIs)* Since the introduction of '365 Response' portal in November 2017, all patient journey requests are channelled via a new single point of contact. Transport requests are now sent out to all providers (there are currently thirty (30) providers on the framework) which can quickly generate a number of bids. There have been cases identified of journeys being direct-awarded to companies that may not have signed up to patient transport-specific Terms & Conditions. Management provided

Title	Assurance Level	High	Medium	Low	Key Messages
					some examples of these journeys and recent invoice from one particular company (September 2019) shows that they are still being used for patient discharges outside the 365 framework - 14 journeys carried out to Ysbyty Glan Clwyd over 10 days period between 2nd and 30th of September 2019 , total of £238. Management advised that similar examples are also available for Ysbyty Gwynedd. *Delivery plan and future management of the NEPTS contract* Historically, the NEPTS SLA was subject to very little performance management. With the establishment of the monthly NEPTS Review and Development Group (RDG), the agreement was subject to monthly scrutiny via the sharing of a graphical analysis by WAST at each meeting. The NEPTS RDG is not currently active and last met in February 2019.
Partnership governance - Section 33 Agreements Review completed November 2019 with Executive approval January 2020 *There is a lack of assurance reported through the management and Committee structure regarding the performance of each Section 33 agreement. In addition, the Health Board is not compliant with the Statutory Instrument where it is the host partner.*	Limited	2	1	-	The review has identified that only the Flintshire Community Equipment Store has a current signed Section 33 Agreement by the Health Board. There is a lack of internal control concerning the governance and management of all Section 33 Agreements where there is no apparent oversight ensuring agreements are subject to regular review and that none lapse. Variances in the agreements were noted when comparing against the Statutory Instrument particularly where the role of 'Pool Manager' was not specified to a specific post, akin to that in the Flintshire agreement. In addition, the Health Board has not complied with the requirements of the Statutory Instrument relating to its hosted Community Equipment Store as there is no apparent audit of the accounts of the pooled fund arrangement – Conversely, the Health Board did report receipt of three pooled budget Memorandum Accounts in 2018/19. Recognising changes have taken place in partnership working and meeting arrangements with the introduction of more recent Legislation,

Title	Assurance Level	High	Medium	Low	Key Messages
					the requirements to maintain scrutiny over the pooled fund remain extant. As such, it is imperative that management ensure the requirements of the relevant agreements continue to be met. Reporting assurance arrangements within the Health Board is poor. For all the agreements we reviewed, we were advised that none are subject to reporting within existing governance reporting structures. This is further evident as we could find no reporting through to SPPH. We note the proactive step taken by the West Area to amalgamate the Specialist Children Service management boards into one meeting with both Gwynedd and Isle of Anglesey County Councils – This should now be formalised through an updated Section 33 Agreement by all three partners.
Quality Improvement Strategy Review completed December 2019 with Executive approval February 2020 *We were unable to confirm that the Strategy has delivered its intended actions over the three years as there was no underpinning plan stating what the Health Board intended to do. Limited reporting on progress was evident and Welcome Boards across some wards are not*	Limited	2	-	-	In reviewing evidence and papers to support this review, we could find no evidence of a formal launch of the QIS, akin to other strategies/initiatives. <u>Implementation Plan</u> Paragraph 6.0 in the QIS titled '*What changes can we make that will result in improvement?'* states the following: *"In order to accomplish our ambitious aims we will need a far reaching plan to engage with staff on finding solutions right across the Health Board."* We met with key officers in the Health Board to request and discuss sight of an implementation plan underpinning the QIS and were advised that, as far as they were aware, no implementation plan existed. Whilst it is apparent that a number of initiatives are being/have been progressed under the umbrella of the QIS [e.g. Sepsis Six; Safe Clean Care; open visiting policy; ward accreditation], we cannot state, definitively, that the QIS (now in its third year) has delivered what it set out to achieve.

Title	Assurance Level	High	Medium	Low	Key Messages
being maintained.					This is predicated on the fact that there is no specific project plan outlining the steps that could/should have been undertaken to deliver the strategy through which management report progress, thus enabling scrutiny – We cannot provide assurance that everything that has been done was timely/needed or what should have been done [at the time of this review] has been done. <u>Reporting progress</u> In reporting progress, the QIS stated in paragraph 9.0 Conclusion *"Progress against the Quality Improvement Strategy will be reported in the Annual Quality Statements to be published each year."* We reviewed the Annual Quality Statements (AQS) for 2017/18 and 2018/19 and recognised that each year, under Welsh Health Circular, each NHS Wales organisation is required to follow a set template report for the AQS. Whilst recognising this, we cannot see sufficient narrative within both AQS that report progress against the QIS. <u>Quality/Welcome Boards</u> We visited forty five (45) wards across the Health Board in November 2019 to review compliance and identified the following themes: • A small number of wards were fully compliant with timely reporting and information required; • Not all wards were using the templates appendix C1A – Patient Safety, C1B Patient safety – run charts or appendix D1 – Patient Experience; • Some key data was not recorded e.g. missing ward telephone number, ward name; • We found it difficult to confirm the requirements of the Standard Operating Procedure for updating weekly/monthly information for patient safety and patient experience is routinely happening – we found examples of patient safety information

Title	Assurance Level	High	Medium	Low	Key Messages
					having not been updated since June, August and September 2019 across several wards; • Nurse staffing data for some wards was not reflective of the month visited, we found September 2019 for one ward.

Work in Progress Summary

4. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Welsh Risk Pool Claims Management Standard	Draft report issued.	2nd March 2020
Budget setting	Draft report issued for management review and management response received 4th March 2020. Await Executive approval to issue.	30th January 2020
Salary overpayments	Draft report issued for management review.	5th March 2020
Deprivation of Liberty Safeguards (DoLS)	We have discussed the draft report and have received comments but await formal management response.	16th January 2020
NHS Wales staff survey – delivering the findings	Draft report issued for management review.	27th February 2020
Recruitment: Medical and Dental Staff	Discussion draft report issued.	4th March 2020
Joint follow-up with Conwy County Borough Council Internal Audit Service: Conwy Community Mental Health Team (CMHT)	The Health Board specific follow-up review was issued on the 5th December 2019 and we met with management on the 12th and 17th December 2019 to agree the report. We met with Conwy Internal Audit Services to discuss both reports on the 6th February 2020; the findings have been consolidated into one report. The Acting Director and Head of Internal Audit are scheduled to meet Conwy's Strategic Director of Social Care and Education and Internal Audit on the 23rd March 2020 to progress the combined draft report.	5th December 2019

Fieldwork

5. The following reviews are currently in progress:

- Delivery of savings against identified schemes – Focusing on Secondary Care – Central (Glan Clwyd), we have met with the interim Chief Finance Officer to

progress the review.

- HASCAS & Ockenden external reports: Recommendation progress and reporting – Two finalised actions have been reviewed and evidence provided supports the management action taken. We have noted that on-going assurance of continuous implementation for both recommendations needs to take place through existing assurance reporting mechanisms.
- Quality Impact Assessment – Review is complete and draft report to be issued.
- Decontamination – Wrexham Maelor, Deeside Community Hospital and Ysbyty Glan Clwyd testing complete with Colwyn Bay Community Hospital and Ysbyty Gwynedd to complete.
- Cyber security – We have met with the Head of ICT Services and received evidence to support the review.
- Welsh Community Care Information System (WCCIS) – Brief agreed and testing to start imminently.
- Managed General Practitioner Practices – Testing has commenced.
- Roster management – Sample has been identified and ward based visits to review evidence of timesheets is to begin.
- North Denbighshire Community Hospital – Fieldwork is complete and draft report to be issued.
- Substance Misuse Action funds – Fieldwork is complete and draft report is being prepared.

Follow Up

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

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

Table 3: Follow-up status of recommendations reviewed

Review Title	Recommendation Title	Follow-up status
HMP Berwyn – Health Board Governance and Assurance	Financial Management Processes	Closed - Verified
Informatics: Service desk	KPI data	Closed - Verified
Job Evaluation	Advertising posts	Closed - Verified
Occupational Health	Occupational Health benchmarking data	Closed – Verified
Occupational Health	Delivery of operational objectives	Closed - Verified

Review Title	Recommendation Title	Follow-up status
Occupational Health	Core aims and objectives - Reduce ill health in workers caused or made worse by work	Closed - Verified
Occupational Health	Core aims and objectives - beyond basic statutory requirements	Closed - Verified
Occupational Health	Questionnaire results	Closed - Verified
Staff Personal Appraisal and Development Reviews (PADRs)	Non-compliance with the NHS Outcomes Framework 2016 (023) Measures 91,92 and 93	Closed - Verified
Staff Personal Appraisal and Development Reviews (PADRs)	Staff Appraisal source data on ESR reconciled to staff personal files	Closed - Verified
Safehaven	Keeping Individuals up to date on the status and outcome of Safehaven concerns	Closed - Verified
Safehaven	Raising Concerns Policy WP4a Whistle Blowing	Closed - Verified
Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference?	Reporting arrangements and assurance	Closed - Verified

Third party assurance

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

Delivering the Plan

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

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

11. The following review has been identified for deferment from the 2019/2020 original plan and has been agreed in principle with the Acting Board Secretary prior and subject to Audit Committee approval:

    Ysbyty Wrexham Maelor Hospital – Backlog maintenance risk management

    Following recent planning discussions, management requested that the commencement of this review be deferred until Q1 of 20/21. Primarily as funding from Welsh Government will not be released until April and that management are currently establishing governance arrangements for the scheme and appointing their key advisers.

12. 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.

13. Table 4 is reporting a positive status across all indicators although management response to draft report has increased to 71% [1%] from the last Committee reporting period. We continue to experience delays in turnaround times of the management response and are referring more this year for the Acting Board Secretary's attention per the Charter.

Table 4 – Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement] with agreed extension by the Executive Lead at time of agreeing the audit brief	Green	71%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 5 – Core Plan 2019-20

Planned output	Outline timing	Status	Assurance
Corporate governance, risk and regulatory compliance			
Annual Governance Statement	Q1	Complete – Head of internal audit annual report.	N/A
Welsh Risk Pool Claims Management Standard	Q4	Draft report issued.	
Health and Safety	Q1-2	Final report issued.	Reasonable
Welsh Language (Wales) Measure 2011	Q1	Final report issued.	Limited
~~Health Board governance arrangements – Quality & Safety~~	~~Q2-3~~	Recommended for deferment.	Recommended for deferment – This review would duplicate that of the Wales Audit Office.
Compliance with Standing Financial Instructions – Procuring goods and services: Estates - GRAMMS	Q1	Final report issued.	Reasonable
Compliance with Standing Financial Instructions – Procuring goods and services: Therapies – Therapy Manager	Q1-2	Final report issued.	Reasonable

Planned output	Outline timing	Status	Assurance
~~Compliance with Standing Financial Instructions – Procuring goods and services: Pharmacy EDS~~	Q1-2	Brief agreed with operational management.	Recommended for removal - The review of information from the system has confirmed that no individual transaction was in excess of £5,000 requiring a competitive quotation/
~~Compliance with Standing Financial Instructions – Procuring goods and services: Community Dental Services~~	Q1-2	Brief agreed with operational management.	Recommended for removal - The review of information from Finance has confirmed that no individual transaction was in excess of £5,000 requiring a competitive quotation/
Strategic planning, performance management and reporting			
Performance measure reporting to the Board – Accuracy of information	Q2-3	Deferred to April 2020.	Audit Committee approved delay of this review to enable March 2020 review of RTT activity and reporting.
Partnership governance - Section 33 Agreements	Q2-3	Final report issued.	Limited
Financial governance and management			
Delivery of savings against identified schemes	Q2-3	Work in progress.	
Budget Setting	Q2-3	Draft report issued.	
Salary overpayments	Q3	Draft report issued.	
Quality and Safety			
Annual Quality Statement	Q1	Final report issued.	Reasonable
HASCAS & Ockenden external reports – Recommendation progress and reporting	Q1-2	Work in progress.	Two of eleven closed actions have been reviewed and we await receipt of evidence relating to the remaining closed actions.
Quality Impact Assessment	Q2	Work in progress.	
Safeguarding Follow-up	Q2-3	Final report issued.	Substantial
Decontamination	Q3	Work in progress.	
Deprivation of Liberty Safeguards (DoLS)	Q3	Draft report issued.	
Quality Improvement Strategy	Q2-3	Final report issued.	Limited
Information governance and security			
Welsh Community Care Information System (WCCIS)	Q4	Work in progress.	
GDPR – Follow-up of the Information Commissioners Office (ICO) review	Q2	Final report issued.	Reasonable
~~Caldicott – Principles into Practice (CPiP) self-assessment~~	~~Q2~~	Deferred.	Approved for deferment by Audit Committee - Planned changes in the reporting tool and migration to a new process are taking place, as advised, in 2019/20.

Planned output	Outline timing	Status	Assurance
Cyber security	Q3	Work in progress.	
Operational service and functional management			
Managed General Practitioner Practices	Q4	Work in progress.	
~~Cluster governance arrangements~~	Q3-4	Deferred.	Recommended for removal - Proposals being considered to develop integrated health & social care localities which potentially will have significant delegated responsibilities for planning and providing for the population. The localities are the same footprint as current clusters we were told that it is unclear, currently, whether they incorporate the current primary care clusters, or run parallel.
~~Continuing Health Care~~	Q3	Deferred.	Recommended for deferment to 2020/21 as the planned scope would duplicate that of the National Commissioning Collaborative (NCC) which the Health Board have engaged. This will allow for any system/process changes agreed by the Health Board following this external review to be embedded.
Non-Emergency Patient Transport Service (NEPTS)	Q3	Final report issued.	Reasonable
Joint follow-up with Conwy County Borough Council Internal Audit Service: Conwy Community Mental Health Team (CMHT)	Q4	Draft report issued.	
Workforce management			
Roster management	Q4	Work in progress.	
NHS Wales staff survey – delivering the findings	Q3-4	Draft report issued.	
Recruitment	Q4	Draft report issued.	
Capital and estates management			
Environmental sustainability report	Q1	Final report issued.	Reasonable
Carbon Reduction Commitment Order	Q1	Final report issued.	Substantial
Statutory Compliance: Fire Safety	Q1-2	Final report issued.	Reasonable
Ysbyty Gwynedd Emergency Department	Q1	Final report issued.	Reasonable
~~Capital Systems: Primary Care benefits realisation~~	Q1	Deferred.	Gateway 5 review will provide assurance to the Health Board.
North Denbighshire Community Hospital	Q4	Work in progress.	

Planned output	Outline timing	Status	Assurance
Ysbyty Wrexham Maelor Hospital – Backlog maintenance risk management	Q4	Recommended for deferment.	Following recent planning discussions, management requested that the commencement of this review be deferred until Q1 of 20/21. Primarily as funding from Welsh Government will not be released until April and that management are currently establishing governance arrangements for the scheme and appointing their key advisers. A revised brief will be issued and the output for the assignment anticipated during late Q1/Q2.
Substance Misuse Action funds	Q3-4	Work in progress.	
Compliance with the public sector internal audit standards – Contingency/assurance reviews			
Ysbyty Gwynedd Emergency Department Patient Monitors	Q1	Final report issued.	Assurance not applicable

Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Partnership governance - Section 33 Agreements

Final Internal Audit Report

BCU 2019/20

January 2020

NHS Wales Shared Services Partnership

Contents **Page**

Review reference:	BCU-1920-11
Report status:	Final Internal Audit Report
Fieldwork commencement:	10th October 2019
Fieldwork completion:	15th November 2019
Draft discussion report issued:	15th November 2019
Draft report issued:	22nd November 2019
Management response received:	8th January 2020
Final report issued:	10th January 2020
Executive approval:	24th January 2020
Auditor/s:	Head of Internal Audit Audit Manager - Capital
Executive sign off:	Director of Finance
Distribution:	Clinical Director Therapy Services Assistant Area Director Community Services (Central) Assistant Area Director of Therapy Services (East) Assistant Area Director Children's Services (West) Assistant Area Director Primary Care (West) Chief Finance Officers – Central; West; East Acting Board Secretary Statutory Compliance, Governance & Policy Manager
Committee:	Audit Committee

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

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

Disclaimer notice - Please note:

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

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

1. Introduction and Background

The purpose of this review sought to provide the Health Board with assurance that existing process delivered against the good practice guide for Boards "Governing Effectively in Partnership" and Section 33 of the NHS (Wales) Act 2006.

"Governing Effectively in Partnership" outlines that delivering high quality healthcare can only be achieved by working in collaboration with other agencies, whether it is public, private, voluntary, and particularly local authorities.

Statutory Instrument *'National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000, No 2993 (W.193)'* came into force the 1st December 2000. These Regulations made provision for certain National Health Service bodies and Local Authorities to enter into arrangements ("partnership arrangements") for the exercise of specified functions.

Section 33 of the National Health Service (Wales) Act 2006 enables local authorities and local health boards (LHBs) to develop formal partnerships and to delegate functions from one body to the other. This legislation was originally introduced with the Health Act 1999 and the measures were consolidated into the 2006 Act. This legislation enables a local authority to delegate certain specified functions from local authorities to the local health board, or for the local health board to delegate certain specified functions to the local authority. The legislation also allowed for the development integrated service provision, integrated commissioning and pooled budgets.

2. Scope and Objectives

The scope of the review considered the Health Board's compliance in ensuring that the formal agreements comply with Section 33 – '*Arrangements between NHS bodies and local authorities*' of the NHS (Wales) Act 2006 (*Chapter 42 Part 3: Local Authorities and the NHS*).

The objective of this review provides assurance over the governance arrangements in place to support the various Section 33 Agreements. The audit:

- Reviewed compliance with the *National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000*, specifically that:
  - the arrangement is underpinned by a written agreement which meets the requirements of the regulations;
  - arrangements for the nominated host are appropriate (including ensuring the host recognises responsibility for the budget's overall accounts and audit); and
  - in-year planned reporting is appropriate to the needs of the Health Board, and meets the minimum requirements of the regulations (the host must provide quarterly reports to all parties to the pool, including income, expenditure and other relevant information).

3. Associated Risks

Risks identified at the outset of this review were:

- Failure to comply with Legislation;
- Absence of accountability and formal partnership arrangements;
- Unclear structure leading to poor management reporting; and
- Lack of ownership of service.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the **Partnership governance - Section 33 Agreements** review is limited assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Written agreements		✓		
2	Nominated host arrangements			✓	
3	In-year reporting		✓		

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Partnership governance - Section 33 Agreements.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weakness in the operation of the designed system/control for Partnership governance - Section 33 Agreements.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

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

We are grateful to the Heads of Internal Audit/Chief Internal Auditors from the six local authority partners who provided us with information that underpinned this review.

Information provided identified eight Section 33 Agreements; a further one which we could not confirm remained a formal agreement; and two further agreements which are currently draft.

The Health Board Scheme of Delegation to Executive Directors, Other Directors and Officers identifies the following, as detailed in table 1:

Table 1 – Delegated Matter

Delegated Matter	Delegated to	Operational responsibility
46. National Health Services (Wales) Act 2006 Section 33 Agreements: Arrangements between NHS Bodies and Local Authorities	Chief Executive	Executive Director of Finance

Source: Health Board web site – Scheme of Delegation to Executive Directors, Other Directors and Officers Version 20
http://www.wales.nhs.uk/sitesplus/documents/861/Schedule%201%20SoRD%20V20.0.pdf

We contacted the Finance Department's contracting section to ascertain if there was a list of all agreements with partners but did not receive any details. We were provided with details from the Chief Finance Officers for Central and West who signposted us to key contacts.

In reviewing the three Area Schemes of Delegation to Executive Directors, Other Directors and Officers, all identified the Area Director responsible for signing the Section 33 Agreement.

Written agreements

The eight agreements we were notified of from Local Authority partners are detailed in table 2 below - Our sample of five agreements we reviewed are shaded.

Table 2 – Section 33 Agreements in place with Local Authority partners

Section 33 Agreement	Local Authority partners	Latest Agreement date	Host partner
Community Equipment Store	Conwy County Borough Council; Gwynedd County Council; Isle of Anglesey County Council	1st April 2018 for 12 months Not signed	Health Board
Community Equipment Store	Denbighshire County Council	1st April 2018 to 31st March 2021 Not signed	Denbighshire County Council
Community Equipment Store	Flintshire County Council	Commencement date is not specified in copy provided Signed by East Area Director 1st August 2018	Flintshire County Council
Health & Social Care Support Workers	Denbighshire County Council	1st April 2018 for 5 years Not signed	Denbighshire County Council
Dementia Support Workers	Gwynedd County Council (recently agreed on 29th September 2019)	Not reviewed	-
Information Family Support Service	Isle of Anglesey County Council	Not reviewed	-
Specialist Children Services	Isle of Anglesey County Council	1st September 2013 to 31st August 2016 (signed under Seal) Not updated and records as a non-pooled fund	Isle of Anglesey County Council

Section 33 Agreement	Local Authority partners	Latest Agreement date	Host partner
Specialist Children Services (Derwen)	Gwynedd County Council	Not reviewed	-

We are grateful to officers within the Areas and Local Authorities who provided agreement specific information to support this review.

There is a template Section 33 Agreement (agreement) available to use and our testing confirmed this was the case for all five agreements reviewed, subject to some local amendment.

Only the Flintshire Community Equipment Store has a current Health Board signed [by the Area Director] agreement.

The remaining four agreements are out of date with the updated agreements for three of the sample as reviewed appearing not to have been signed by the Health Board.

In meeting the Assistant Area Director to review the Specialist Children Service agreement with the Isle of Anglesey County Council, we noted evidence of discussions to update the agreement as it is out of date and does not appear to have been updated since 2016; it is apparent through reviewing the agreement it is no longer reflective of the Health Board's organisational structure.

National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 No.2993 (W.193) – Pooled fund arrangements specifies expected content for an agreement and we reviewed each agreement to this.

We identified:

- All recorded the aims and objectives of the agreement.
- Contributions from partners is noted, however these are out of date and not reflective of current financial year agreed funding. We also noted one was a non-pooled fund agreement and one did not include the contributions as the appendix was missing.
- Functions of both the NHS and Local Authority covered by the agreement were recorded.
- Service user details covered by the agreement were noted although one was incomplete.
- Not all agreements were explicit on accommodation arrangements.
- Duration of the agreement and termination arrangements were clear.
- All recorded the lead partner (host organisation) for the agreement.

