Bundle Joint Audit and QSE Committee 24 November 2020

9.30am via Webex video conferencing
Public Session

1 JAQS20/1 Chairs' Welcome

2 JAQS20/2 Declarations of Interest

3 JAQS20/3 Apologies for Absence

Sue Green, Arpan Guha,Sue HIll, Eifion Jones, Teresa Owen, Chris Stockport

4 JAQS20/4 Review of Summary Action Log

JAQS20.4 Summary Action log JAQS Committee 17.11.20.docx

5 JAQS20/5 Clinical Audit Annual Report 2019-20 : Kate Clark

Recommendation:
The Joint Committee asked to approve the Clinical Audit Annual Report 2019/20.

JAQS20.5a Clinical Audit Annual Report 2019-2020.docx

JAQS20.5b Clinical Audit Annual Report 2019-2020 Appendix 1.docx

JAQS20.5c Clinical Audit Annual Report Tier 2 Appendix 2.pdf

JAQS20.5d Clinical Audit Annual Report Tier 3 Appendix 3.docx

6 JAQS20/6 Delivering Effective Clinical Audit : Kate Clark

Recommendation:
The Joint Committee is asked to discuss whether they agree the proposed actions will provide an effective clinical audit function that will support quality improvement leading to safe, high quality care whilst providing the assurance required by the Joint Committee.

JAQS20.6 Delivering Effective Clinical Auditv2.docx

7 JAQS20/7 Progress Update on Risk Management Strategy : Simon Evans-Evans

Recommendation:
The Joint Audit and QSE Committee is asked to:
1. Review the report.
2. Note the progress implementing the Health Board\`s new Risk Management Strategy & Policy.

JAQS20.7 Risk Management Update Report - v2-Final.docx

8 JAQ20/8 Audit Reviews - Debra Hickman

Appendix 1 (falls briefing note) to follow
Andrew Kent to attend to provide verbal update on Operating Theatres Review

Recommendation:
The Joint Committee is asked to receive the update.

JAQS20.8a Audit Reviews cover report.docx

JAQS20.8b - Appendix 2 Audit Reviews.pdf

9 JAQS20/9 Quality Governance Self-Assessment Action Plan : Matt Joyes

Recommendation:
The Joint Committee is asked to note the enclosed update of the Quality Governance Self-Assessment Action Plan.

JAQS20.9a Quality Governance Arrangements Cover Paper.docx

JAQS20.9b Quality Governance Arrangements Action Plan Appendix 1.docx

10 JAQS20/10 Governance Arrangements During Covid-19 : Dawn Sharp

Recommendation:
The Joint Committee is asked to note:-
(1) the Internal Audit report and in particular the priority considerations for the future;
(2) that these priority considerations are being actively via Team Central and reported to the Audit Committee;
(3) the Guidance as issued by Welsh Government in respect of discharging Board Committee responsibilities during COVID-19 response phase.

JAQS20.10a Governance arrangements during COVID.docx

JAQS20.10b Appendix 1 -Final BCUHB 2020-21 Covid19 Governance Advisory Report.pdf

JAQS20.10c Appendix 2 - Governance principles.docx

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Actions from meeting held on 9.11.17				
Adrian Thomas	JAQS 17/5 Clinical Audit Report – Future reports to take on board the suggestions put forward by the Committee namely