Nominated host arrangements

The review has identified that host arrangements are relevant for the service. Reviewing the agreements we noted the following:

- Except for Flintshire Community Equipment Store, none of the remaining four agreements clearly detailed an officer, by post, who was the 'Pool Manager'.
- Host partner responsibilities were recorded however we noted one did not have specific narrative on audit of the fund and one is also a non-pooled fund.
- The Health Board does receive Memorandum Accounts from Denbighshire County Council (for both pooled funds) and Flintshire County Council as recorded in the 2018/2019 Annual Accounts: Memorandum Note 32 – Pooled Budgets.
- Health Board is not compliant with the audit requirements of the Community Equipment Store at Bryn y Neuadd as there is no specific audit of the pooled fund sent to partner organisations, per the following extract from *National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 No.2993 (W.193) – Pooled fund arrangements*:
  - *(6) The host partner shall arrange for the audit of the accounts of the pooled fund arrangements and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under section 28(1) (d) of the Audit Commission Act 1998(1).*

In-year reporting

The Health Board has assigned responsibility for partnership assurance to the Strategy, Partnerships and Population Health Committee (SPPH) with paragraph 3.1.7 of its Terms of Reference recording the following:

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

We reviewed the SPPH agenda for reference to Section 33 agreements and assurance reporting and identified that for the April; July; September and October 2019 meetings, no reference or performance update was formally reported to the Committee.

National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 No.2993 (W.193) – Pooled fund arrangements – Section 4b states that the 'Pool Manager' is responsible for:

- *submitting to the partner's quarterly reports, and an annual return, about the income of, and expenditure from, the pooled fund and other information by which the partners can monitor the effectiveness of the pooled fund arrangements.*

All agreements referenced governance arrangements with establishment of an overarching meeting to manage the service, financial and performance elements of the agreement.

Table 3 details the findings from reviewing agenda and minutes and whether they have met the stated reporting requirements – We have not reviewed compliance with Terms of Reference for any agreement.

Table 3 – Agreement meetings report financial and performance data for 2019 financial year

Section 33 Agreement	Governance meeting	Meeting timeline per Agreement	Finding
Llanfairfechan Community Equipment Store	ICES Partnership Board	Bi-monthly	Meetings held 18th June; 20th August; and 15th October 2019 – No meeting evident for April 2019. Agenda Items noted for Finance and Performance reports with the month 12 finance report presented to the June meeting.
Denbighshire Community Equipment Store	Partnership Management Group	Bi-monthly	Monthly Partnership Locality Forum meetings held however we found no finance or performance reports being presented for this service agreement; we did note presentation of Integrated Care Fund monies report and a standing agenda item titled – *Sign off of Section 33* but it is unclear to which agreement this refers
Flintshire Community Equipment Store	Partnership Management Board	Quarterly	Meetings noted for 14th May (postponed); 13th August; and 12th November 2019 with finance and performance matters on the agenda.
Health & Social Care Support Workers	Partnership Management Group	Quarterly	Monthly Partnership Locality Forum meetings held however we found no finance or performance reports being presented for this service agreement; we did note presentation of Integrated Care Fund monies reports and a

Section 33 Agreement	Governance meeting	Meeting timeline per Agreement	Finding
			standing agenda item titled – Sign off of Section 33 but it is unclear to which agreement this refers.
Specialist Children Services	Management Board	Quarterly	Meetings noted for 7th February; 11th April; 18th July; and 17th October 2019 with the October meeting stood down due to a strategy launch. The 7th February 2019 meeting was the first joint meeting with the Gwynedd Specialist Children Service and has remained a joint meeting since this time. Review of agenda does not identify any discussion around performance or finance and now does not meet the management board criteria per the agreement.

Whilst officers from the Health Board attend the relevant partnership management board/group meetings, we sought to evidence how the outcome from these meetings are formally reported for assurance, noting that nothing apparent is reported to SPPH.

We were advised that no routine reporting from these meetings is undertaken through the current operational management structure.

7. Conclusion

The review has identified that only the Flintshire Community Equipment Store has a current signed Section 33 Agreement by the Health Board.

There is a lack of internal control concerning the governance and management of all Section 33 Agreements where there is no apparent oversight ensuring agreements are subject to regular review and that none lapse.

Variances in the agreements were noted when comparing against the Statutory Instrument particularly where the role of 'Pool Manager' was not specified to a specific post, akin to that in the Flintshire agreement.

In addition, the Health Board has not complied with the requirements of the Statutory Instrument relating to its hosted Community Equipment Store as there is no apparent audit of the accounts of the pooled fund arrangement –

Conversely, the Health Board did report receipt of three pooled budget Memorandum Accounts in 2018/19.

Recognising changes have taken place in partnership working and meeting arrangements with the introduction of more recent Legislation, the requirements to maintain scrutiny over the pooled fund remain extant. As such, it is imperative that management ensure the requirements of the relevant agreements continue to be met.

Reporting assurance arrangements within the Health Board is poor. For all the agreements we reviewed, we were advised that none are subject to reporting within existing governance reporting structures. This is further evident as we could find no reporting through to SPPH.

We note the proactive step taken by the West Area to amalgamate the Specialist Children Service management boards into one meeting with both Gwynedd and Isle of Anglesey County Councils – This should now be formalised through an updated Section 33 Agreement by all three partners.

8. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**1**	**0**	**3**

Finding - ISS.1 –Section 33 Agreements and compliance with Statutory Instrument (Operating effectiveness)	Risk
Our review has identified that four of the five agreements reviewed have elapsed, are out of date, not reflective of current practice and have not been signed by the Health Board – We did note however requests from partner organisations to the Health Board to sign new agreements. Reviewing the requirement to provide finance and performance data as part of the agreements identified not all were routinely reporting this. There is no corporate oversight of the agreements.	Non-compliance with Statutory Instrument.
Recommendation	**Priority level**
The Executive Director of Finance (delegated operational responsibility) ensures the Health Board undertakes a review of all Section 33 Agreements to ensure they remain fit for purpose, deliver the expected benefits to service users/partners and comply with the requirements of the Statutory Instrument – Agreements should then be signed as a matter of urgency. We believe a central repository, akin to health related contracts maintained by Finance Contracting section, should be applied for Section 33 Agreements.	**High**
Management Response	**Responsible Officer/ Deadline**
Finance Contracts Team will add Section 33 Agreements to the list of Contracts for the 2020/21 Financial Year onwards. West Area - A draft section 33 has been produced for the Community Equipment	Interim Head of Contracts - April 2020 Assistant Area Director Primary

Store and will be progressed and signed for the financial year 2020/2021. West Area- Children's Disability Partnership. A new agreement to reflect the Gwynedd/Anglesey/BCUHB partnership will be produced with partners. Central Area – Denbighshire CeSI and Health & Social Care Support Workers Section 33 Agreements to be reviewed and signed as a matter of urgency.	Care (West) - May 2020 Assistant Area Director Children's Services (West) - December 2020 Assistant Area Director of Therapy Services (Central) / Assistant Area Director Community Services (Central) – April 2020

Finding - ISS.2 – Health Board as Host Partner (Operating effectiveness)	**Risk**
Our review has identified that the Health Board has not arranged the audit of the accounts of the pooled fund in accordance with *National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 No.2993 (W.193) – Pooled fund arrangements*: *(6) The host partner shall arrange for the audit of the accounts of the pooled fund arrangements and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under section 28(1)(d) of the Audit Commission Act 1998(1).*	Non-compliance with Statutory Instrument.
Recommendation	**Priority level**
The Executive Director of Finance ensures compliance with the requirements of the Statutory Instrument where the Health Board is Host Partner and	**High**

accountable for the audit of the pooled fund accounts.	
Management Response	**Responsible Officer/ Deadline**
The Finance Department will prepare a memorandum account for the pooled budget which will be provided to all partners to the arrangement for inclusion in their respective annual accounts. The memorandum account, along with background information on the pooled budget arrangement, will be included within the Health Board's 2019-20 annual accounts submission and will be audited by Wales Audit Office in accordance with the requirements.	Chief Finance Officer (Central) and Financial Accountant - April 2020

Finding - ISS.3 – Reporting arrangements (Operating effectiveness)	**Risk**
There is a lack of reporting through the organisational and Committee structure on both financial and performance data in relation to S33 Partnership agreements. Had this oversight been in place and scrutiny been applied the unsigned, out of data agreements would have been identified as part of the assurance framework.	Lack of oversight through organisational and corporate governance structure.
Recommendation	**Priority level**

Area Directors, Executive Director of Finance and Board Secretary review the reporting of Section 33 Agreements through the Organisational and Committee Structure to ensure the Health Board is sighted on all partnership matters.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Reporting of Partnership funding and arrangements will be made through the Strategic Partnership & Population Health Committee (SPPH), with the first report being presented to the February 2020 Meeting. West Area - Minutes of the Community Equipment Partnership and the Children's Disability Partnership will be included in the West Area Finance and Performance Committee agenda. Central Area reporting of Partnership arrangements is managed through the Area Integrated Services Board (AISB) East Area - oversight will be via the area Finance and Performance meeting.	Chief Finance Officer (Central) - February 2020 Assistant Area Director Primary Care (West) & Assistant Area Director Children's Services (West) – Immediate Area Director – Central - April 2020 Assistant Area Director of Therapy Services (East) – April 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Quality Improvement Strategy

Internal Audit Report

BCU 2019/20

February 2020

NHS Wales Shared Services Partnership

Contents **Page**

Review reference:	BCU-1920-35
Report status:	Internal Audit Report
Fieldwork commencement:	1st November 2019
Fieldwork completion:	18th December 2019
Draft discussion report issued:	18th December 2019
Draft report issued:	8th January 2020
Management response received:	12th February 2020
Final report issued:	13th February 2020
Auditor/s:	Head of Internal Audit Audit manager - Capital
Executive sign off:	Director of Nursing & Midwifery
Distribution:	Associate Director of Quality Assurance Quality Improvement Corporate Nursing Lead Medical Director Quality & Transformation Lead Manager for Quality, OMD Senior Associate Medical Director Acting Board Secretary Statutory Compliance, Governance & Policy Manager
Committee:	Audit Committee

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

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

Disclaimer notice - Please note:

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

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

1. Introduction and Background

The Health Board has developed the Quality Improvement Strategy 2017-20 (QIS) clearly setting out Health Board's intentions, aims and priorities, as follows:

> *"Improving health and providing excellent care is a responsibility BCUHB take very seriously, an ethos also echoed in the 'NHS Wales Delivery Framework' and Future Plans. The NHS Wales delivery Framework is aligned with Ministerial Policy and the need to drive up standards and outcomes. It sets out the processes which are in place to monitor progress and provide support and intervention as necessary.*
>
> *Consisting of five quality 'domains' and evidenced in the 'Quality and Safety' domain is the seeking of assurance that services are safe, standards are improving and quality care for people in NHS Wales is provided in a safe environment, while protecting them from avoidable harm."*

On the 6th June 2017, the Quality Safety and Experience Committee (QSE) considered and endorsed the QIS under Minute QS17/106.4:

- *QS17/106.4 The Committee endorsed the aims of the Quality Improvement Strategy.*

Further, the Health Board received the QIS at its meeting of the 15th June 2017 and supported the recommendations made:

> *It is recommended that the Health Board*
>
> · *Considers the refreshed strategy and the aspirations to further improve quality*
>
> · *Endorses the content of the Quality Improvement Strategy*
>
> · *Considers the proposals for reporting progress to QSE and the Board*

Minute 17/125.3 of this meeting recorded:

- *17/125.3 The Board noted the report and supported the recommendations.*

2. Scope and Objectives

The overall objective was to review the launch and regular reporting of progress in implementing the Strategy across the Health Board.

The scope of the review was limited to:

- Obtaining and reviewing the implementation plan to identify whether the various stages to implement each aim have been achieved by the planned timelines.
- Review the reporting of progress to the QSE and Board as outlined in the QIS – *Measuring Success: Implementation and Monitoring* section.
- Sample visits to clinical areas that respective Quality Boards are on display and current [most recent reporting period].

3. Associated Risks

The risks considered at the outset of this review were:

- There is no planned and consolidated approach towards implementing the QIS;
- Lack of evidence to demonstrate effective implementation of the QIS across the Health Board;
- Reporting of progress made through implementation of the QIS lacks clarity whether benefits and progress has been achieved.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Quality Improvement Strategy review is limited assurance.

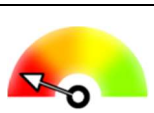
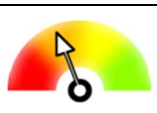
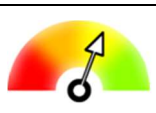
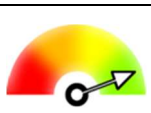
RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with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

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

5. Assurance Summary

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

Assurance Summary					
1	Implementation Plan	✓			
2	Reporting Progress		✓		
3	Quality/Welcome Boards		✓		

Assurance Summary					
4	Other quality steps taken			✓	

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Quality Improvement Strategy.

Operation of System/Controls

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

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

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

In reviewing evidence and papers to support this review, we could find no evidence of a formal launch of the QIS, akin to other strategies/initiatives.

Implementation Plan

Paragraph 6.0 in the QIS titled '*What changes can we make that will result in improvement?'* states the following:

> *"In order to accomplish our ambitious aims we will need a far reaching plan to engage with staff on finding solutions right across the Health Board."*

We met with key officers in the Health Board to request and discuss sight of an implementation plan underpinning the QIS and were advised that, as far as they were aware, no implementation plan existed.

Whilst it is apparent that a number of initiatives are being/have been progressed under the umbrella of the QIS [e.g. Sepsis Six; Safe Clean Care; open visiting policy; ward accreditation], we cannot state, definitively, that the QIS (now in its third year) has delivered what it set out to achieve.

This is predicated on the fact that there is no specific project plan outlining the steps that could/should have been undertaken to deliver the strategy through which management report progress, thus enabling scrutiny – We cannot provide assurance that everything that has been done was timely/needed or what should have been done [at the time of this review] has been done.

Reporting progress

The QIS outlines the five aims that are the foundation upon which the Health Board will progress to deliver its commitments, these being:

- Aim 1 – No Avoidable Deaths.
- Aim 2 – Safe; Continuously Seek Out and Reduce Patient Harm.
- Aim 3 – Effective; Achieve the Highest Level of Reliability for Clinical Care.
- Aim 4 – Caring; Deliver What Matters Most: Work in partnership with patients, carers and families to meet all their needs and actively improve their health.
- Aim 5 - Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living.

Within each aim, there are a clear set of 'measures' that, used for reporting purposes, would provide assurance on how successful management action has been in delivering the QIS.

In reporting progress, the QIS stated in paragraph 9.0 *Conclusion "Progress against the Quality Improvement Strategy will be reported in the Annual Quality Statements to be published each year."*

Noting this, we reviewed the Annual Quality Statements (AQS) for 2017/18 and 2018/19 respectively and sought to identify reported progress, per measure, and whether actions had made things better.

At the outset, we were sighted on the fact that each year, under Welsh Health Circular, each NHS Wales organisation is required to follow a set template report for the AQS.

Whilst recognising this, we cannot see sufficient narrative within both AQS that report progress against the QIS.

To supplement this, we also reviewed the Integrated Quality and Performance Report (IQPR) presented to the November 2019 Health Board meeting (7th) and Quality, Safety and Experience Committee (19th).

In reviewing Board and Committee agenda, we recognise that numerous strategies/assurance reports have been presented [e.g. Dementia Strategy 2018-2021; 'CLIICH' report; Listening and Learning from Patient and Service User Experience Report; Mortality Surveillance Report] that report progress/performance, however none of these are referenced in the QIS.

Table 1 details our findings whether reference was made in the AQS/IQPR.

Table 1: Summary of findings to the AQS and IQPR where it references or provides performance data to specific measures

Reported Measure by Aim	AQS 2017/18	AQS 2018/19	IQPR
Aim 1			
Using crude mortality as an indicator we will identify any variation from normal	✓	✘	✘

Reported Measure by Aim	AQS 2017/18	AQS 2018/19	IQPR
and initiate investigation at case-note level to ascertain lessons to be learned			
Serious untoward incidents that resulted in patient death	✓	✓	✗
Incidence of still births	✗	✗	✗
Number of patients able to die in their place of choice	✗	✗	✗
Reduction in mental health suicides	✗	✗	✗
Aim 2			
Unexpected admissions to critical care environment	✗	✗	✗
Number of Cardiac arrest calls in a non-critical environment	✗	✗	✗
Reduction in incidents reported with harm specifically:	✗	✗	✗
• Reduction in pressure ulcers	✓	✓	✓
• Reduction in falls	✓	✓	✓
• Never Events	✗	✗	✗
• Infection rates	✓	✓	✓
Quality Audit performance, including safety thermometer, maternity dashboard & accreditation frameworks	✓	✗	✗
Medication errors - Safety Thermometer	✗	✗	✗
Aim 3			
Results of national audits recommendations	✓	✗	✓
Strengthen our clinical pathways to ensure reliability against NICE, NCEPOD, WHO checklists etc.	✗	✗	✗
Performance against the new accreditation programme for wards, departments and community	✓	✗	✓
Adherence to the GROW programme	✗	✗	✗
Adherence with Sepsis Six	✓	✗	✓

Reported Measure by Aim	AQS 2017/18	AQS 2018/19	IQPR
Aim 4			
Performance in national patient surveys	✗	✗	✗
Results of real time patient feedback	✓	✓	
The number of local resolutions managed by the introduction of the PALs team	✓	✗	✗
Number of serious complaints	✓	✗	✗
Number of service changes involving patients	✗	✗	✗
National waiting time standards (e.g., A&E waiting times)	✓	✗	✗
Hospital appointment cancellations	✗	✗	✗
The introduction of an Open Visiting policy across BCUHB to completely embed 'John's campaign'	✓	✗	✗
Full implementation of the Dementia strategy	✓	✗	✗
Performance in staff feedback surveys	✓	✗	✗
Aim 5			
Community Dashboard	✓	✗	✗
Performance against the Accreditation Frameworks	✓	✗	✗
Patient Surveys in community and intermediate settings	✓	✗	✗
Responsiveness of our community crisis teams	✗	✓	✓
Number of patients able to die at home if this is their choice	✗	✗	✗

Please note: Where a ✓ is recorded indicates we were able to note reference to a specific measure, however it does not mean it has been implemented in full due to the lack of narrative/data on which performance can be measured.

At the Health Board meeting of the 15th June 2017 which considered the QIS, the covering paper included in its recommendation "*Considers the proposals for reporting progress to QSE and the Board".* Minute 17/125.3 of this meeting recorded:

- *17/125.3 The Board noted the report and supported the*

recommendations.

We subsequently reviewed the Agenda and Minutes of both Board and Quality, Safety and Experience Committee to identify what progress reports were presented.

Health Board

- 15th June 2017 – Agenda Item 17/125 Quality Improvement Strategy 2017/2020

  Submission of the QIS for Board approval.

Quality, Safety and Experience Committee

- 6th June 2017 – Agenda Item QS17/106 *Quality Improvement Strategy 2017/2020*

  Submission for consideration and approval.

- 25th September 2018 – Agenda Item QS18/156 *Presentation: Quality Improvement Strategy Update*

  The presentation updated the Committee on progress, a synopsis detailed as follows (extract from the presentation):

  - *Re-established avoidable mortality Group*
  - *Learning from Deaths Policy developed & introduced*
  - *Improving access to data via IRIS*
  - *Sepsis dashboard (currently being reviewed)*
  - *AKI dashboard developed*
  - *Timely access to real time data through interactive dashboards leading to focused improvements at ward level*
    - *Development of Antibiotic dashboard to support better stewardship*
  - *Health Board wide improvement-Safe Clean Care*
  - *Health Board wide collaborative's –Hospital/Community Acquired Pressure Ulcer collaborative & Falls*
  - *Open Visiting successfully implemented*
  - *Patient Advisory Support Service*
  - *Dignified end of life care*
  - *Listening and learning from real time feedback-focus groups, Viewpoint*
  - *Implementation of Ward Accreditation Programme to all wards by August 2019*
  - *Clinical Pathways strengthened-Sepsis, AKI, VTE, dementia care*
  - *QI Hub –Co designed and launched 20th September*

- 16th July 2019 – Agenda Item QS19/108 *Quality Improvement Strategy Presentation*

The presentation updated the Committee on progress, a synopsis detailed as follows (extract from the presentation):

- *Crude death rate (CDR) has [reduced] 11% between 2017/18 & 2018/19*[1]
- *Safe Clean Care campaign – reducing HCAIs*
- *Ward accreditation*
- *Pressure ulcer collaborative*
- *Sepsis collaborative –to improve uptake of sepsis 6 bundle; focussing on ED*
- *HAT project rollout across BCU*
- *Raise awareness of AKI – IRIS dashboard development*
- *Learning from Deaths Policy for MH/LD division developed*
- *Complete spread of HAT work across BCU*
- *Develop systems for monitoring primary care*
- *Support improvements in End of Life Care*
- *Ward Accreditation Progress to date: 42 wards across all areas confirmed accreditation score: 23 Silver, 12 Bronze, 7 White*
- *Patient Advise & Liaison Service across HB*
- *Dignified end of life care - Strategic group to oversee development*
- *Listening and learning from real time feedback-focus groups, Viewpoint*
- *Clinical Pathways strengthened - Sepsis, AKI, VTE, dementia care*
- *Ability to report real time harm data*
- *Learning systems-PTR, external reviews, patient feedback*
- *QI Hub – Co designed and launched September 2018 average of 35 new Twitter followers per month*
- *Master Classes methodology, e-handbooks & QI clinics*
- *Training in programmes in place - Silver* IQT-*107* staff trained in the past year

<u>Strategy, Partnerships and Population Health Committee</u>

- 1st October 2019 – Agenda Item SP19/88.1 *Enabling Strategies: Quality Improvement Strategy briefing*

  A similar presentation to that made to Quality, Safety and Experience Committee on 16th July 2019 with some updated data around the number of wards subject to accreditation.

[1] We have been advised by the Senior Associate Medical Director [19th December 2019] that the mortality reduction requires clarifying: *"There has been no significant reduction in crude mortality rate between years as any improvements noted have been the results of expected variation."*

Presentations made to both Committees do not include detail whether reported actions have delivered against expected progress/measures.

Quality/Welcome Boards

Standard Operating Procedure (SOP) *Welcome Boards SOP (V1.4)* [updated June 2019] provides detail of its purpose and use, stipulating where set information should be published; frequency for updating is specified [patient safety – weekly, patient experience – monthly].

We visited forty five (45) wards across the Health Board in November 2019 to review compliance and identified the following themes:

- A small number of wards were fully compliant with timely reporting and information required;
- Not all wards were using the templates appendix C1A – Patient Safety, C1B Patient safety – run charts or appendix D1 – Patient Experience;
- Some key data was not recorded e.g. missing ward telephone number, ward name;
- We found it difficult to confirm the requirements of the SOP for updating weekly/monthly information for patient safety and patient experience is routinely happening – we found examples of data patient safety information having not been updated since June, August and September 2019 across several wards;
- Nurse staffing data for some wards was not reflective of the month visited, we found September 2019 for a ward;
- We noted separate boards were also maintained on some wards which detailed comprehensive patient experience and feedback reports.

Other quality steps taken

Whilst we can find no underpinning plan to verify implementation of specific projects/actions, it is evident that a great deal of other quality initiatives have been progressed within the Health Board. We met with key officers to identify what has been undertaken and were provided with the following evidence, which we have not corroborated:

- BCU QI Hub

  Launched 20th September 2018 with four aims:

  - Nurture a culture of continuous improvement;
  - Develop skills & knowledge;
  - Be confident to develop better ways of working; and
  - Work together to provide excellent services and have more fun at work.

  Focus has been delivering the national Silver IQT programme.

  There is a dedicated website at https://www.bcuqi.cymru/
- Reducing avoidable mortality steering group.

- Falls Collaborative with a recorded aim: *To Reduce inpatient Falls (for cohort wards):15% by November 2019 and 30% by April 2020*.
- Hospital Acquired Thrombosis (HAT) with a recorded deliverables for: *All sites to achieve or maintain formal risk assessment compliance at 95% or greater; All sites to achieve or maintain potentially preventable HAT cases as never events.*

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - ISS.1 - Reporting progress of Quality Improvement Strategy (QIS) (Operating effectiveness)	Risk
There is a lack of sufficient detail within the Annual Quality Statements (AQS) for the Health Board to take assurance that the aims and specified measures within the QIS have progressed or had positive impact on service quality [we recognise that production of the AQS is governed by Welsh Health Circular]. There is no underlying plan to deliver the strategy and verify progress; we could find no evidence of an official launch of the QIS (akin to other quality projects). Whilst updates to Committees, via presentations, was evident, they did not routinely report progress against the specific aims/associated measures or report action taken has impacted on performance measures that could be attributed to measures. There is evidence of quality related assurance being reported [through the 'CLIICH' report; Listening and Learning from Patient and Service User Experience Report; Mortality Surveillance Report] however it is challenging to subsequently marry these back to delivery of the QIS.	There is a lack of reported progress by aim/measure to demonstrate that the QIS is having a positive impact on services and user experience.
Recommendation	**Priority level**
For the planned publication and launch of a new QIS for 2020 onwards, management should ensure the QIS: • Is underpinned by a clear and concise implementation plan that records what actions/tasks are expected, by when and how success will be measured. • Regular reports of progress should include clear performance and delivery per the implementation plan.	High

Management Response	Responsible Officer/ Deadline
The planning of the new QIS is in progress currently and has built in a clear, concise and robust implementation plan with clear identified milestones,that will highlight progress against the clear aims of the QIS and its implementation. The new QIS will have clear mechanism for regular monitoring of progress/ reporting against the aims of the QIS and the QIS implementation plan as agreed by QSE.	Associate Director of Quality Assurance 1st August 2020

Finding - ISS.2 – Quality/Welcome Boards (Operating effectiveness)	Risk
The QIS clearly places the quality/welcome boards at the heart of openness and reporting to service users and staff in publishing ward performance against set indicators [outlined in the QIS and through supplementary procedure]. We identified some wards were fully compliant however noted that several lacked up to date information. In addition we identified some wards had additional boards on wards with comprehensive patient experience and feedback reports published.	Openness and transparency is undermined through lack of up to date information.
Recommendation	**Priority level**
Management ensure Quality/Welcome Boards are maintained in accordance with the operational procedure – Hospital and Area Directors of Nursing should routinely ensure they receive assurance that this information is up to date.	High
Management Response	**Responsible Officer/ Deadline**

The supporting SOP for the ward welcome boards has been updated with clearer guidance for ward teams. The monitoring of the data displayed at ward level is an integral part of the ward accreditation process currently and will be monitored monthly via the revised Matrons Quality Audit about to be launched, 12 months post implementation of the monthly Ward Accreditation metrics completed by Ward Managers.	Associate Director of Quality Assurance 1st April 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 19th March 2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Internal Audit Plan 2020/21 and Internal Audit Charter 2020**
Cyfarwyddwr Cyfrifol: Responsible Director:	Justine Parry – Acting Board Secretary
Awdur yr Adroddiad Report Author:	Dave Harries – Head of Internal Audit
Craffu blaenorol: Prior Scrutiny:	The draft plan and audit Charter has been considered and approved by the Acting Board Secretary and following this was shared with the Executive Team for comment.
Atodiadau Appendices:	• Appendix 1: Internal Audit Plan 2020/21 and Internal Audit Charter 2020

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Approve the draft plan for 2020/21 and internal audit Charter 2020.

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

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

Sefyllfa / Situation:

The draft audit plan has been developed in accordance with mandated Public Sector Internal Audit Standards – Standard 2010 - Planning to enable the Head of Internal Audit to provide internal audit services in a way which will facilitate:

•The provision to the Accountable Officer, of an overall annual opinion on the organisation's risk management, control and governance, which may in turn support the preparation of the Annual Governance Statement; and

•Audit of the organisation's risk management, control and governance through operational audit plans, in a way which affords suitable priority to the organisation's objectives and risks.

The Charter is produced and updated regularly to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the Health Board's own Standing Orders and Standing Financial Instructions.

Cefndir / Background:

The plan has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement; and
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.

The Charter is required to ensure the Health Board is compliant with the Public Sector Internal Audit Standards as issued by the Welsh Government.

Asesiad / Assessment & Analysis

Strategy Implications

The Internal Audit plan for 2020/21 requires approval by the Audit Committee to ensure it focuses on key risks that may undermine the Health Board delivering its corporate objectives.

Financial Implications

The plan focuses on areas that could have financial implications for the Health Board.

Risk Analysis

The plan is risk based and focuses on areas identified through reviewing the corporate risk register and risk meetings with Executive Directors.

Legal and Compliance

The plan is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.3 Internal audit support to the Audit Committee* and *Section 4.4 Reviewing the internal audit plan.*

Impact Assessment

The Internal Audit plan recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk.

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

Betsi Cadwaladr University Local Health Board

Internal Audit Plan 2020/21

Internal Audit Charter 2020

March 2020

NHS Wales Shared Services Partnership
Audit and Assurance Services

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2020/21 ('the Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

As a reminder, the Accountable Officer (the Health Board's Chief Executive) is required to certify in the Annual Governance Statement that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards require that "The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities."

Accordingly this document sets out the risk based approach and the Plan for 2020/21. The Plan will be delivered in accordance with the Internal Audit Charter. All internal audit activity will be provided by Audit & Assurance Services, a division of NHS Wales Shared Services Partnership.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;

- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- quantification of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering the:

- organisation's risk assessment and maturity;
- coverage of the audit domains;
- previous years' internal audit activities; and
- audit resources required to provide a balanced and comprehensive view.

Our planning also takes into account the NHS Wales Planning Framework 2020/23 and is also mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the 3 year plan and/or Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

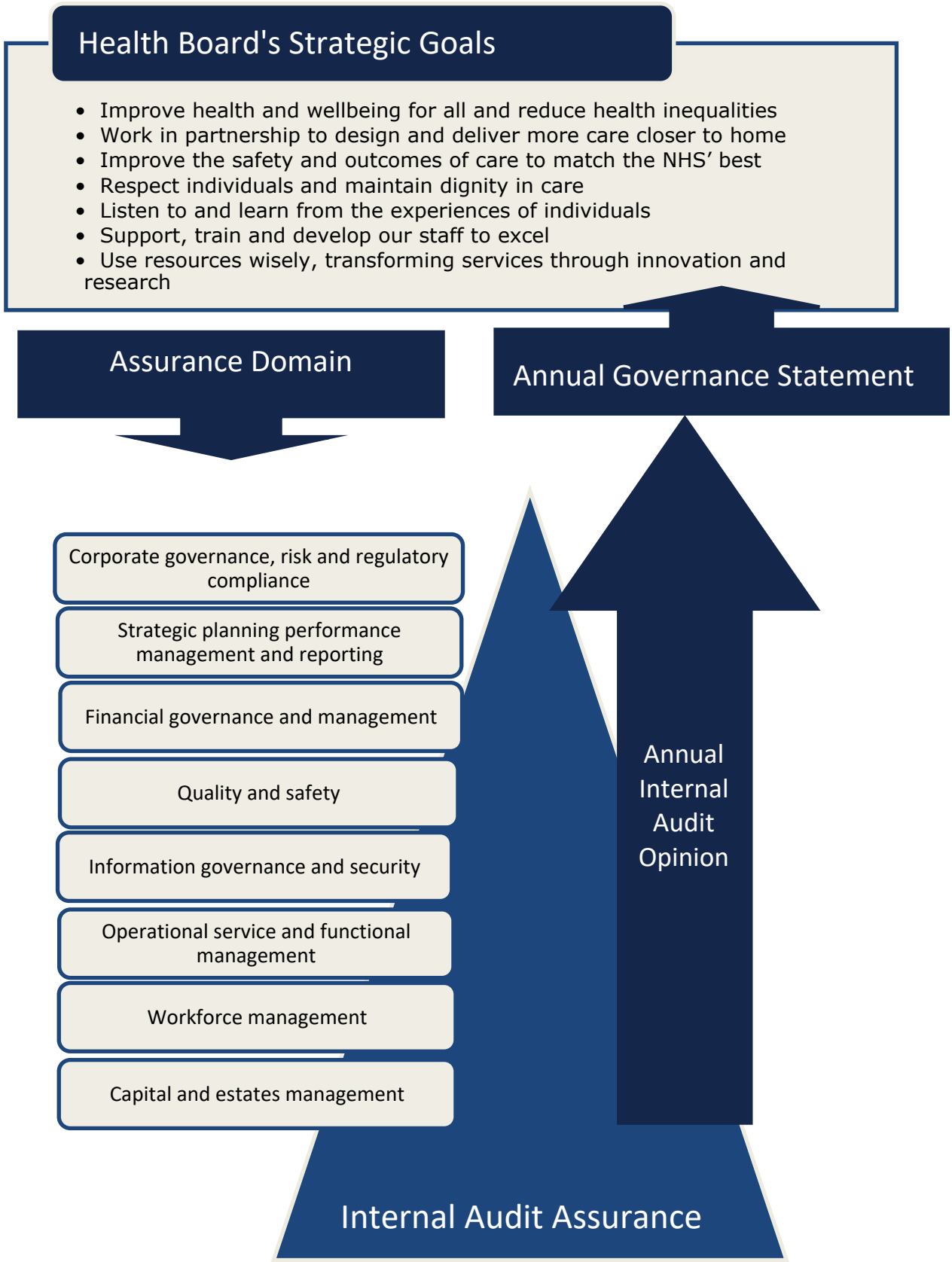
We will ensure that the Plan remains fit for purpose by reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control require annual review, and some work is mandated by Welsh Government, our risk based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe), categorised into eight assurance domains. The risk associated with each domain is assessed and this determines the appropriate frequency for review.

The eight audit domains are shown in figure 1 which also shows how the cumulative internal audit coverage of them contributes to the Annual Internal Audit Opinion which in turn feeds into the Annual Governance Statement and the achievement of the key objectives for the organisation.

The mapping of the Plan to the eight assurance domains is designed to give balance to the overall annual audit opinion which supports the Annual Governance Statement.

Figure 1 Internal Audit assurance on the domains



2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; thus we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the draft three year plan;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and Quality, Safety and Experience Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- other assurance processes including planned audit coverage of systems and processes now provided through NHS Wales Shared Services Partnership (NWSSP) and, where appropriate, WHSSC, EASC and NWIS;
- work undertaken by other assurance bodies including the Health Board's Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV);
- work undertaken by other bodies including Wales Audit Office (WAO); Healthcare Inspection Wales (HIW); Health and Safety Executive (HSE); Public Services Ombudsman for Wales (PSOW); and
- coverage necessary to provide reasonable assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit, working in partnership with the Wales Audit Office Performance Audit Lead, sought to meet with a number of Health Board Executives and Independent Members to discuss current areas of risk and related assurance needs. We have contacted/met with the following key individuals during the planning process:

- Chair of the Audit Committee;
- Deputy Chief Executive/Director of Nursing & Midwifery;
- Director of Finance;
- Director of Planning and Performance;
- Director of Primary & Community Care;
- Director of Workforce & OD;
- Director of Public Health;
- Medical Director;
- Acting Director of Mental Health & LDS;
- Area Directors; and

- Recovery Director.

The draft Plan was then discussed with and by the Acting Board Secretary with the Executive Team to ensure that internal audit resource was best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal control). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, potential for fraud and sensitivity.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2020/21

The Plan is set out in Appendix A and identifies the audit assignment, lead executive officer, outline scope, and proposed timing.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management and WAO requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

Audit coverage in terms of capital audit and estates assurance will be delivered locally through our Specialist Services Unit. Given the specialist nature of this work and the assurance link with the all-Wales capital programme we will need to refine with management the scope and coverage on specific schemes. The Plan will then be updated accordingly to integrate this tailored coverage.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above. We will review and update the risk assessment and rolling three year audit plan annually giving definition to the upcoming operational year and extending the strategic view outward.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. Hence, the plan will be kept under review and may be subject to change to ensure

it remains fit for purpose. In particular the Plan will need to be periodically reviewed to ensure alignment with the developing systems of assurance.

Consistent with previous years and in accordance with best professional practice an unallocated contingency provision has been retained in the plan to enable internal audit 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 the Wales Audit Office as the External Auditor and Healthcare Inspectorate Wales will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan indicates an indicative resource requirement of 1,000 days to provide balanced assurance reports to the Chief Executive as Accountable Officer in accordance with the Public Sector Internal Audit Standards.

This assessment is based upon an estimate of the audit resource required to review the design and operation of controls in review areas for the purpose of sizing the overall resource needs for the Plan. Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

This total resource allocation covers the servicing of the local audit plan plus some of the earmarked estates assurance audit coverage. These numbers are consistent with previous years.

The top-slice funding passed to NWSSP together with the recharge of £12,592.16 agreed by management for capital audit assurance work is sufficient to meet these audit resource needs. The recharge sum for 2020/21 reflects a reduction of £20,002 compared to the originally agreed 2019/20 audit plan (and a reduction of £41,926 compared to 2018/19).

However, this further reduction is predicated upon agreement of integrated audit and assurance plans for the major capital developments at North Denbigh, Ablett Unit and Wrexham Maelor Hospital – Redevelopment/Backlog Requirements to be funded through business case submissions [see page 13 for details]. The above will need to be reviewed in future in the event that adequate audit provisions are not provided within respective integrated audit and assurance plans.

No resources are taken from this plan to support the national audits undertaken at NWSSP; NWIS; WHSSC and EASC.

The Public Sector Internal Audit Standards enable internal audit to provide consulting services to management. The commissioning of these additional services by the Health Board is discretionary and therefore not included in the Plan. Accordingly, any requirements to service management consulting requests would be additional to the Plan and would need to be negotiated separately.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2020/21 and:

- Approve the Internal Audit Plan for 2020/21;
- Approve the Internal Audit Charter; and
- Note the associated internal audit resource requirements and key performance indicators.

Dave Harries CMIIA QiCA
Pennaeth yr Archwiliad Mewnol (Bwrdd Iechyd Prif Ysgol Betsi Cadwaladr)
Head of Internal Audit (Betsi Cadwaladr University Local Health Board)
Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2020/2021

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
Corporate governance, risk and regulatory compliance				
Annual Governance Statement	Mandatory	To provide an Opinion on key aspects of Board governance to underpin the completion of the Statement.	Board Secretary	Q1
Welsh Risk Pool Claims Management Standard	Mandatory	In accordance with the Welsh Risk Pool Standards, we will review a sample of completed files to ensure the required process has been complied with. In addition, we will report on themes/trends, by hospital/area, identified during the review.	Director of Nursing & Midwifery	Q4
Risk Management		We will review the implementation of the new Risk Management Strategy across the Health Board.	Deputy Chief Executive	Q2-3
Health and Safety	CRR21	We will review health and safety governance and accountability arrangements to ensure divisions/directorates are actively managing health and safety progress taken by the Health Board for the management and scrutiny of health and safety arrangements. This will include implementation of actions as a result of the recent comprehensive assessment.	Director of Workforce & Organisational Development	Q1-2
Security	CRR20	Working in partnership with the Associate Director of Health, Safety & Equality, we will identify key risk areas as well as reviewing compliance with the Welsh Government published Security Management Framework.	Director of Workforce & Organisational Development	Q1-2
Violence and Aggression – Obligatory responses to violence in healthcare	CRR20	We will review the Health Board's implementation of its responsibilities to the all Wales agreement which took effect on the 21st November 2018.	Director of Workforce & Organisational Development	Q2
Engagement of interim appointments		We will review the Health Board's compliance with Standing Financial Instructions and procurement arrangements.	Director of Finance	Q1
Strategic planning performance management and reporting				
Performance measure reporting to the Board – Accuracy of information	Audit Committee	In discussion with the Audit Committee, we will validate the reporting of a sample of performance measure(s) back to source data to confirm the integrity, accuracy and controls in place.	Director of Planning and Performance	Q1
Improvement Groups		We will review the governance and effectiveness of the Improvement	Director of Workforce &	Q1-2

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
		Groups against established governing documentation coupled with reporting arrangements and assurance to the Board. We will also review the linkage of projects to the reporting of progress against key actions in the annual plan and the use of Post project business benefits reviews.	Organisational Development	
Financial Governance and management				
Delivery of savings against identified schemes	CRR06	We will review areas that have consistently not delivered against their savings plans to understand why this is the case; what support they have received; and how they plan to remedy the non-delivery of savings.	Interim Director of Recovery/ Director of Workforce & OD	Q2-3
Budgetary Control & Financial Reporting	CRR06	To review key financial controls and compliance in accordance with Finance policies/procedures.	Director of Finance	Q2-3
Travel & Expenses	CRR06	Using Travel Bureau and E-Expenses data, we will review compliance with the Health Board's travel and subsistence related procedures; We will analyse the data using CAATTs (computer assisted audit tools and techniques).	Director of Finance	Q2-3
Quality & safety				
Annual Quality Statement	Mandatory	The Board must assure itself that the information published is both accurate and representative. To provide an opinion on the process that has been adopted and the evidence recorded supports data sources.	Director of Nursing & Midwifery	Q1
HASCAS & Ockenden external reports – Recommendation progress and reporting	Special Measures & CRR13	We will review the reporting of progress against the agreed management actions for those recommendations formally accepted by the Health Board.	Director of Nursing & Midwifery	Q1-4
Clinical Audit	CRR05	Following adoption of the Clinical Audit Policy, we will review the clinical audit process, with particular focus on the management of recommendations and follow-up.	Medical Director	Q2-3
Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices	CRR05	We will review the process operated in the Health Board for the receipt of a sample of notices; circulation; and receipt of assurance that they have been actioned, where applicable.	Deputy Chief Executive	Q1
Follow up of previous Healthcare		We will conduct follow-up reviews throughout the year to provide the	Board Secretary/	Q1-4

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
Inspectorate Wales reports		Audit and Quality, Safety and Experience Committees with assurance regarding management's implementation of agreed actions.	Deputy Chief Executive	
Information Governance and Security				
IM&T Control and risk assessment	CRR10A & CRR10C	To review and assess the control environment for the management of IM&T within the organisation.	Medical Director	Q2
Information Governance Toolkit		Following submission of the IG toolkit self-assessment, we will review the evidence underpinning the submission.	Deputy Chief Executive	Q1
Disaster Recovery/Business Continuity Plan	CRR10C	We will review the Informatics Department recovery/continuity plan and seek evidence of regular testing and learning from each test.	Medical Director	Q2-3
Digital Strategy	CRR10C	We will review progress against the timelines set out in the plan to understand if the Health Board is achieving its expected goals.	Medical Director	Q1-2
Operational service and functional management				
Health and Social Care Localities governance and accountability	CRR09	We will review a sample of Localities governance and accountability arrangements and assess in accordance with Welsh Government issued *Primary Care Cluster Governance – A Good Practice Guide.*	Director of Primary & Community Care	Q2-3
Community Mental Health Team partnership arrangements - Denbighshire	CRR13	We will review the partnership governance arrangements in place to deliver this service in Denbighshire.	Director of Mental Health & LDS	Q1-2
Community Mental Health Team partnership arrangements – Ynys Môn	CRR13	We will review the partnership governance arrangements in place to deliver this service in Ynys Mon.	Director of Mental Health & LDS	Q1-2
Programme Management Office (PMO)	CRR06	We will review the process adopted by the PMO to ensure due diligence of scheme project initiation documents (PIDs).	Director of Workforce & OD	Q1
Workforce management				
Recruitment – Employment of staff including interim posts and locum doctors	CRR15	In accordance with standard operating procedure MD01 *Medical Agency Locum Appointments* and other operating procedures, we will review the process in place for ensuring pre-employment checks are undertaken of seeking references from the most recent employer.	Director of Workforce & OD	Q1-2

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
Sickness management – Recording reason for the sickness episode		For a sample of sickness reasons recorded as S99 – Unknown Causes/Not Specified, we will review to source documentation and discuss with local managers why the reason has not been updated.	Director of Workforce & OD	Q3
Establishment control – Leaver management		We will review the submission of employee leaver forms for timeliness.	Director of Workforce & OD	Q1-2
On-Call arrangements		We will review the on-call arrangements in operation across the Health Board.	Deputy Chief Executive/ Director of Workforce & OD	Q2
Capital and Estates				
Environmental sustainability report	Mandatory	To provide an opinion that the Health Board has robust systems in place to record and report minimum sustainability requirements as required by Welsh Government.	Director of Planning & Performance	Q1
Control of Contractors	CRR21	The Health & Safety Executive (HSE) has produced a range of guidance on the safe management of contractors, including "Managing Contractors" (HSG 159) and the "Using Contractors – a Brief Guide". We will assess compliance with the requirements of this guidance.	Director of Planning & Performance	Q2
Statutory Compliance: Water Safety	CRR12	To determine the adequacy of, and operational compliance with, the systems and procedures of the Health Board, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.	Director of Planning & Performance	Q1
Follow Up (capital and Estates)		To ensure appropriate management action/ closure is demonstrated for agreed audit recommendations incorporated on the TeamCentral Tracker system.	Director of Planning & Performance	Q1-4
Capital Systems	CRR12	The audit coverage reviews a key stage within the Procedure Manual for Managing Capital Projects – Stage 2: Design.	Director of Planning & Performance	Q1-4
Integrated Audit and Assurance Plans: • North Denbighshire • Ablett Unit	CRR12	NHS Wales Infrastructure Investment Guidance (updated guidance issued by Welsh Government in October 2018) requires an Integrated Assurance and Approval Plan (IAAP), which sets out assurance and approval points for each stage of the Business Case process. Accordingly, the	Director of Planning & Performance	Q1-4

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
• Wrexham Maelor Hospital - Backlog maintenance requirements		organisation is required to outline the various formalised assurance mechanisms proposed (e.g. internal audit, Gateway reviews, functional reviews etc.) and the timing of each. The Integrated Audit Plans proposed include a combination of programme-level, functional and consultancy assurance that, when combined, provide a balanced programme for the client to achieve the desired level of assurance required by Welsh Government. These plans have been agreed by the Director of Planning & Performance subject to Audit Committee approval.		
Compliance with the Public Sector Internal Audit Standards				
Contingency		This element of the plan allows the flexibility to respond to management requests in order to meet specific Health Board needs throughout the course of the financial year. The Head of Internal audit, working with the Deputy Chief Executive, will provide support and scrutiny in the implementation of the revised governance structure.	Board Secretary	Q1-4
Audit Management and Reporting		An allocation of time is required for management:- • Planning liaison and management – Incorporating preparation and attendance at Audit Committee; completion of risk assessment and planning; liaison with WAO; HIW; PSOW; HSE and organisation of the audit reviews; and • Reporting and meetings – Key reports will be provided to support this, including preparation of the annual plan and progress reports to the Audit Committee.	Board Secretary	Q1-4
Follow up of previous audit reports		We will conduct follow-up reviews throughout the year to provide the Audit Committee with assurance regarding management's implementation of agreed actions – reviews that received limited or no assurance.	Board Secretary	Q1-4

Appendix B: Key performance indicators (KPI)

The KPIs reported monthly for Internal Audit are:

KPI	SLA required	Target 2020/21
Audit plan 2020/21 agreed/in draft by 30 April	✓	100%
Audit opinion 2019/20 delivered by 31 May	✓	100%
Audits reported vs. total planned audits	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [20 days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Appendix C: Internal Audit Charter

Betsi Cadwaladr University Local Health Board

INTERNAL AUDIT CHARTER

February 2020

Contents

1 Introduction

1.1 This Charter is produced and updated regularly to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Betsi Cadwaladr University Local Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Betsi Cadwaladr University Local Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Betsi Cadwaladr University Local Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control[1]. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;

[1] *Audit work designed to deliver an audit opinion on the risk management, control, and governance arrangements is referred to in this Internal Audit Charter as Assurance Work because management use the audit opinion to derive assurance about the effectiveness of their controls.*

- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective advisory service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such advisory work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit budget and resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Public Sector Internal Audit Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly the Head of Internal Audit has a direct right of access to the Accountable Officer the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance e.g. Quality, Safety and Experience Committee.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, internal audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

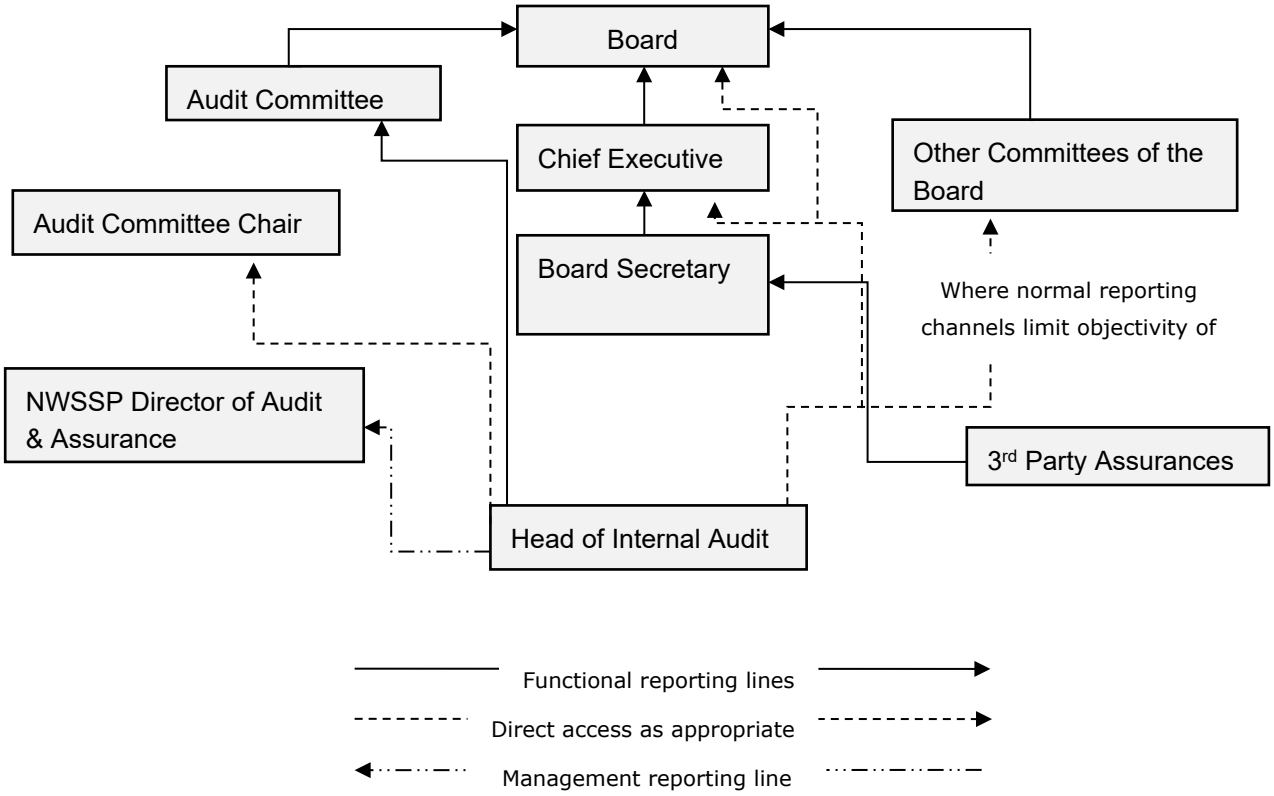
5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, e.g. the NHS Wales Shared Services Partnership, WHCCS, EASC and NWIS.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The key organisational reporting lines for Internal Audit are summarised in Figure 1 overleaf. As part of this, the Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all reports.

Figure 1 Audit reporting lines



6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2019) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;

- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- reviewing arrangements for demonstrating compliance with the Health and Care Standards.
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit, or prejudice the ability of internal audit to deliver a services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

7.4 The scope of the audit coverage will take into account and include any hosted body.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit

work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 2:

Figure 2 Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales to meet
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Public sector Internal Audit Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisations objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which "are appropriate, sufficient and effectively deployed to achieve the approved plan";
- effective co-operation with external auditors and other review bodies functioning in the organisation; and

- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information, and outlining the scope and timing of audit assignments to be completed during the year ahead.

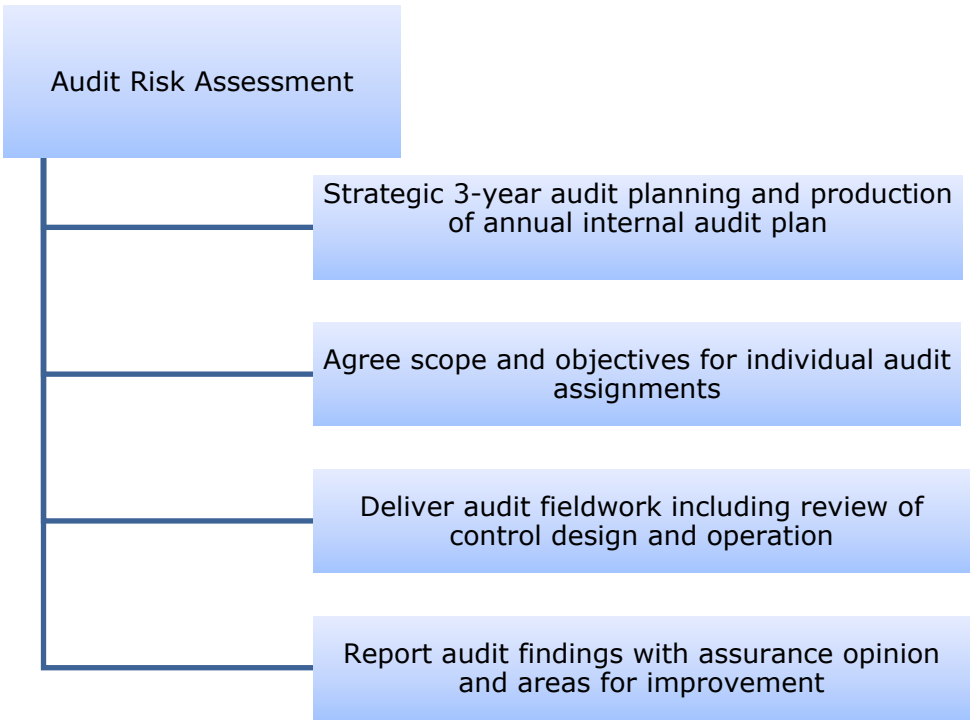
8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board. The Office of the Board Secretary will also screen Internal Audit Plan long lists to determine which audit topics link to Board Champion roles. The Office of the Board Secretary will then notify the relevant Board Champion that their area of interest features in the IA plan.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead, and will also be copied to the Board Secretary. The key stages in this risk based audit approach are illustrated in figure 3 below.

Figure 3 Risk based audit approach



9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement. The process for arriving at the appropriate assurance level for each Head of Internal Audit opinion was subject to a review process during 2013/14, which led to the creation of a set of criteria for forming the judgement that was adopted and used for 2013/14 opinions onwards;
- The Head of Internal Audit opinion will:

a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes, with reference to compliance with the Health and Care Standards;

b) Disclose any qualification to that opinion, together with the reasons for the qualification;

c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;

d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;

e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and

f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below and presented in flowchart format in Appendix A:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B. The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 20 working days of issue, stating their agreement or otherwise to the content of the report, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;

  Where the Executive lead advises Internal Audit that responding to the draft report within 20 days cannot be achieved due to the geographical nature of the Health Board, an alternative number of days will be agreed and formally reported to the Board Secretary and Audit Committee.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the

Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;

- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Final reports inclusive of management comments will be issued by Internal Audit to the relevant Executive Director within 10 working days of management responses being received; and
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee. Where relevant, the Office of the Board Secretary will forward the final report to the Independent Member identified as Board Champion for the subject matter.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

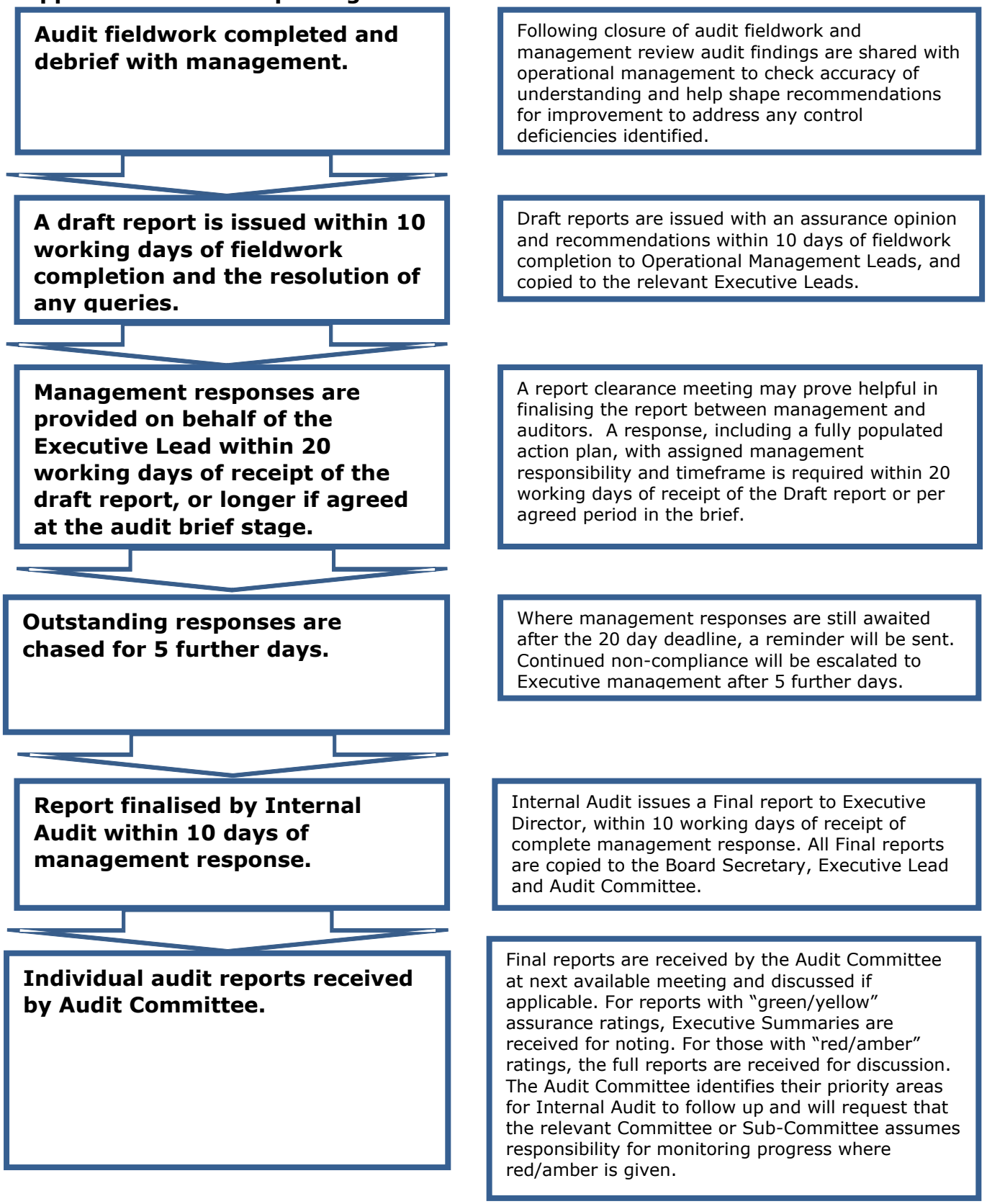
13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Director of Shared Services.

14 Review of the Internal Audit Charter

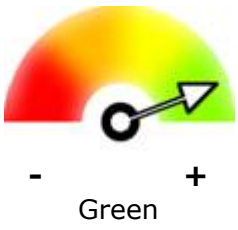
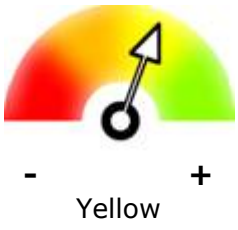
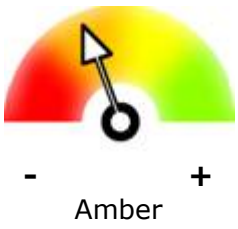
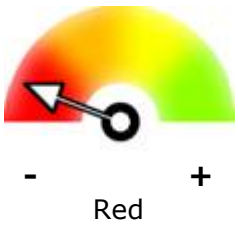
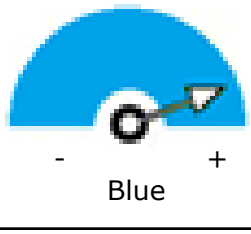
14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance - NHS Wales Shared Services Partnership
February 2020

Appendix A: Audit Reporting Process



Appendix B: Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	 Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	 Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.
Assurance not applicable	 Blue	**Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Cyfarfod a dyddiad: Meeting and date:	**19 March 2020**
Cyhoeddus neu Breifat: Public or Private:	All Wales Audit Office (WAO) papers will be in the public agenda of the committee
Teitl yr Adroddiad Report Title:	• Wales Audit Office Audit Programme Update; • audit plan; • Arrangements for interim senior staff appointments
Cyfarwyddwr Cyfrifol: Responsible Director:	Justine Parry, on behalf of the executive team
Awdur yr Adroddiad Report Author:	Andrew Doughton, Amanda Hughes and Dave Thomas
Craffu blaenorol: Prior Scrutiny:	All final Wales Audit Office reports on Betsi Cadwaladr University Health have passed through a clearance process with the lead Executive Director.
Atodiadau Appendices:	• Appendix b: WAO Update report • Appendix c: WAO Audit Plan • Appendix d: Review of arrangements for interim staff appointments

Argymhelliad / Recommendation:

The Audit Committee is requested to:

- Note the content of the audit progress update.
- Receive and discuss the Wales Audit Office Audit Plan
- Receive and discuss the Review of arrangements for interim staff appointments.

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

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

Sefyllfa / Situation:

The documents for audit committee include the regular audit update alongside reports finalised since the last audit committee.

Cefndir / Background:

Asesiad / Assessment & Analysis

Strategy Implications

The progress report may record issues/risks, identified as part of a specific review. The findings should be used to inform areas of work that support the Health Board in developing and delivering its associated strategies.

Financial Implications

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

Risk Analysis
The progress report may record issues/risks, identified as part of a specific review, the findings of which should be used to inform the Health Boards Risk Strategy and associated risk registers.

Legal and Compliance
Wales Audit Office reports and the copyright comprised therein is and remains the property of the Auditor General for Wales. It contains information which has been obtained by the Auditor General and the Wales Audit Office under statutory functions solely to discharge statutory functions.

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit Committee Update – **Betsi Cadwaladr University Health Board**

Date issued: March 2020

Contents

About this document

1 This document provides the Audit Committee of Betsi Cadwaladr University Local Health Board (the Health Board) with an update on current and planned Wales Audit Office work.

2 Financial and performance audit work is covered, and information is also provided on the Auditor General's programme of national value-for-money examinations.

Financial audit update

3 The planning work for the audit of the 2019-20 financial statements is progressing well and has informed the audit plan. Detailed work on the accounts will commence following their receipt on 28 April 2020.

4 The planned key outputs and milestones from financial audit outputs and milestones for the 2019-20 financial audit are summarised in Exhibit 1 below.

Exhibit 1: Delivering the 2018-19 financial audit work

Planned Output	Planned Start Date	Planned Reporting Date	Report Finalised
Audit Plan	January 2020	March 2020	March 2020
Audit of Financial Statements report	May 2020	May 2020	
Opinion on the Financial Statements	May 2020	June 2020	
Whole of Government Accounts submission	May 2020	June 2020	
Audit of Charitable Funds Financial Statements report	August 2020	September 2020	
Opinion on the Charitable Funds Financial Statements	September 2020	October 2020	

Source: Wales Audit Office

Performance audit update

5 Exhibit 2 below provides members of the Audit Committee with a brief overview of the performance audit work reported to the Health Board in the last six months.

Exhibit 2: Performance audit update

Work completed in last six months (links to the report, where available, are in red)				
Topic	**Key findings**	**Date finalised**	**Executive Lead**	**Received at Audit Committee/ other**
Review of legacy systems and infrastructure – ICT Asset Management Review	The Health Board is improving its operational ICT asset management approach but is struggling to allocate sufficient resources for technology replacement.	November 2019	David Fearnley	Digital and Information Governance Committee - November 2019[1]
Well Being of Future Generations (Wales) Act 2015	The Health Board has made progress in applying the sustainable development principle and the five ways of working, although differences in stakeholder priorities remain.	October 2019	Mark Wilkinson	December 2019
Structured Assessment 2019	The Health Board is still grappling with many of the key challenges we identified in last year's structured assessment. There is evidence of improvements in respect of some important quality metrics as well as a commitment and action to address long-standing problems with finance and key aspects of performance. However, much of the latter is geared towards short-term solutions which are not yet securing the scale of improvement needed.	December 2019	Gary Doherty	December 2019

[1] Note: There is sensitive information within the ICT Asset Management report relating to ICT infrastructure. We have therefore recommended that the report should be handled in the private session of the committee.

Work completed in last six months (links to the report, where available, are in red)				
Topic	**Key findings**	**Date finalised**	**Executive Lead**	**Received at Audit Committee/ other**
Review of interim director appointment arrangements	Our 'facts only' report sets out the key matters relating to the five appointments which were made by the Health Board between February and October 2019. We found that: • all of the interim appointments have been made using firms listed on approved framework agreements. • The Welsh Government agreed to contribute £350,000 towards the cost of the Interim Recovery Director, but played no part in the appointment itself. • We found that the £1,890 daily rate being paid by the Health Board for the Interim Recovery Director is higher than most of the benchmark comparators that were used by officials during the appointment process. • In contrast to the other four interim appointments, the Health Board only secured verbal references before appointing the Interim Director of Recovery.	Final report	Sue Green	March 2020

Ongoing work and work due to start in 2019 and 2020				
Topic	**Focus of the work**	**Status**	**Executive Lead**	**Expected date of final report**
Orthopaedic Services follow-up	This work is examining the progress made in orthopaedic services since our 2015 all-Wales review. This includes assessing whether recommendations and areas that we identified for improvement have been effectively responded to and to determine whether health boards are developing arrangements to help manage the demand on, and supply of, orthopaedic services.	Fieldwork ongoing	Gill Harris	May 2020

Ongoing work and work due to start in 2019 and 2020				
Topic	**Focus of the work**	**Status**	**Executive Lead**	**Expected date of final report**
Quality Governance arrangements	As an extension of the structured assessment work, we will undertake a specific review of quality governance arrangements and how these underpin the work of quality and safety committees. This will include examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting.	Fieldwork ongoing	Gill Harris	July 2020
Refurbishment/ Asbestos removal at Ysbyty Glan Clwyd	The Auditor General plans to issue a report that focuses on the events that contributed to the unanticipated escalation in the cost of the refurbishment project at Ysbyty Glan Clwyd. Much has already been written about these events. However, the Auditor General's report will consider whether the Health Board and NHS Wales more widely have identified and addressed the range of issues that arose. We anticipate that the report will be laid before the Public Accounts Committee early in 2020, and we shall also keep the BCU Board informed of our key findings and relevant recommendations'.	Draft report issued	Mark Wilkinson	May 2020
Local audit review: Continuing Healthcare management arrangements	This review will determine whether the Health Board's Continuing Healthcare (CHC) management arrangements are fit for purpose. This review will consider the extent to which the corporate CHC function is able to maintain strategic oversight and monitor compliance and performance of continuing healthcare services. Note: the function of the multi-disciplinary team and independent review panel is not within the scope of this review.	Drafting report	Chris Stockport	June 2020

Ongoing work and work due to start in 2019 and 2020				
Topic	**Focus of the work**	**Status**	**Executive Lead**	**Expected date of final report**
Local audit review: Ophthalmology services	Our review will assess the economy, efficiency and effectiveness of ophthalmology services. This will consider the services provided in the acute setting, wider service developments and modernisation and also local implementation of national requirements, such as the eye care measure.	Scoping	Gill Harris and Chris Stockport	July 2020
Local audit review: A cross-cutting review focussed on North Wales partnerships	The exact nature of this work will be discussed with the Health Board and other partners, including local government bodies. At present, it is likely that this work will focus on regional approaches for care and nursing home commissioning.	Not yet started	To be confirmed	To be confirmed
Review of Welsh Health Specialist Services Commissioning Committee	This work will focus on the governance and assurance arrangements of WHSSC. The approach will draw on relevant methodology already in place for the Structured Assessment reviews	Fieldwork started	Sian Lewis, WHSSC Managing Director	September 2020
Review of Unscheduled Care	This work will examine different aspects of the unscheduled care system. It will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Where relevant, this will also seek to examine the progress made in responding to my previous recommendations relating to unscheduled care, including GP out-of-hours and Emergency Ambulance Services Commissioning (EASC).	Scoping	To be confirmed	To be confirmed

Ongoing work and work due to start in 2019 and 2020				
Topic	**Focus of the work**	**Status**	**Executive Lead**	**Expected date of final report**
Structured Assessment 2020	Structured assessment will continue to form the basis of the work to examine the existence of proper arrangements for the efficient, effective and economical use of resources. This work will also maintain a high-level view on how well each NHS body is embedding their statutory requirements under the Well-being of Future Generations (Wales) Act 2015 into corporate arrangements.	Not yet started	Simon Dean	November 2020

Source: Wales Audit Office

Other Auditor General studies

The Audit Committee may also be interested in the following studies/planned outputs. Where the work is completed and reported, these are highlighted in red, and include a link to the report.

Exhibit 3: Other Auditor General Studies and reports

Recent publications / planned publications	
Topic	**Update**
A joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board – November 2019	Following well-publicised concerns about maternity services at the Health Board, the joint review examined the organisation's overall approach to quality governance. The report highlights the need for stronger and broader leadership in respect of quality and patient safety. The work found that directorate-level arrangements for oversight of quality and safety of services need to be strengthened and made more consistent with more clearly defined roles and responsibilities and better business processes. Crucially there needs to be a shift in organisational approach to enable directorates to take better ownership of responses to concerns and complaints. More broadly, reviewers found gaps in key governance arrangements associated with the management and identification of risk, and the provision of information to support effective scrutiny by the board and its committees. The need for improvements in the way incidents are classified and reported was also highlighted. Whilst the review has highlighted a significant number of concerns, it does note that the Health Board has started to take actions to address them. It also highlights the impact that new leadership is starting to have in tackling what is a considerable set of challenges.
Public sector counter fraud arrangements	The Auditor General for Wales is undertaking a review of the effectiveness of counter fraud arrangements across the public sector in Wales, with a view to publishing his findings in June of next year. That publication will be informed by fieldwork across a range of public sector organisations, including all NHS bodies. The fieldwork to inform the national report is underway and is drawing on information and intelligence that has already been gathered as part of our structured assessment. The review forms part of the Auditor General for Wales's wider programme of value for money examinations, and is therefore not being funded from local audit fees.

Good Practice Exchange

6 The Good Practice Exchange (GPX) helps public services improve by sharing knowledge and practices that work. We run events where people can exchange knowledge face to face and share resources online.

7 Details of past and forthcoming events, shared learning seminars and webinars can be found on the GPX page on the Wales Audit Office's website. The table below lists recent and forthcoming events.

Exhibit 4: Good Practice Exchange

Recent and forthcoming events
Recent events
Accountability and governance in partnership services – This seminar focused on how to achieve effective governance and accountability in partnership working to deliver efficient public services. This event was based around a scenario and provided a practical walk through of how public services can successfully work together to achieve a common goal – to identify and reduce vulnerability within local communities. The event output will be available at the following link, once available https://www.audit.wales/good-practice
Forthcoming events
The Adverse Childhood Experiences Journey: Where we are and where we need to be This seminar will be an opportunity for conversations about recognising and addressing the challenges, and how to provide ACE aware services. This event follows on from ACE Support Hub's work in raising awareness of ACEs, including the #aceawaresowhat [opens in new window] campaign. This event will provide an opportunity for delegates to evaluate where we are now and what needs to happen next. We will celebrate the successes to date and focus on moving the conversation forward to enable trauma informed services to be the norm. 19 Mar 2020 - 10:00am - 3:00pm, Llanrwst.

8 Diary markers and details of new events are circulated in advance to the Health Board, together with information on booking delegate places. Further information on any of our past or planned GPX events can be obtained by contacting the local audit team or emailing good.practice@audit.wales.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

2020 Audit Plan – **Betsi Cadwaladr University Local Health Board**

Audit year: 2020

Date issued: March 2020

Document reference: 1786A2020-21

This document was produced by Dave Thomas, Richard Harries, Amanda Hughes and Andrew Doughton on behalf of the Auditor General for Wales.

Contents

2020 Audit Plan

Summary

1 As your external auditor, my objective is to carry out an audit which discharges my statutory duties as Auditor General and fulfils my obligations under the Code of Audit Practice, namely to:

- examine and certify whether your financial statements are 'true and fair' and lay them before the National Assembly together with any report that I make on them;
- satisfy myself that the expenditure and income reported in your accounts have been incurred or received lawfully and in accordance with the authorities which govern them; and
- assess whether you have made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

2 The purpose of this plan is to set out my proposed work, when it will be undertaken, how much it will cost and who will undertake it.

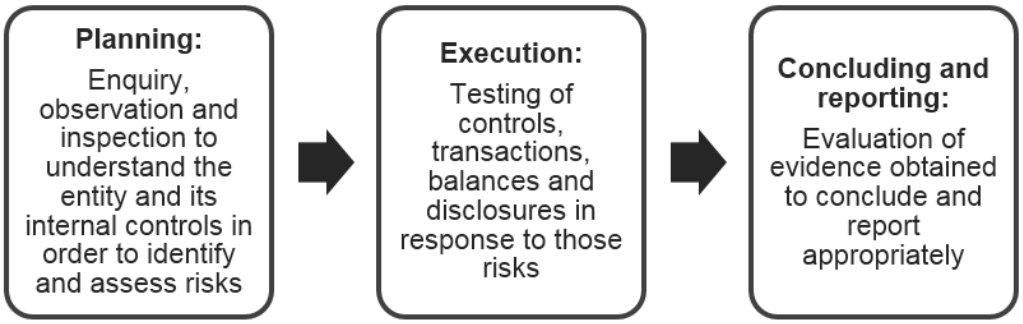
3 My responsibilities, along with those of management and those charged with governance, are set out in Appendix 1.

Financial audit

4 It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on their 'truth and fairness' and the regularity of the expenditure and income within them. Appendix 1 sets out my responsibilities in full.

5 The audit work we undertake to fulfil our responsibilities responds to our assessment of risks. This understanding allows us to develop an audit approach which focuses on addressing specific risks whilst providing assurance for the financial statements as a whole. Our audit approach consists of three phases as set out in Exhibit 1.

Exhibit 1: my financial audit approach



6 The risks of material misstatement which I consider to be significant, and which therefore require special audit consideration, are set out in Exhibit 2 along with the work I intend to undertake to address them.

Exhibit 2: financial audit risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk [ISA 240.26-27].	My audit team will consider the completeness of miscellaneous income.
The Board will once again fail to meet its first financial duty to break even over a three-year period. The position at month 10 shows a year-to-date deficit of £34.3 million and a forecast year-end deficit of £41 million. This, combined with the outturns for 2017-18 and 2018-19, predicts a three-year deficit of £121.1 million. As a result, I will be qualifying my regularity audit opinion and placing a substantive report on the financial statements highlighting the failure.	My audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias.

Financial audit risks	Proposed audit response
Significant risks	
The current financial pressures on the Board increase the risk that management judgements and estimates could be biased to ensure the forecast deficit does not worsen further.	
Other areas of audit attention	
On 18 December 2019 the First Minister issued a formal Ministerial Direction to the Permanent Secretary requiring her to implement a 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff.	We are considering the accounting treatment and audit implications of the direction (the first in Wales since 1999) in conjunction with the National Audit Office which is currently addressing the same issue in NHS England.
Introduction of IFRS 16 Leases in 2020-21 may pose implementation risks.	My team will undertake some early work to review preparedness for the introduction of IFRS 16 Leases. See Appendix 3, Exhibit 8 for more detail.

7 I do not seek to obtain absolute assurance on the truth, fairness and regularity of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit Committee prior to completion of the audit.

8 For reporting purposes, we will treat any misstatements below a 'trivial' level (set at 5% of materiality) as not requiring consideration by those charged with governance and, therefore, we will not report them.

9 My fees and planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided in accordance with the agreed timescales, to the quality expected and have been subject to a robust quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];
- appropriate accommodation and facilities are provided to enable my audit team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;

[1] The agreed audit deliverables document sets out the expected working paper requirements to support the financial statements and includes timescales and responsibilities.

- you have all the necessary controls and checks in place to enable the Accountable Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

10 I am also responsible for the audit of the Health Board's charitable funds accounts. The audit will be undertaken in accordance with the timescales agreed with the Board and the Charity Commission.

Performance audit

11 It is my responsibility to satisfy myself that the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance work each year.

12 I set out in this section the programme of performance audit work to be undertaken at the Health Board. The content of the programme is informed by an ongoing analysis of the risks and challenges facing NHS Wales as well as consideration of issues and risks that are specific to the Board. I have also taken account of the work programme of Healthcare Inspectorate Wales (HIW)[2] [3].

13 The topics I plan to examine as part of my 2020 performance audit work are summarised in Exhibit 3.

Exhibit 3: contents of my 2020 performance audit work programme

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work I do at each NHS body to examine the existence of proper arrangements for the efficient, effective and economical use of resources. Building on previous years' work, I will seek to describe the progress that is being made in embedding sound arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management. I also plan to use my structured assessment work to maintain a high-level view on how well each NHS body is embedding their statutory requirements under the Well-being of Future Generations (Wales) Act 2015 into corporate arrangements.

[2] **An operational protocol between HIW and the Auditor General sets out how the two organisations will work together**, March 2015

[3] Wales Audit Office, **Working Together to Provide Assurance describes the collective arrangements the AGW and HIW make use of to review governance arrangements in the NHS**, November 2016

Theme	Approach/key areas of focus
All Wales Thematic Reviews	**Unscheduled care arrangements** During 2020, I plan to scope and roll out a thematic review which will examine different aspects of the unscheduled care system. This work will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. This data analysis will help me to determine which aspects of the unscheduled care system I will then focus on during the remainder of 2020. Where relevant, my work will also seek to examine the progress made in responding to my previous recommendations relating to unscheduled care, including GP out-of-hours and Emergency Ambulance Services Commissioning (EASC). **Welsh Health Specialised Services Committee (WHSSC)** I also plan to use an element of the 2020 audit fee to undertake a review of WHSSC. This work will use aspects of my structured assessment methodology to examine the governance arrangements of WHSSC.
Locally focused work	My thematic performance audit work that reflects issues specific to the Health Board. This work includes: • **review of interim director appointment arrangements**. The Auditor General will complete a review of the arrangements that were taken to appoint interim directors. The review considers the governance and procurement processes for the appointments, and where possible will consider implications for value for money. • **a cross-cutting review focussed on North Wales partnerships.** The exact nature of this work will be discussed with the Health Board and other partners, including local government bodies. At present, it is likely that this work will focus on regional approaches for care and nursing home commissioning.
Implementing previous audit recommendations	The examination of governance arrangements I undertake as part of my structured assessment work includes a review of the arrangements that the Health Board has in place to track progress against my previous audit recommendations. This allows my team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables me to more explicitly measure the impact my work is having.

14 In addition to my Structured Assessment work, where my broader programme as set out in Exhibit 3 allows me to do so, I may take opportunities to make comments on the Health Board's application of the sustainable development principle[4] as set out in the Well-being of Future Generations (Wales) Act 2015. Where this is identified, my audit team will raise this with the relevant Health Board lead.

15 The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with the Health Board, are set out in Appendix 2.

Fee, audit team and timetable

Fee

16 Your estimated fee for 2020 is set out in Exhibit 4. My fees for 2020 have reduced overall by 4.7% compared to the fee set out in the 2019 annual audit plan.

Exhibit 4: audit fee

Audit area	Proposed fee for 2020 (£)[5]	Actual fee for 2019 (£)
Financial accounts work:		
• Health Board Accounts	224,750	244,750
• Charitable Funds Accounts	10,250	10,250
Financial audit work total	**235,000**	**255,000**
Performance audit work:		
• Structured Assessment	58,519	64,348
• All-Wales thematic reviews[6]	72,619	65,963
• Local projects	41,783	42,610
Performance audit work total	**172,921**	**172,921**
Total fee	**407,921**	**427,921**

17 Planning will be ongoing, and changes to my programme of audit work and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance.

[4] The Act defines the sustainable development (SD) principle as acting in a manner: '…which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs'.

[5] The fees shown in this document are exclusive of VAT, which is no longer charged to you.

[6] As detailed in the respective audit plans.

18 Further information on my fee scales and fee setting can be found on our website.

Audit team

19 The main members of my local audit team, together with their contact details, are summarised in Exhibit 5.

Exhibit 5: my local audit team

Name	Role	Contact number	E-mail address
Dave Thomas	Engagement Director and Engagement Lead – Performance Audit	02920 320604	dave.thomas@audit.wales
Richard Harries	Director with responsibility for financial audit work	07789 397018	richard.harries@audit.wales
Amanda Hughes	Financial Audit Manager	07969 919986	amanda.hughes@audit.wales
Andrew Doughton	Audit Lead (performance audit)	07812 094642	andrew.doughton@audit.wales
Gareth Evans	Audit Lead (financial audit)	07773 945116	gareth.evans@audit.wales

20 I can confirm that my team members are all independent of the Health Board and your officers. In addition, I am not aware of any potential conflicts of interest that I need to bring to your attention.

Timetable

21 I will provide reports, or other outputs as agreed, to the Board covering the areas of work identified in this document. My key milestones are set out in Exhibit 6.

Exhibit 6: timetable

Planned output	Work undertaken	Report finalised
2020 Audit Plan	December 2019 to February 2020	March 2020
Financial accounts work: • Health Board Audit of Financial Statements Report • Health Board Opinion on Financial Statements • Charitable Funds Audit of Financial Statements Report and Opinion on the Charitable Funds Accounts	January to June 2020 July 2020 to September 2020	May 2020 June 2020 September 2020
Performance work: • Structured Assessment • Unscheduled Care • WHSSC • Local project work	Timescales for individual projects will be discussed with the Health Board and detailed within the specific project briefings produced for each study.	
Annual Audit Report for 2020	October to November 2020	December 2020
2021 Audit Plan	December 2020 to January 2021	March 2021

Future developments to my audit work

22 Details of other future developments, including forthcoming changes to key International Financial Reporting Standards (IFRS), and for charitable funds, future changes to UK Generally Accepted Accounting Practice (UK GAAP), the Wales Audit Office's Good Practice Exchange seminars and my work on the readiness of the Welsh public sector for Brexit, are set out in Appendix 3.

Data Protection Legislation

23 Data protection legislation, including the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR), has introduced updated requirements for processing personal data.

24 The Auditor General for Wales' (AGW's) access rights are not affected by the new data protection legislation or the Digital Economy Act, which also grants data sharing powers. Information about the AGW's access rights is available in the Guide to Legislation, as well as the shorter Access Rights leaflet which can be found on our website.

25 Fair Processing (Privacy) Notices provided to your employees, contractors and service users should include reference to the collecting and sharing of data with the AGW in connection with his audit work and studies.

26 Our own general fair processing notice is available on our website and, where appropriate, we shall provide further fair processing notices in connection with our work.

27 If you would like to discuss any of the matters raised above, our Data Protection Officer can be contacted at martin.peters@audit.wales

Appendix 1

Respective responsibilities

My powers and duty to undertake your financial audit are set out in the Public Audit (Wales) Act 2004. It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on:

- their 'truth and fairness', providing assurance that they:
  - are free from material misstatement, whether caused by fraud or error;
  - comply with the statutory and other applicable requirements; and
  - comply with all relevant requirements for accounting presentation and disclosure;
- whether the remuneration report is properly prepared;
- the regularity of the expenditure and income; and
- the consistency of other information presented with the financial statements.

It must also state by exception if the Annual Governance Statement does not comply with requirements, if proper accounting records have not been kept, if disclosures required for remuneration and other transactions have not been made or if I have not received all the information and explanations I require.

In addition, I may place a substantive report on the financial statements if I wish to make additional observations on any matters within them.

My powers to undertake performance audit work at the Health Board are set out in the Government of Wales Acts 1998 and 2006 and this work also discharges my duty under the Public Audit (Wales) Act 2004 to satisfy myself that the body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

My audit work does not relieve management and those charged with governance of their responsibilities which include:

- the preparation of the financial statements and annual report in accordance with applicable accounting standards and guidance;
- the keeping of proper accounting records;
- ensuring the regularity of financial transactions; and
- securing value for money in the use of resources.

Appendix 2

Performance audit work in last year's audit plan still in progress

Exhibit 7: performance audit work still in progress

Performance audit project	Status	Comment
Orthopaedic Services (Follow-up)	Reporting	Local reports for health boards setting out progress against the issues the Auditor General originally identified in 2015 will be issued during February. A national summary report will also be published in Spring 2020.
Quality Governance arrangements	Set Up	Scoping of this work has been informed by the Joint Review of Quality Governance at Cwm Taf Morgannwg UHB. Wider work across Wales will be undertaken in close collaboration with Healthcare Inspectorate Wales and will be undertaken during Spring and early Summer 2020.
Local audit review: Ophthalmology services	Scoping	The review will assess the economy, efficiency and effectiveness of ophthalmology services. This will consider the services provided in the acute setting and wider service developments. The report will be issued by July 2020.
Local audit review: Continuing Healthcare management arrangements	Fieldwork ongoing	This is a focussed review to determine whether the Health Board's Continuing Healthcare (CHC) management arrangements are fit for purpose. The report will be issued by June 2020.

Appendix 3

Other future developments

Forthcoming key IFRS changes

Exhibit 8: changes to IFRS standards

This table details the key future changes to International Financial Reporting Standards

Standard	Effective date	Further details
IFRS 16 Leases	2020-21	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.
IFRS 17 Insurance Contracts	2021-22 at earliest	IFRS 17 replaces IFRS 4 **Insurance Contracts**, which permitted a variety of accounting practices resulting in accounting diversity and a lack of transparency about the generation and recognition of profits. IFRS 17 addresses such issues by requiring a current measurement model, using updated information on obligations and risks, and requiring service results to be presented separately from finance income or expense. It applies to all insurance contracts issued, irrespective of the type of entity issuing the contracts, so not relevant only for insurance companies. Entities will need to consider carefully whether any contractual obligations entered into meet the definition of an insurance contract. If that is the case, entities will need to determine whether they are covered by any of IFRS 17's specific scope exclusions.

Future changes to UK GAAP: applicable to charitable funds accounts

Following the introduction of the new UK GAAP accounting regime in 2015-16, and the replacement of the Financial Reporting Standard for Smaller Entities (FRSSE) by Section 1A of FRS 102 in 2016-17, there are only limited changes to FRS 102 in 2019-20.

More significant amendments are expected from 2022-23, reflecting recent changes in International Financial Reporting Standards, including accounting for financial instruments and leases.

Good Practice Exchange (GPX)

The Wales Audit Office's GPX helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face to face and resources shared online. Further information, including details of forthcoming GPX events and outputs from past seminars.

Brexit: preparations for the United Kingdom's departure from membership of the European Union

The Auditor General has reported on preparations in Wales for a 'no-deal Brexit', publishing a report in February 2019 and a follow-up letter to the External Affairs and Additional Legislation Committee in September 2019. At the time of reporting, there was a possibility that the UK would leave the EU without a Withdrawal Agreement in place (the no-deal scenario), which would potentially have had significant consequences for Welsh public services and the wider economy and society.

Following the general election, the United Kingdom left the membership of the European Union on 31 January 2020 under the terms of the Withdrawal Agreement concluded between the EU and UK in October 2019. The next phase will involve negotiating and agreeing the future relationship between the UK and EU.

There will be a transition period to 31 December 2020, during which the UK will continue to participate in EU programmes and follow EU regulations. The Withdrawal Agreement provides for the transition period to be extended by up to two years, with the agreement of the UK and EU. The deadline for agreeing to extend the transition is 31 June 2020. The UK Government has said that it does not intend to extend the transition period.

Despite there being an agreement on the terms of withdrawal, there remain some significant uncertainties:

- given the very tight timetable for reaching agreement, there is a possibility of the UK leaving the transition period at the end of 2020 without an agreement about the future relationship in place. In this scenario many of the issues previously identified around a 'no-deal Brexit', such as disruption to supply chains, would arise again.
- the UK Government's position of seeking a future relationship based on a free trade agreement (rather than a closer relationship aligned to the single market) has

implications that are not yet clear but which create opportunities and risks for Wales' economy, society and environment.

- there are also significant unresolved constitutional questions around how powers in areas where devolved governments were directly applying EU law, such as regional development and agriculture, will be exercised across the UK after the transition period.

In light of these uncertainties, the Auditor General will continue to keep a watching brief over developments and will make a decision later in the year as to what, if any, further work is required to look at public bodies' preparations for either a new relationship or a no-trade-deal exit from the transition period.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Trefniadau ar gyfer Penodi Uwch Aelodau o Staff Dros Dro – **Bwrdd Iechyd Prifysgol Betsi Cadwaladr**

Blwyddyn archwilio: 2019-20

Dyddiad cyhoeddi: Mis Mawrth 2020

Cyfeirnod y ddogfen: 1782A2020-21

Paratowyd y ddogfen hon fel rhan o waith a wnaethpwyd yn unol â swyddogaethau statudol.

Os gwneir cais am wybodaeth y gallai'r ddogfen hon fod yn berthnasol iddi, tynnir sylw at y Cod Ymarfer a gyhoeddwyd o dan adran 45 o Ddeddf Rhyddid Gwybodaeth 2000. Mae Cod adran 45 yn nodi'r arfer a ddisgwylir gan awdurdodau cyhoeddus wrth ymdrin â cheisiadau, gan gynnwys ymgynghori â thrydydd partïon perthnasol. Yng nghyswllt y ddogfen hon, ystyrir Archwilydd Cyffredinol Cymru a Swyddfa Archwilio Cymru yn drydydd partïon perthnasol. Dylid anfon unrhyw ymholiadau ynglŷn â datgelu neu ailddefnyddio'r ddogfen hon i Swyddfa Archwilio Cymru: infoofficer@audit.wales.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi. We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay.

Mae'r ddogfen hon ar gael yn Saesneg hefyd. This document is also available in English.

Roedd y tîm a gyflawnodd y gwaith yn cynnwys Ian Hughes ac Andrew Doughton, yn gweithio o dan gyfarwyddyd Mike Usher.

Cynnwys

Roedd ein hadolygiad yn edrych ar y broses a ddilynodd Bwrdd Iechyd Prifysgol Betsi Cadwaladr i benodi pump uwch aelod o staff dros dro rhwng mis Chwefror a mis Hydref 2019, gan gynnwys y Cyfarwyddwr Adfer Dros Dro. Arweiniodd cost sylweddol y penodiad hwnnw at sylw yn y wasg a diddordeb ymhlith Aelodau Cynulliad, ac roedd ein hadolygiad ni yn canolbwyntio ar y swydd hon.

Adroddiad cryno

Adroddiad manwl

Atodiadau

Adroddiad cryno

Yr adolygiad hwn

1 Ar 11 Tachwedd 2019, dywedodd yr Archwilydd Cyffredinol wrth y Pwyllgor Cyfrifon Cyhoeddus ei fod yn bwriadu edrych ar y trefniadau yr oedd Bwrdd Iechyd Prifysgol Betsi Cadwaladr (y Bwrdd Iechyd) wedi'u defnyddio wrth benodi sawl uwch aelod o staff dros dro yn ystod y flwyddyn honno.

2 Mae ein hadolygiad wedi edrych ar y pum penodiad canlynol:

- Cyfarwyddwr Adfer Dros Dro;
- Rheolwr Gyfarwyddwr Dros Dro, Wrecsam Maelor;
- Rheolwr Gyfarwyddwr Dros Dro, Ysbyty Glan Clwyd;
- Pennaeth Gwella Gofal wedi'i Gynllunio;
- Cyfarwyddwr Gwasanaethau Acíwt Dros Dro.

3 Mae Atodiad 1 yn rhoi crynodeb o'r costau oedd yn gysylltiedig â phob un o'r penodiadau hyn, ynghyd â'r telerau cyflogi oedd yn rhan o'u contract.

4 Gan ystyried y costau sylweddol oedd yn gysylltiedig â phenodi'r Cyfarwyddwr Adfer Dros Dro, a'r sylw mae hyn wedi'i gael yn y wasg ac ymhlith Aelodau Cynulliad, y swydd hon oedd ffocws ein hadolygiad ni. Cytunodd y Bwrdd Iechyd i dalu cyfradd o £1,990 y dydd i'r asiantaeth oedd yn cyflenwi'r Cyfarwyddwr Adfer Dros Dro, ac roedd hynny'n cynnwys ad-daliad wedi'i gapio o £100 y dydd ar gyfer treuliau rhesymol a fyddai'n golygu bod yr unigolyn ar ei golled. Cychwynnodd deiliad y swydd yn y rôl ym mis Gorffennaf 2019, a disgwylir y bydd y contract yn dod i ben ar 27 Mawrth 2020. Y gost a glustnodwyd ar gyfer y penodiad hwn dros gyfnod o naw mis yw £340,200.

5 Drwy edrych ar benodiad pump uwch aelod o staff dros dro dros gyfnod tebyg, rydym wedi gallu cymharu a chyferbynnu'r prosesau a ddilynwyd, gan esbonio penodiad y Cyfarwyddwr Adfer Dros Dro mewn cyd-destun caffael ehangach.

Prif ganfyddiadau

6 Mae'r adroddiad 'ffeithiau yn unig' hwn yn amlinellu'r prif faterion oedd yn gysylltiedig â phum penodiad y Bwrdd Iechyd rhwng mis Chwefror a mis Hydref 2019. Dyma grynodeb ohonynt:

- canfuwyd bod pob un o'r penodiadau dros dro wedi cael eu gwneud drwy ddefnyddio cwmnïau oedd wedi'u rhestru ar gytundebau fframwaith cymeradwy. Mae hyn yn cyd-fynd â'r darpariaethau yng Nghyfarwyddiadau Ariannol Sefydlog y Bwrdd Iechyd ac yn y Canllawiau Caffael ar gyfer Staff.
- roedd Llywodraeth Cymru wedi cytuno i gyfrannu £350,000 tuag at y gost o gyflogi'r Cyfarwyddwr Adfer Dros Dro, ond nid oedd wedi chwarae unrhyw ran yn y penodiad ei hun, oedd wedi cael ei wneud gan y Bwrdd Iechyd cyn i'r cyllid hwn gael ei gadarnhau. Nid oedd y penderfyniad i benodi yn ddibynnol ar sicrhau arian gan Lywodraeth Cymru.

- er bod y Bwrdd Iechyd yn mynnu bod cyfraddau cystadleuol wedi cael eu trafod ar gyfer y penodiad, canfuwyd bod y gyfradd ddyddiol o £1,890 yr oedd y Bwrdd Iechyd yn ei thalu yn uwch na chyfraddau'r rhan fwyaf o'r cymaryddion meincnodi a ddefnyddiwyd gan y swyddogion yn ystod y broses benodi.
- yn wahanol i'r pedwar penodiad dros dro arall, dim ond geirdaon ar lafar a gafodd y Bwrdd Iechyd cyn penodi'r Cyfarwyddwr Adfer Dros Dro. Serch hynny, rydym yn nodi bod Prif Weithredwr y Bwrdd Iechyd (ar y pryd) ac aelod annibynnol o'r panel cyf-weld wedi cael profiad blaenorol o weithio gyda'r ymgeisydd llwyddiannus. Hefyd, er mwyn cael eu cymeradwyo ar y Fframwaith, rhaid i bob cyflenwr gadw geirdaon cyfredol ar gyfer yr holl weithwyr a ddarperir.

7 Mae angen edrych ar ganfyddiadau'r adroddiad hwn yng nghyd-destun y sylwadau canlynol a welir yn yr Asesiad Strwythuredig, a roddwyd i'r Bwrdd Iechyd ym mis Rhagfyr 2019:

- mae'n anodd dweud faint yn union o effaith bersonol y mae'r Cyfarwyddwr Adfer Dros Dro yn ei chael ar ymdrechion y Bwrdd Iechyd i adfer ei hun yn ariannol, gan gofio bod staff ym mhob rhan o'r sefydliad yn cyfrannu at hyn mewn gwahanol ffyrdd. Mae sawl ffactor yn effeithio ar y sefyllfa, gan gynnwys gwahaniaethau o ran amseru a gwahaniaethau yn natur unrhyw arbedion ariannol (rhai yn arbedion untro ac eraill yn rheolaidd).
- rydym wedi gweld arweinyddiaeth ariannol glir fel rhan o'r broses adfer, gyda chyfrifoldeb wedi'i ddirprwyo ar gyfer adferiad ariannol a chyfleoedd i adnabod a sicrhau arbedion. Mae ffocws y Bwrdd Iechyd ar adferiad, gafael a rheolaeth ariannol yn gryfach nag o'r blaen.
- mae risg sylweddol o hyd i sicrhau'r diffyg o £35 miliwn y mae'r Bwrdd Iechyd am ei weld ar gyfer 2019-20. Mae'r Bwrdd Iechyd yn sôn am lithriant wrth geisio sicrhau'r arbedion sydd i fod i gael eu gwneud, ac o ran twf mewn costau yn ystod y flwyddyn, sydd wedi golygu bod angen dod o hyd i arbedion ychwanegol.
- mae llawer o ffactorau eraill yn dal i gyflwyno heriau, ac oni fydd y rhain yn cael sylw, byddant yn arwain at risg y bydd y cylch ariannol blynyddol o ddiffygion ac ymdrechion i adfer yn digwydd dro ar ôl tro.

Digwyddiadau'n arwain at benodi'r Cyfarwyddwr Adfer Dros Dro

8 Ym mis Mehefin 2015, rhoddodd Llywodraeth Cymru y Bwrdd Iechyd mewn 'mesurau arbennig' am nifer o resymau, gan gynnwys safon prosesau llywodraethu ac arwain y Bwrdd Iechyd, pryderon ynghylch gwasanaethau y tu allan i oriau meddygon teulu, gwasanaethau iechyd meddwl a gwasanaethau mamolaeth, yn ogystal â'r modd yr oedd yn cynllunio gwasanaethau ac yn ymgysylltu â'r cyhoedd.

9 Ar 1 Chwefror 2018, cyhoeddodd Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol y gallai'r gwasanaethau mamolaeth gael eu dad-ddwysau ond fod angen i rai elfennau o berfformiad aros o dan y trefniadau 'mesurau arbennig'. Cydnabuwyd bod angen i'r Bwrdd Iechyd gryfhau ei arweinyddiaeth a'i brosesau llywodraethu yn ei dri safle acíwt.

10 Cyflwynodd y Bwrdd Iechyd swydd fewnol, sef Cyfarwyddwr Trawsnewid, i sicrhau bod costau'n cael eu harbed a bod arbedion effeithlonrwydd yn parhau i gael eu gwneud. Fodd bynnag, ni lwyddodd y trefniadau mewnol i sicrhau'r gwelliannau angenrheidiol. Roedd y diffyg ariannol yn cynyddu, a'r cynlluniau ar gyfer arbedion yn rhy syml ac eto'n rhy uchelgeisiol, ac nid oedd digon o gapasiti i gyflwyno'r cynlluniau tra bod pwysau ar wasanaethau eraill. Gyda Llywodraeth Cymru, penderfynwyd y byddai'n syniad da cyflwyno swydd arbenigol i helpu'r Bwrdd Iechyd â'i adferiad ariannol.

11 Mae'r Pwyllgor Cyfrifon Cyhoeddus wedi craffu ar berfformiad a phrosesau llywodraethu'r Bwrdd Iechyd yn rheolaidd, ac yn ei adroddiad ym mis Mai 2019, dywedodd y Pwyllgor:

- Nid ydym wedi ein hargyhoeddi bod digon o adnoddau'n cael eu neilltuo i gamau trawsnewid, ac er bod y Bwrdd wedi penodi Cyfarwyddwr Trawsnewid[1], rydym yn argymell y dylai'r Bwrdd ystyried cyflwyno arbenigwyr allanol ychwanegol ar drawsnewid er mwyn cynorthwyo yn hyn o beth.

12 Ar 19 Gorffennaf 2019, ysgrifennodd Prif Weithredwr y Bwrdd Iechyd (ar y pryd) at Gyfarwyddwr Cyffredinol Grŵp Iechyd a Gwasanaethau Cymdeithasol Llywodraeth Cymru yn cynnig strwythur newydd ar gyfer gweithrediaeth ei sefydliad ac yn gofyn i Lywodraeth Cymru gefnogi amrywiaeth o gynlluniau ar gyfer cryfhau gallu a chapasiti. Roedd y cynlluniau newydd hyn yn deillio o waith yr oedd y Bwrdd Iechyd wedi'i wneud yn ddiweddar gyda chymorth PricewaterhouseCoopers (PWC).

[1] Cyfeiriad at benodiad mewnol a wnaethpwyd gan y Bwrdd Iechyd cyn penodi Cyfarwyddwr Adfer Dros Dro allanol ym mis Mehefin 2019.

13 Gofynnodd y Bwrdd Iechyd i Lywodraeth Cymru ddarparu £350,000 o gyllid 2019-20 ychwanegol tuag at y gost o gyflogi Cyfarwyddwr Adfer. Roedd llythyr y Prif Weithredwr yn dweud:

- mae angen i'r Cyfarwyddwr Adfer gael effaith arwyddocaol ac uniongyrchol ar ein cyfradd rhedeg ac ar Gynlluniau Gwella Costau dros y ddeufis nesaf er mwyn ein galluogi i sicrhau ein cyfanswm rheoli ariannol ar gyfer 2019-20.

14 Roedd atodiad i lythyr y Prif Weithredwr yn rhoi rhagor o fanylion am y rôl:

- Yn dilyn trafodaethau ag Uned Gyflawni Cyllid Llywodraeth Cymru ynghylch cryfhau'r broses drawsnewid, ynghyd ag argymhelliad gan PWC, roedd y Bwrdd Iechyd wedi cymryd camau i wella ei allu i drawsnewid pethau drwy drefnu i gael gwasanaethau ymgynghori gan Gyfarwyddwr Adfer. Bydd hyn am gyfnod o ddim mwy na 9 mis, hyd at ddiwedd Mawrth 2020, a'r nod yw ein galluogi i wella ein gwaith cyflawni ariannol fwy byth, a chefnogi'r broses o ddatblygu cynllun effeithlonrwydd ar gyfer y tymor hwy.

15 Atebodd y Cyfarwyddwr Cyffredinol ar 29 Awst 2019:

- Rwy'n llawn sylweddoli pa mor hanfodol yw'r gwaith adfer ariannol, a pha mor bwysig yw sicrhau arweinyddiaeth gadarn llawn ffocws er mwyn cyflawni hyn. Yn amodol ar gymeradwyaeth gan Weinidogion, rwy'n fodlon mewn egwyddor cytuno i roi £350,000 tuag at gostau yn y maes pwysig hwn. Rwyf hefyd yn gefnogol, mewn egwyddor, i ddarparu'r adnoddau y gofynnwyd amdanynt ar gyfer gwella gwasanaethau, ond mae angen rhagor o fanylion am eich methodoleg, sut mae'n cyd-fynd â'r cymorth ychwanegol sy'n cael ei dderbyn gan PWC ar hyn o bryd, a'r trefniadau pontio i ddatblygu eich gallu mewnol i gyflawni'r agenda trawsnewid.

16 Cyn yr ohebiaeth hon ddechrau Mehefin 2019, roedd PWC wedi darparu CV unigolion a allai gael eu hystyried ar gyfer rôl Cyfarwyddwr Adfer Dros Dro i'r Bwrdd Iechyd. Roedd y Bwrdd Iechyd wedi llunio rhestr fer ac wedi cyf-weld tri pherson ar gyfer y rôl. Roedd y panel cyf-weld yn cynnwys unigolyn annibynnol gyda phrofiad proffesiynol perthnasol yn y maes hwn.

17 Ystyriodd y panel sgiliau a phrofiadau pob un o'r ymgeiswyr a gyfwelwyd. O blith y tri, yr ymgeisydd llwyddiannus ddangosodd y sgiliau mwyaf priodol o ran arddull a chefndir (clinigol) ar gyfer y rôl. Yn ogystal â hyn, roedd y ddau ymgeisydd arall yn gofyn am 'gyfnod sylfaenol' gydag unrhyw sefydliad yr oeddent yn ei gefnogi. Roedd y cyfnod sylfaenol hwn yn amrywio o 18 mis i ddwy flynedd.

18 Roedd y Prif Weithredwr oedd yn cadeirio'r panel cyf-weld wedi awdurdodi'r penderfyniad i benodi Cyfarwyddwr Adfer Dros Dro drwy Hunter Healthcare Resourcing Ltd, asiantaeth a restrir ar gytundeb fframwaith y GIG. Byddai'r penodiad yn cychwyn ar 1 Gorffennaf 2019 ac yn dod i ben ar 27 Mawrth 2020. Roedd y Cyfarwyddwr Cyllid hefyd wedi cymeradwyo'r penodiad ac wedi llofnodi'r cytundeb gyda Hunter Healthcare Resourcing Ltd ar 17 Mehefin 2019.

19 Cytunodd y Bwrdd Iechyd i dalu cyfradd o £1,990 y dydd i'r asiantaeth oedd yn cyflenwi'r Cyfarwyddwr Adfer Dros Dro, ac roedd hynny'n cynnwys ad-daliad wedi'i

gapio o £100 y dydd ar gyfer treuliau rhesymol a fyddai'n golygu bod yr unigolyn ar ei golled.

20 Yn ôl y cytundeb, nod rôl y Cyfarwyddwr Adfer Dros Dro oedd:

- darparu goruchwyliaeth ychwanegol ar gyfer y gyfradd rhedeg ariannol, gan roi cyngor ynglŷn ag arbedion effeithlonrwydd a chefnogi'r gwaith o'u cyflwyno;
- cynghori a chefnogi'r gwaith o ddatblygu rhaglen effeithlonrwydd yn unol â sefyllfa ariannol ac adferiad y Bwrdd Iechyd;
- cefnogi'r broses o roi'r strwythurau hanfodol sydd eu hangen i gyflwyno rhaglen effeithlonrwydd ariannol ar waith;
- gweithio gyda'r Cyfarwyddwr Cyllid a Chyfarwyddwr y Gweithlu i sicrhau bod y broses o adrodd yn ôl am gynnydd yn gadarn, a bod y Prif Weithredwr yn cael gwybod am bob risg neu rwystr;
- rhoi cyngor ar yr adnoddau angenrheidiol sydd ar gael i wneud yn siŵr bod y rhaglen adfer yn cael ei chyflawni.

21 Penodwyd yr unigolyn i'r swydd, a chytunodd y Bwrdd Iechyd ar delerau'r contract ym mis Mehefin 2019, cyn llythyr y Prif Weithredwr i'r Cyfarwyddwr Cyffredinol ar 19 Gorffennaf, a chadarnhad Llywodraeth Cymru ynghylch y cais am £350,000 mewn egwyddor ar gyfer Cyfarwyddwr Adfer Dros Dro ar 29 Awst. Nid oedd y Bwrdd Iechyd yn dibynnu ar y cyllid hwn i fwrw ymlaen â'r penodiad oherwydd byddai modd defnyddio ffynonellau mewnol i'w ariannu.

22 Mae swyddogion Llywodraeth Cymru wedi dweud wrthym fod disgwyl i'r Bwrdd Iechyd benodi'n unol â'r Cyfarwyddiadau Ariannol Sefydlog wrth ddyfarnu'r cyllid hwn.

Cydymffurfio â Chyfarwyddiadau Ariannol Sefydlog y Bwrdd Iechyd

23 Mae'r adran nesaf yn edrych yn fanylach ar y broses ddilynodd y Bwrdd Iechyd wrth benodi'r pum aelod o staff dros dro. Drwy edrych ar benodiad pump uwch aelod o staff dros dro dros gyfnod tebyg, rydym wedi gallu cymharu a chyferbynnu'r prosesau a ddilynwyd, gan esbonio penodiad y Cyfarwyddwr Adfer Dros Dro mewn cyd-destun caffael ehangach.

24 Mae gan y Bwrdd Iechyd reolau clir ynghylch caffael. Maent wedi'u nodi yn ei Ganllawiau Caffael ar gyfer Staff ac yn ei Gyfarwyddiadau Ariannol Sefydlog cymeradwy. Mae'r Cyfarwyddiadau Ariannol Sefydlog yn bodloni'r canllawiau a gyhoeddwyd gan Gwerth Cymru ar ran Llywodraeth Cymru, sydd yn eu tro yn adlewyrchu Rheoliadau Llywodraeth y DU a Chyfarwyddebau'r Undeb Ewropeaidd. Wrth ymateb i gais am wybodaeth, mynegodd y Bwrdd Iechyd fod pob un o'r pum

penodiad dan sylw wedi cael eu gwneud yn unol â'i Gyfarwyddiadau Ariannol Sefydlog[2].

25 Mae'r Cyfarwyddiadau Ariannol Sefydlog yn cyfeirio at y trothwyon sylfaenol ar gyfer dyfynbrisiau a thendro cystadleuol. Mae'r trothwyon hyn yn adlewyrchu gofynion Rheoleiddiol y DU a Chyfarwyddebau'r Undeb Ewropeaidd. Maent wedi'u crynhoi yn y tabl canlynol:

Tabl 1: trothwyon y Bwrdd Iechyd ar gyfer tendro a chaffael

Mae'r tabl hwn yn dangos sut mae'n rhaid i'r Bwrdd Iechyd gaffael nwyddau a gwasanaethau, gan gadw at y trothwyon bandio yn ei weithdrefnau a'i bolisïau ariannol.

Gwerth y Contract (heb gynnwys TAW)	Cystadleuaeth Sylfaenol
<£5,000	Yn ôl disgresiwn y Cyfarwyddwr priodol
Rhwng £5,000 a £25,000	Tri dyfynbris ysgrifenedig
£25,000 – trothwy Cyfnodolyn Swyddogol yr Undeb Ewropeaidd	Pedwar Tendr
Uwchben trothwy Cyfnodolyn Swyddogol yr Undeb Ewropeaidd (£118,133 ar hyn o bryd)	Pum tendr
Contractau rhwng £500,000 ac £1 miliwn	Cymeradwyaeth gan Weinidogion Llywodraeth Cymru ar gyfer nodi
Contractau dros £1 miliwn	Rhaid cael Cymeradwyaeth gan Weinidogion Llywodraeth Cymru

26 Mae'r Cyfarwyddiadau Ariannol Sefydlog hefyd yn nodi[3] y gellid hepgor gweithdrefnau dyfynbrisiau/tendro cystadleuol os oes gan y Bwrdd Iechyd fynediad cyfreithlon at gontract Cymru Gyfan/Cytundeb Fframwaith Cenedlaethol neu gontract Consortiwm Cyflenwadau, ar yr amod y cedwir at reolau cytundeb fframwaith neu gontract o'r fath.

27 Mae cytundebau fframwaith yn gallu bod yn ffordd gosteffeithiol ac effeithlon o sicrhau nwyddau a gwasanaethau gan fod materion fel sicrhau ansawdd a'r cyfraddau uchaf wedi cael eu pennu ymlaen llaw drwy gydgytundeb. Fodd bynnag, mae llawer iawn o gytundebau, ac mae eu telerau ac amodau yn amrywio.

28 Canfuwyd bod pob un o'r penodiadau dros dro wedi cael eu gwneud drwy ddefnyddio cwmnïau oedd wedi'u rhestru ar gytundebau fframwaith cymeradwy. Mae hyn yn cyd-fynd â'r darpariaethau yng Nghyfarwyddiadau Ariannol Sefydlog y

[2] Llythyr gan y Bwrdd Iechyd ar 24 Hydref 2019 – cyfeirnod 335/19/FOI.

[3] Yn Atodlen 1, Canllawiau Atodol ar gyfer Caffael Gwaith, Nwyddau a Gwasanaethau.

Bwrdd Iechyd ac yn y Canllawiau Caffael ar gyfer Staff, fel y nodir ym Mharagraff 26 uchod.

29 O ran y Cyfarwyddwr Adfer Dros Dro, mae dogfennau'r Bwrdd Iechyd yn cadarnhau bod yr asiantaeth a ddefnyddiwyd, sef Hunter Healthcare Resourcing Ltd, wedi'i restru ar fframwaith GIG ar gyfer staff cyfnod penodol a dros dro heb fod yn glinigol. Fodd bynnag, dywedodd y Bwrdd Iechyd wrthym ei fod wedi:

- ymrwymo i gontract â'r asiantaeth [Hunter Healthcare Resourcing Ltd] ar delerau y nodir eu bod yn fwy ffafriol na phe bai fframwaith perthnasol y GIG wedi cael ei ddefnyddio.

30 Mae'r Bwrdd Iechyd wedi darparu gwybodaeth sy'n cefnogi ei arddeliad i ni ei fod, drwy drafodaethau â'r Asiantaeth, wedi sicrhau cyfradd ffafriol, a'i fod ym mhob ystyr arall wedi sicrhau'r un telerau ag y byddai wedi'u sicrhau pe bai wedi cydymffurfio'n llawn â thelerau'r cytundeb fframwaith. Nid ydym wedi datgelu rhagor o fanylion am y trafodaethau er mwyn sicrhau cyfrinachedd masnachol cyfreithlon bob parti.

31 Drwy wneud hyn, a chynnal 'mini-gystadleuaeth' yn unol ag arferion cyffredin ar gyfer personél asiantaethau unigol, mae'r Bwrdd Iechyd yn argyhoeddedig ei fod wedi cydymffurfio â'i bolisïau a'i weithdrefnau caffael. Er nad oes gennym ragor o sylwadau am yr elfen hon o'r broses gaffael, rydym yn sôn yn fanylach am y cyfraddau a dalwyd mewn gwirionedd o'u cymharu â'r cyfraddau yr oedd cyrff iechyd eraill wedi'u talu am wasanaeth Cyfarwyddwr Adfer Dros Dro.

Costau penodi'r Cyfarwyddwr Adfer Dros Dro

32 Cytunodd y Bwrdd Iechyd i dalu cyfradd o £1,890 y dydd i'r asiantaeth oedd yn cyflenwi'r Cyfarwyddwr Adfer Dros Dro, ac roedd hynny'n cynnwys ad-daliad wedi'i gapio o £100 y dydd am naw mis ar gyfer treuliau rhesymol a fyddai'n golygu bod yr unigolyn ar ei golled. Mae'r taliad yn cyd-fynd â Pholisi Treuliau'r Bwrdd Iechyd. Y gost a glustnodwyd ar gyfer y penodiad hwn dros y naw mis yw £340,200. Mae Llywodraeth Cymru wedi cytuno i gyfrannu £350,000 tuag at y costau hyn.

33 Gan ystyried y gost sylweddol o gyflogi Cyfarwyddwr Adfer Dros Dro, aethom ati i geisio gweld sut yr oedd y Bwrdd Iechyd wedi argyhoeddi ei hun fod y gyfradd ddyddiol oedd yn rhan o'r contract yn werth da am arian. Dywedodd y Bwrdd Iechyd wrthym ei fod wedi:

- meincnodi cyfradd y farchnad yn erbyn cyfraddau'r ymgeiswyr eraill, ynghyd â phrofiad y panel cyf-weld o benodiadau blaenorol mewn sefydliadau eraill, gan gofio bod pob un ohonynt wedi cael profiad o gyflogi Cyfarwyddwyr Trawsnewid/Adfer yn y gorffennol.

34 Fel yr eglurwyd yn gynharach, cyfwelwyd tri ymgeisydd ar gyfer y rôl. Roedd cyfradd ddyddiol un o'r ymgeiswyr gryn dipyn yn uwch na chyfradd ddyddiol yr ymgeisydd llwyddiannus, ac roedd cyfradd y trydydd ymgeisydd fymryn yn is. Nid ydym yn datgelu'r cyfraddau gwirioneddol er mwyn sicrhau cyfrinachedd masnachol. Roedd Cyfarwyddwr Gweithredol y Gweithlu hefyd yn ymwybodol o

enghreifftiau eraill yn y cyfryngau lle'r oedd cyfraddau'n £1,700 a £3,000 y dydd. Mae costau blynyddol y cymaryddion hyn i'w gweld yn Nhabl 2 isod.

35 Yn ogystal â hyn, dywedodd y Cyfarwyddwr Cyllid Gweithredol Dros Dro hefyd fod y Bwrdd Iechyd wedi edrych ar gyfraddau a gyhoeddwyd ar gyfer Cyfarwyddwyr Adfer/Trawsnewid sefydliadau NHS England. Mae'r rhain wedi'u cynnwys yn Nhabl 2 isod.

Tabl 2: cyfraddau cyrff cymharol NHS England a ddefnyddiwyd gan y Bwrdd Iechyd i feincnodi cost y Cyfarwyddwr Adfer Dros Dro

Mae'r tabl hwn yn dangos y cyfraddau y mae rhai cyrff iechyd yn Lloegr yn eu talu am Gyfarwyddwyr Adfer Dros Dro, ac mae'n cymharu'r rhain â'r gyfradd a negodwyd gan Fwrdd Iechyd Betsi Cadwaladr ac a gytunwyd gydag asiantaeth Hunter Healthcare Resourcing Ltd. Nid ydym wedi enwi sefydliadau NHS England ar sail cyfrinachedd masnachol.

Cymharydd – NHS England	Cyfradd fisol	Cost flynyddol
Cymharydd 1	£45,000	£540,000
Cymharydd 2	£34,000	£408,000
Cymharydd 3	£34,000	£408,000
Cymharydd 4	£30,000	£375,000
Cymharydd 5	£30,000	£360,000
Cymharydd 6	£28,000	£338,000
Cymharydd 7	£25,000	£300,000
Bwrdd Iechyd Lleol Betsi Cadwaladr (contract Mehefin 2019)	£37,800 (cyfradd ddyddiol o £1,890 yn seiliedig ar fis 20-diwrnod)	£453,600 (gwerth y contract naw mis yw £340,200)

36 At ddibenion cymharu, mae'r gost a'r gyfradd ddyddiol a gyllidebwyd ar gyfer y Cyfarwyddwr Adfer Dros Dro dros y cyfnod o naw mis yn cyfateb i £453,600 y flwyddyn[4]. Fel y mae Tabl 2 yn ei ddangos, mae hon yn gyfradd uwch na'r hyn a welir ar gyfer y cymaryddion yn NHS England, a ddarparwyd gan y Cyfarwyddwr Cyllid.

[4] £340,200/9 mis x 12 mis.

Gwybodaeth arall a ystyriwyd fel rhan o'n hadolygiad

37 Mae deddfwriaeth cyfryngwyr yn berthnasol yn yr amgylchiadau hyn lle mae'r unigolyn yn hawlio 'statws oddi ar y gyflogres' at ddibenion treth ac Yswiriant Gwladol. Cyfrifoldeb y cyflogwr yw gwneud yn siŵr y cedwir at y ddeddfwriaeth yn briodol fel rhan o'i drefniadau diwydrwydd dyladwy. Aseswyd bod tri o'r uwch benodiadau dros dro o blith y pump yn bodloni'r meini prawf ar gyfer 'statws oddi ar y gyflogres'. Mae'r dogfennau gofynnol yn eu lle ar gyfer y tri chontract.

38 Cafwyd o leiaf un geirda ysgrifenedig gan gyflogwr diweddar ar gyfer pedwar o'r pump uwch benodiad dros dro a adolygwyd fel rhan o'r archwiliad.

39 Ni chafwyd unrhyw eirdaon ysgrifenedig ar gyfer y Cyfarwyddwr Adfer Dros Dro ond dywedodd y Bwrdd Iechyd wrthym:

- cafodd geirdaon llafar eu darparu'n uniongyrchol gan PWC i Gadeirydd a Phrif Swyddog Gweithredol Bwrdd Iechyd Prifysgol Betsi Cadwaladr, a gan Gyfarwyddwr Cyllid Ymddiriedolaeth GIG Blackpool i Brif Swyddog Gweithredol Bwrdd Iechyd Prifysgol Betsi Cadwaladr. Roedd gan y Prif Swyddog Gweithredol a'r aelod annibynnol o'r panel cyf-weld brofiad blaenorol o weithio gyda'r ymgeisydd llwyddiannus; ac
- er mwyn cael eu cymeradwyo ar y Fframwaith, rhaid i bob cyflenwr gadw geirdaon cyfredol ar gyfer yr holl weithwyr a ddarperir.

40 Ar 12 Rhagfyr, cyflwynodd y Cyfarwyddwr Cyllid Gweithredol Dros Dro Adroddiad Cydymffurfio Ariannol i gyfarfod Pwyllgor Archwilio'r Bwrdd Iechyd. Roedd yr adroddiad yn amlinellu cydymffurfiad o ran caffael wrth gyflogi gweithwyr dros dro yn ystod y cyfnod rhwng mis Gorffennaf a mis Medi 2019. Roedd yr 11 enghraifft o staff dros dro a gyflogwyd yn ystod y cyfnod hwn yn cynnwys y Cyfarwyddwr Adfer Dros Dro a'r Cyfarwyddwr Gofal Acíwt Dros Dro.

41 Dyma un o ganfyddiadau'r adroddiad o ran penodi staff dros dro:

- Nid oedd y tîm caffael wedi'u cynnwys yn y prosesau cyflogi hyn yn amserol, ac nid oedd Archebion Prynu wedi cael eu codi cyn i'r gwariant gael ei ymrwymo.

42 Mae'r adroddiad cydymffurfio yn dangos bod archebion prynu ôl-weithredol wedi cael eu codi ar gyfer chwech o'r 11 aelod o staff dros dro a gychwynnodd yn eu swydd yn ystod ail chwarter 2019-20. Roedd y Cyfarwyddwr Adfer Dros Dro yn un o'r chwe rôl a restrwyd fel rhai nad oeddent yn cydymffurfio.

Cynnydd y Bwrdd Iechyd o ran adferiad ariannol

43 Mae rôl dros dro y Cyfarwyddwr Adfer yn cynnwys dwy elfen graidd; canfod a sicrhau arbedion; a sefydlu trefniadau llywodraethu a fydd yn gallu cynnal gwell sefyllfa ar gyfer y dyfodol.

44 Mae'n anodd dweud faint yn union o effaith bersonol y mae'r Cyfarwyddwr Adfer Dros Dro yn ei chael ar ymdrechion y Bwrdd Iechyd i adfer ei hun yn ariannol, gan gofion bod staff ym mhob rhan o'r sefydliad yn cyfrannu at hyn mewn gwahanol ffyrdd. Mae sawl ffactor yn effeithio ar y sefyllfa, gan gynnwys gwahaniaethau o ran amseru a gwahaniaethau yn natur unrhyw arbedion ariannol (rhai yn arbedion untro ac eraill yn rheolaidd).

45 Fodd bynnag, yn fy Asesiad Strwythuredig o'r Bwrdd Iechyd ym mis Rhagfyr 2019, nodwyd bod y dull o ymdrin ag adferiad ariannol o fewn y Bwrdd Iechyd wedi bod yn gryfach o'i gymharu â blynyddoedd blaenorol. Rydym wedi gweld arweinyddiaeth ariannol glir fel rhan o'r broses adfer, gyda chyfrifoldeb wedi'i ddirprwyo ar gyfer adferiad ariannol a chyfleoedd i adnabod a sicrhau arbedion. Mae ffocws y Bwrdd Iechyd ar adferiad, gafael a rheolaeth ariannol yn gryfach nag o'r blaen.

46 Fel y nodais yn fy Asesiad Strwythuredig, mae risg sylweddol o hyd i sicrhau'r £35 miliwn o ddiffyg ar gyfer 2019-20 y mae'r Bwrdd Iechyd am ei weld. Mae'r Bwrdd Iechyd yn sôn am lithriant wrth geisio sicrhau'r arbedion sydd i fod i gael eu gwneud, ac o ran twf mewn costau yn ystod y flwyddyn, sydd wedi golygu bod angen dod o hyd i arbedion ychwanegol. Mae llawer o ffactorau eraill yn dal i gyflwyno heriau, ac oni fydd y rhain yn cael sylw, byddant yn arwain at risg y bydd y cylch ariannol blynyddol o ddiffygion ac ymdrechion i adfer yn digwydd dro ar ôl tro.

Atodiad 1

Crynodeb o'r costau oedd yn gysylltiedig â'r pump uwch benodiad a adolygwyd, ynghyd â'r telerau cyflogi oedd yn rhan o'u contract

Tabl 3: crynodeb o'r costau a'r telerau cyflogi oedd yn rhan o'r contractau

Teitl swydd	Cyfarwyddwr Adfer Dros Dro	Rheolwr Gyfarwyddwr Dros Dro Wrecsam Maelor	Rheolwr Gyfarwyddwr Dros Dro Ysbyty Glan Clwyd	Pennaeth Gwella Gofal wedi'i Gynllunio	Cyfarwyddwr Gwasanaethau Acíwt Dros Dro
Dyddiad Penodi Cychwynnol[5]	1 Gorffennaf 2019	25 Chwefror 2019	24 Ebrill 2019	15 Ebrill 2019	2 Medi 2019
Hyd y contract	Naw mis	Tri mis, wedi'i ymestyn am chwe mis arall	Chwe mis	27 wythnos, wedi'i ymestyn am naw wythnos arall	31 wythnos ond wedi dod i ben ar ôl wyth wythnos
Statws – Llawn Amser/Rhan Amser	Llawn Amser	Llawn Amser	Llawn Amser	Llawn Amser	Llawn Amser
Cyflenwr a gontractiwyd	Hunter Healthcare Resourcing Ltd	Melber Flinn Ltd	Melber Flinn Ltd	Tricordant Ltd	Xylem Resourcing Partners

[5] Contractau a adnewyddwyd o leiaf unwaith gan arwain at fwy nag un Archeb Brynu

Teitl swydd	Cyfarwyddwr Adfer Dros Dro	Rheolwr Gyfarwyddwr Dros Dro Wrecsam Maelor	Rheolwr Gyfarwyddwr Dros Dro Ysbyty Glan Clwyd	Pennaeth Gwella Gofal wedi'i Gynllunio	Cyfarwyddwr Gwasanaethau Acíwt Dros Dro
Cyflenwr a gontractiwyd ar fframwaith cymeradwy?	Wedi ymrwymo i gontract â'r asiantaeth ar delerau y nodir eu bod yn fwy ffafriol na phe bai'r Bwrdd Iechyd wedi defnyddio'r fframwaith GIG perthnasol. Ond mae'r cyflenwr ar Fframwaith CCS RM6160.	RM971 Ddim yn feddygol nac yn glinigol (NMNC)[6]	RM971 ar gyfer achosion heb fod yn feddygol nac yn glinigol (NMNC)	Dywedodd y Bwrdd Iechyd mai Tricordant Ltd oedd y cyflenwr, sydd ar Fframwaith Health Trust Europe (HTEF)[7]	Byddai'r contract yn cael ei drefnu drwy Tricordant Ltd, sy'n ymgynghorydd partner iddynt, sydd ar Fframwaith Health Trust Europe.
Cyfradd Ddyddiol a Delir i'r Cyflenwr	£1,890 (costau llety wedi'i gapio ar £100 y dydd)	£1,000	£1,118	£715	£1,380 (yn cynnwys y ffioedd a'r treuliau i gyd)

[6] Mae'r fframwaith hwn wedi dod i ben erbyn hyn ac wedi cael ei ddisodli gan RM6160 wef 1 Gorffennaf 2019. Mae Melber Flinn wedi'i restru ar y fframwaith hwn.

[7] Mae Tricordant Ltd wedi'i restru ar nifer o gontractau Fframwaith, gan gynnwys HTEF.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Arrangements for Interim Senior Staff Appointments – **Betsi Cadwaladr University Health Board**

Audit year: 2019-20

Date issued: March 2020

Document reference: 1782A2020-21

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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

The team who delivered the work comprised Ian Hughes and Andrew Doughton, working under the direction of Mike Usher.

Contents

Our review examined the process followed by Betsi Cadwaladr University Health Board in appointing five interim senior staff between February and October 2019, including the Interim Recovery Director. The significant cost of that appointment has attracted attention in the media and amongst Assembly members and our review was centred on this role.

Summary report

What this review is about

1 The Auditor General advised the Public Accounts Committee on 11 November 2019 that he intended to examine the arrangements that Betsi Cadwaladr University Health Board (the Health Board) had put in place when making several interim senior staff appointments in the course of that year.

2 Our review has examined the following five appointments:

- Interim Recovery Director;
- Interim Managing Director, Wrexham Maelor;
- Interim Managing Director, Ysbyty Glan Clwyd;
- Head of Planned Care Improvement; and
- Interim Director of Acute Services.

3 Appendix 1 summarises the costs associated with each of these appointments, together with their contractual terms of engagement.

4 Given the significant costs associated with the appointment of the Interim Recovery Director and the attention that this has attracted in the media and amongst Assembly members, our review was centred on this role. The Health Board agreed to pay the agency supplying the Interim Recovery Director the rate of £1,990 per day, inclusive of a capped reimbursement of 'out-of-pocket' reasonable expenses at £100 per day. The post-holder took up this role in July 2019 and the contract is expected to end on 27 March 2020. The committed cost of the assignment over a nine-month period is £340,200.

5 By examining five senior interim appointments over a similar time period, we have been able to compare and contrast the processes followed and to explain the appointment of the Interim Recovery Director in a wider procurement context.

Key findings

6 This 'facts only' report sets out the key matters relating to the five appointments which were made by the Health Board between February and October 2019, and these are summarised as follows:

- we found that all of the interim appointments have been made using firms listed on approved framework agreements. This is consistent with the provisions set out in the Health Board's SFIs and Procurement Guidance for Staff.
- the Welsh Government agreed to contribute £350,000 towards the cost of the Interim Recovery Director, but played no part in the appointment itself, which was made by the Health Board before this funding had been confirmed. The decision to appoint was not dependent on securing the funding from Welsh Government.

- whilst the Health Board asserts that competitive rates were negotiated for the appointment, we found that the £1,890 daily rate being paid by the Health Board is higher than most of the benchmark comparators that were used by officials during the appointment process.
- in contrast to the other four interim appointments, the Health Board only secured verbal references before appointing the Interim Director of Recovery. However, we note that both the Health Board's (then) Chief Executive and an independent member of the interview panel had previous experience of working with the successful candidate. Also, in order to secure approval on the Framework, all suppliers must retain up-to-date references for all workers supplied.

7 The findings of this report need to be viewed in the context of the following observations set out in our Structured Assessment report issued to the Health Board in December 2019:

- it is difficult to identify the specific personal impact that the Interim Recovery Director is having on the Health Board's financial recovery efforts, given that staff across the organisation are contributing to this in various ways. There are many factors that impact on the position to include timing differences and differences in the nature of any financial savings (some are one off and others recurring).
- we have seen clear financial leadership for recovery, with delegated responsibility of financial recovery and the identification and achievement of savings. The focus by the Health Board on financial recovery, grip and control is stronger than before.
- there remains a significant risk to achieving the £35 million deficit for 2019-20 that is planned by the Health Board. The Health Board is reporting slippage against delivery of planned savings, together with aspects of in-year cost growth which have created a need to identify additional savings.
- several other factors continue to present challenges which, if unaddressed, create a risk that the annual financial cycle of 'deficit and attempted recovery' will continue to be repeated.

Detailed report

The events leading up to the appointment of the Interim Recovery Director

8 In June 2015, the Welsh Government placed the Health Board into 'special measures', because of a number of issues including the quality of the Health Board's governance and leadership, concerns over its mental health, maternity and GP out-of-hours services and its approach to service planning and public engagement.

9 On 1 February 2018, the Cabinet Secretary for Health and Social Services announced that maternity services could be de-escalated but some areas of performance needed to remain under the 'special measures' arrangements. It was recognised that the Health Board needed to strengthen leadership and governance across its three acute sites.

10 The Health Board introduced an internal post of Turnaround Director to secure cost savings and ongoing efficiencies. However, the internal arrangements were not effective in securing the improvements needed. Its financial deficit was increasing, and its savings plans were assessed as both simplistic and overly ambitious, with insufficient capacity to deliver the plans alongside other pressures on services. In conjunction with the Welsh Government it was decided to introduce specialist capacity to help the Health Board with its financial recovery.

11 The Public Accounts Committee has regularly scrutinised the Health Board's governance and performance, and in its May 2019 Report the Committee stated that:

- 'We are unconvinced that sufficient resources are being devoted to turnaround action and although the Board has appointed a Director of Turnaround[1], we recommend the Board consider bringing in additional specialist external turnaround expertise to assist with this.'

12 On 19 July 2019 the (then) Chief Executive of the Health Board wrote to the Director General of the Welsh Government's Health and Social Services Group, proposing a new executive structure for his organisation and asking for Welsh Government support for a range of capacity and capability-strengthening initiatives. These new initiatives arose from work that the Health Board had recently conducted with support from PricewaterhouseCoopers (PWC).

13 The Health Board asked the Welsh Government to provide £350,000 additional 2019-20 funding towards the cost of engaging a Recovery Director. The Chief Executive's letter said that:

- 'the Recovery Director (RD) needs to deliver an immediate and significant impact on our run rate and [Cost Improvement Plans] over the next two months to enable us to deliver our [2019-20 financial] control total'.

[1] A reference to an internal appointment made by the Health Board prior to the appointment of an external Interim Recovery Director in June 2019.

14 An appendix to the Chief Executive's letter provided further detail about the role:

- 'Following discussions with the [Welsh Government's Finance Delivery Unit] regarding a strengthening of turnaround approach and a recommendation from PWC the Health Board [had] taken steps to improve its turnaround capability by securing consultancy services from a Recovery Director. This will be for a maximum of 9 months to the end of March 2020 and is aimed at enabling us to achieve greater levels of improvement in our financial delivery and support the development of a longer-term efficiency plan.'

15 The Director General replied on 29 August 2019 in the following terms:

- 'I fully recognise the imperative of the work on financial recovery and the importance of ensuring strong, focussed leadership to ensure delivery. Subject to Ministerial approval, I am content in principle to agree £350,000 towards the costs in this key area. I am also supportive, in principle, of providing the resources requested for service improvement but require more detail on your methodology, how it sits with the additional support currently being received from PWC and transition arrangements to develop your in-house capability to deliver on the transformation agenda.'

16 Prior to this exchange of correspondence in early June 2019, PWC had provided the Health Board with the CVs of individuals who could be considered for the role of Interim Recovery Director. The Health Board shortlisted and interviewed three people for the role. Their interview panel included an independent person with relevant professional experience in this field.

17 The panel considered the skills and experience of each of the candidates interviewed. Of the three candidates, the successful candidate demonstrated the most appropriate skills; style and background (clinical) for the role. In addition, the other two candidates described a requirement for a 'minimum term' with any organisation they were supporting. This minimum term ranged from 18 months to two years.

18 The Chief Executive who chaired the interview panel authorised the decision to appoint the Interim Recovery Director, via Hunter Healthcare Resourcing Ltd, an agency listed on an NHS framework agreement. His appointment would commence on 1 July 2019 and conclude on 27 March 2020. The Director of Finance also approved the appointment and signed the agreement with Hunter Healthcare Resourcing Ltd on 17 June 2019.

19 The Health Board agreed to pay the agency supplying the Interim Recovery Director the rate of £1,990 per day, inclusive of a capped reimbursement of 'out-of-pocket' reasonable expenses at £100 per day.

20 The role of the Interim Recovery Director was set out in the agreement as being to:

- provide additional oversight of the financial run rate with a view to advising on and supporting delivery of efficiencies;
- advise and support the development of an efficiency programme in line with the Health Board's financial position and recovery;

- support the implementation of necessary structures needed to deliver a financial efficiency programme;
- work with the Director of Finance and Director of Workforce to ensure progress reporting is robust, with all risks or barriers escalated to the Chief Executive; and
- advise on necessary resources that are available to ensure the delivery of the recovery programme.

21 The appointment was made, and the contract terms agreed by the Health Board in June 2019, in advance of both the Chief Executive's letter of 19 July to the Director General, and also the Welsh Government's confirmation on 29 August of the requested £350,000 funding allocation in principle for an Interim Recovery Director. The Health Board was not dependent on this funding in order to make the appointment since it could be financed from internal sources.

22 Welsh Government officials have told us that in awarding this funding it was expected that the Health Board would make the appointment in accordance with its Standing Financial Instructions (SFIs).

Compliance with the Health Board's Standing Financial Instructions

23 This next section looks in more detail at the process followed by the Health Board in making the five interim staff appointments. By examining five senior interim appointments over a similar time period we have been able to compare and contrast the processes followed and explain the appointment of the Interim Recovery Director in a wider procurement context.

24 The Health Board has clear rules on procurement as set out within its approved SFIs and Procurement Guidance for Staff. The SFIs meet the guidelines issued by Value Wales on behalf of the Welsh Government, which in turn reflect UK Government Regulations and European Union Directives. The Health Board stated in a response to an information request that all the five posts under consideration had been appointed in accordance with its SFIs[2].

25 The SFIs reference the minimum thresholds for quotes and competitive tendering. These thresholds reflect EU Directives and UK Regulatory requirements, and are summarised in the following table:

[2] A letter issued by the Health Board on 24 October 2019 – reference 335/19/FOI.

Table 1: the Health Board's tendering and procurement thresholds

This table sets out the way in which the Health Board has to procure goods and services within banding thresholds set out in its financial policies and procedures.

Contract Value (ex VAT)	Minimum Competition
<£5,000	At discretion of appropriate Director
£5,000 to £25,000	Three written quotations
£25,000 – OJEU threshold	Four tenders
Above OJEU threshold (currently £118,133)	Five tenders
Contracts between £500,000 and £1 million	Welsh Government Ministerial Approval for noting
Contracts above £1 million	Welsh Government Ministerial Approval required

26 The SFIs also state[3] that the Health Board's 'competitive tendering/quotation procedures may be waived where the [Health Board] has legitimate access to a National Framework Agreement/All Wales contract or Supplies Consortium contract provided that the rules under such contract or framework agreement are adhered to'.

27 Framework agreements can provide a cost effective and efficient means of securing goods and services since matters such as quality assurance and maximum rates have been predetermined in advance through a collective agreement. However, there are a large number of agreements and their terms and conditions vary.

28 We found that all of the interim appointments have been made using firms listed on approved framework agreements. This is consistent with the provisions set out in the Health Board's SFIs and Procurement Guidance for Staff as set out in paragraph 26 above.

29 In the case of the Interim Recovery Director, Health Board documentation confirms that the agency used, Hunter Healthcare Resourcing Ltd, is listed on an NHS framework for non-clinical temporary and fixed-term staff. However, the Health Board told us that they had:

- 'contracted with the agency [Hunter Healthcare Resourcing Ltd] on terms which are stated to be more preferential than if [it] had used the relevant NHS framework'.

30 The Health Board has provided information which supports its assertion to us that a preferential rate was secured through its negotiations with the Agency and in all

[3] In Schedule 1, Procurement of Works, Goods and Services Supplementary Guidance.

other regards they secured the same terms as they would have done by complying fully with the terms of the framework agreement. We have not disclosed further details of the negotiations in order to maintain the legitimate commercial confidentiality of both parties.

31 In doing this and by holding a 'mini-competition' in line with common practice for individual agency personnel, the Health Board is satisfied it has complied with its procurement policies and procedures. Whilst we do not have any further observations to make on this aspect of the procurement process, we do set out more detail about the rates that were actually paid compared to the rates paid by other health bodies for the service of an Interim Recovery Director.

The costs of the Interim Recovery Director appointment

32 The Health Board agreed to pay the agency supplying the Interim Recovery Director the rate of £1,890 per day with a capped reimbursement of 'out-of-pocket' reasonable expenses paid of £100 per day for a nine-month period. Payment is in accordance with the Health Board's Expenses Policy. The committed cost of this assignment for the nine-month period is £340,200. The Welsh Government has agreed to contribute £350,000 towards those costs.

33 We sought to establish how the Health Board had satisfied itself, given the significant cost of procuring an Interim Recovery Director, that the contracted daily rate represented good value for money. The Health Board told us that they had:

- 'benchmarked the market rate against the other candidates' rates together with the [interview] panel's experience of previous appointments in other organisations, given that [they] all had experience of engaging Turnaround/Recovery Directors previously.'

34 As explained earlier, three candidates were interviewed for the role. The daily rate of one candidate was significantly higher than that of the successful candidate and the rate of the third candidate was slightly less. We are not disclosing the actual rates to maintain commercial confidentiality. The Executive Director of Workforce was also aware of other examples disclosed in the media at £1,700 a day and £3,000 a day. We have reflected the annual cost of these comparators in Table 2 below.

35 The Interim Executive Director of Finance also said that the Health Board had also reviewed published rates for Recovery/Turnaround Directors from NHS England organisations which are included below in Table 2.

Table 2: comparator English NHS body rates used by the Health Board to benchmark the cost of the Interim Recovery Director

This table shows the rates paid by some health bodies in England for interim Recovery Directors and compares these with the rate negotiated by Betsi Cadwaladr Health Board and agreed with the agency Hunter Healthcare Resourcing Ltd. We have not named the NHS England organisations on grounds of commercial confidentiality.

Comparator NHS body	Rate per month	Annualised cost
Comparator 1	£45,000	£540,000
Comparator 2	£34,000	£408,000
Comparator 3	£34,000	£408,000
Comparator 4	£30,000	£375,000
Comparator 5	£30,000	£360,000
Comparator 6	£28,000	£338,000
Comparator 7	£25,000	£300,000
Betsi Cadwaladr Local Health Board (June 2019 contract)	£37,800 (the daily rate of £1,890 based on a 20-day month)	£453,600 (the nine-month contract value is £340,200)

36 For comparative purposes, the nine-month budgeted cost and daily rate of the Interim Recovery Director employed by the Health Board equates to an annual cost of £453,600[4]. As shown in Table 2, this is a higher rate than the NHS England comparator cases provided by the Director of Finance.

Other information considered as part of our review

37 Intermediaries legislation applies in these circumstances where the individuals claim an 'off payroll status' for tax and National Insurance purposes. It is the employer's responsibility to ensure the legislation is correctly applied as part of their due diligence. Three of the five interim senior appointments were assessed as meeting the criteria for 'off payroll status'. The required documentation is in place for the three contracts.

38 At least one written reference from a recent employer was obtained for four of the five interim senior appointments reviewed as part of the audit.

[4] £340,200/9 months x 12 months.

39 No written references were obtained for the Interim Recovery Director, although the Health Board told us that:

- 'verbal references were provided direct to Chair and CEO of BCUHB by PWC and by the Director of Finance at Blackpool NHS Trust to the BCUHB CEO and both [the CEO and an independent interview panel member] had previous experience of working with [the successful candidate]'; and
- 'that in order to secure approval on the Framework, all suppliers must retain up to date references for all workers supplied'.

40 A Financial Conformance Report was presented to the 12 December meeting of the Health Board's Audit Committee by the Interim Executive Director of Finance. The report set out the procurement conformance of instances of employing interims during the period July to September 2019. The 11 instances of interims employed in this period included the Interim Recovery Director and the Interim Director of Acute Care.

41 One of the report's findings in relation to the appointment of interim staff was that:

- 'Procurement were not involved in these engagements on a timely basis and Purchase Orders were not raised in advance of the expenditure being committed.'

42 The conformance report highlights that retrospective purchase orders were raised for six of the 11 Interim staff whose roles commenced during quarter two of 2019-20. The Interim Recovery Director was one of the six listed as non-conformant.

Financial recovery progress at the Health Board

43 There are two core aspects to the interim role of the Recovery Director; the identification and securing of savings; and embedding governance arrangements that can sustain an improved position for the future.

44 It is difficult to identify the specific personal impact that the Interim Recovery Director is having on the Health Board's financial recovery efforts, given that staff across the organisation are contributing to this in various ways. There are many factors that impact on the position to include timing differences and differences in the nature of any financial savings (some are one off and others recurring).

45 However, in my December 2019 Structured Assessment of the Health Board, we noted that there had been a stronger approach to financial recovery within the Health Board, compared to previous years. We have seen a clear financial leadership for recovery, with delegated responsibility of financial recovery and the identification and achievement of savings. The focus by the Health Board on financial recovery, grip and control is stronger than before.

46 As I noted in my Structured Assessment, there remains a significant risk to achieving the £35 million deficit for 2019-20 that is planned by the Health Board. The Health Board is reporting slippage against delivery of planned savings, together with aspects of in-year cost growth which have created a need to identify

additional savings. Several other factors continue to present challenges which, if unaddressed, create a risk that the annual financial cycle of ‘deficit and attempted recovery’ will continue to be repeated.

Appendix 1

Summary of the costs associated with the five senior appointments reviewed together with their contractual terms of engagement

Table 3: summary of costs and contractual terms of engagement

Job title	Interim Recovery Director	Interim Managing Director Wrexham Maelor	Interim Managing Director Ysbyty Glan Clwyd	Head of Planned Care Improvement	Interim Director of Acute Services
Initial Appointment Date[5]	1 July 2019	25 February 2019	24 April 2019	15 April 2019	2 September 2019
Length of contract	Nine months	Three months, extended for another six months	Six months	27 weeks, extended for another nine weeks	31 weeks but ended after eight weeks
Full/Part Time Status	Full Time	Full Time	Full Time	Full Time	Full Time
Contracted supplier	Hunter Healthcare Resourcing Ltd	Melber Flinn Ltd	Melber Flinn Ltd	Tricordant Ltd	Xylem Resourcing Partners

[5] Contracts renewed on at least one occasion resulting in multiple Purchase Orders

Job title	Interim Recovery Director	Interim Managing Director Wrexham Maelor	Interim Managing Director Ysbyty Glan Clwyd	Head of Planned Care Improvement	Interim Director of Acute Services
Contracted supplier on an approved framework?	'Contracted with the agency on terms which are stated to be more preferential than if the Health Board had used the relevant NHS framework.' But supplier is on Framework CCS RM6160.	RM971 for Non-Medical Non-Clinical (NMNC)[6]	RM971 for Non-Medical Non-Clinical (NMNC)	Health Board stated that the supplier was Tricordant Ltd which is on the Health Trust Europe Framework (HTEF)[7]	'Contract would be arranged through their partner consultancy Tricordant Ltd who are on the Health Trust Europe Framework.'
Daily Rate Paid to Supplier	£1,890 (accommodation expenses capped at £100 per day)	£1,000	£1,118	£715	£1,380 (inclusive of all fees and expenses)

[6] This framework has since expired and has been replaced with RM6160 wef 1 July 2019. Melber Flinn are listed on this framework.

[7] Tricordant Ltd are listed on a number of Framework contracts to include HTEF.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee** **19/03/20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Audit Committee Cycle of Business 2020/21
Cyfarwyddwr Cyfrifol: Responsible Director:	Acting Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Acting Board Secretary
Atodiadau Appendices:	1. Audit Committee Proposed Annual Cycle of Business: 2020-21

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Note and agree the contents of this report and agree the 2020/21 Cycle of Business (CoB)

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

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

Sefyllfa / Situation:

As part of the 2019/20 cycle of business, Members are asked to review and agree the proposed CoB for the next financial year.

Cefndir / Background:

Following discussion with the Chair, the Acting Board Secretary and Auditors, a decision was made to include the proposed CoB in Public Committee. The CoB for 2020/21 is detailed at Appendix 1.

Asesiad / Assessment & Analysis

Strategy Implications

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

Financial Implications

This report is purely administrative. There are no associated finance implications other than those that may be included in the individual items on the CoB.

Risk Analysis

This report is purely administrative. There are no associated Risk implications other than those that may be included in the individual items on the CoB.

Legal and Compliance

Improved transparency in accordance with the Standing Orders, s.7 and the Standards of Business Conduct, s.8.

Impact Assessment

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

Appendix 1: Audit Committee Proposed Annual Cycle of Business - 2020-21

Agenda Item	07/05/20 (May) workshop	28/05/20 (May)	17/09/20 (Sept)	17/12/20 (Dec)	18/03/21 (March)	Notes	Public or Private Ctte
Opening Business							
Members discussions with internal and external audit		√	√	√	√	IMs and Auditors to have 15 minute pre-meeting before each meeting (agreed 19.3.15)	Private
Apologies for absence	√	√	√	√	√		Public
Minutes of previous meeting for accuracy & matters arising and review of summary action plan		√	√	√	√		Public
Governance							
Chair's Assurance Report Risk Management Group (RMG)		√	√	√	√	Risk Management Group. Standing item added as of March 2020	Public
Review Corporate Risk and Assurance Framework (CRAF)					√	CRAF and Risk Management (RM) Strategy previously one item. Split into separate items to take into account revised RM Strategy and incorporate annual review prior to Board ratification	Public
Risk Management Strategy Review					√	Annual review prior to final approval at Board	Public
Review of Corporate Risk Register				√			Public

Agenda Item	07/05/20 (May) workshop	28/05/20 (May)	17/09/20 (Sept)	17/12/20 (Dec)	18/03/21 (March)	Notes	Public or Private Ctte
Other sources of assurance (audit reports, regulatory body reports, external reviews, shared services reports)		√	√	√	√		Varies depending on content
Note business of other committees and review inter-relationships	review cttee annual reports				x self-assessment	Self-assessment now being undertaken via Committee Business Management Group (CBMG)	Public
Review of amendments to Standing Orders (SOs)		√	√	√	√		Public
Review draft Annual Governance Statement (AGS)	draft	approval					Public
Review draft Annual Quality Statement (AQS)		approval				Draft received in 19/03/20 Committee. Approval in May. Publish 31/05/20	Public
Review organisation's annual report (incorporating sustainability report)		approval					Public
Annual review of gifts & hospitality and Declarations of Interest (DoI) registers			√				Public
Special Measures Progress Update on relevant areas						Revised schedule awaited	Public
Legislation Assurance Framework			√		√		Public

Agenda Item	07/05/20 (May) workshop	28/05/20 (May)	17/09/20 (Sept)	17/12/20 (Dec)	18/03/21 (March)	Notes	Public or Private Ctte
Annual review of submissions on Database to capture externally commissioned reports etc. E.g. Delivery Unit, Community Health Council etc.		√				To be incorporated within tracker report	Private
Finance							
Review of amendments to Standing Financial Instructions (SFIs)		√	√	√	√		Public
Post payment verification progress report			√		√	Post Payment Verification year-end report and next financial year plans received in March	Private
Dental Assurance Report			√		√	Dental data 6 monthly, next iteration Sep 2020, as agreed by Chair 08/01/20.	Private
Financial Conformance report (inc review of losses & special payments, review of risks and controls and reporting of any SO breaches)		√	√	√	√		Private
Agree financial accounting timetable				√		Included in Financial Conformance Report	Private
Review annual accounting progress					√	Included in Financial Conformance Report	Private
Schedule of Financial Claims		√	√	√	√		Public

Agenda Item	07/05/20 (May) workshop	28/05/20 (May)	17/09/20 (Sept)	17/12/20 (Dec)	18/03/21 (March)	Notes	Public or Private Ctte
Review of audited annual accounts and financial statements including Charitable Funds if ready		√		CF final			Public
Internal Audit							
Internal Audit (IA) progress report		√	√	√	√		Public
Report from IA tracker tool		√	√	√	√		Private
Audit reports issued to the Health Board		√	√	√	√		Public
Review and approval of internal audit plan					√		Public
Internal Audit Charter (incorporating Terms of Reference for internal audit)					√		Public
Receive annual internal audit report (Head of IA opinion)		√					Public
Review effectiveness of internal audit		√	√	√	√	Continuous process and via regular meetings prior to Committee	Public
Any no assurance or limited assurance reports as a substantive item		√	√	√	√		Public
External Audit							
Auditor General's external audit (EA) progress reports		√	√	√	√		Public
Report from EA tracker tool		√	√	√	√		Private

Agenda Item	07/05/20 (May) workshop	28/05/20 (May)	17/09/20 (Sept)	17/12/20 (Dec)	18/03/21 (March)	Notes	Public or Private Ctte
Audit reports issued to the Health Board		√	√	√	√		Public
National audit reports for information		√	√	√	√		Public
Review and approval of Auditor General's (external audit) plan					√		Public
Structured Assessment				x feedback	x final report		Public
Receive Auditor General's report to those charged with governance (through letter of representation)		√					Public
Receive the Auditor General's annual audit report					√		Public
Review the effectiveness of external audit (through quarterly WAO progress reports)		√	√	√	√	Continuous process and via regular meetings prior to Committee	Public
Counter Fraud							
Review counter fraud progress reports		√	√	√	√		Private
Agree counter fraud annual work plan					√	Annual work plan usually received in March. 2019/20 submission in May due to Committee timings	Private
Review effectiveness of Local Counter Fraud Specialist (through NHS Protect Assessment)			√				Private
Counter fraud annual report		√					Private

Agenda Item	07/05/20 (May) workshop	28/05/20 (May)	17/09/20 (Sept)	17/12/20 (Dec)	18/03/21 (March)	Notes	Public or Private Ctte
Clinical Audit							
Clinical audit plan		√			√		Public
Audit Committee							
Plan how to discharge audit committee duties					Agree Cycle of Business		Public
Undertake self-assessment of Committee effectiveness						Undertaken via CBMG - process of continual assessment	N/A
Briefings and update sessions (as appropriate)	√	√	√	√	√		Public
Produce Committee annual report including refresh of ToR	x draft	x final					Public
Members discussion with Head of Counter Fraud				√		To be arranged outside of meetings between Chair and Head of Counter Fraud	Private
Closing Business							
Summary of In Committee business to be reported in public		√	√	√	√		Public
Issues of Significance		√	√	√	√		Public
Date of Next meeting(s)		√	√	√	√		Public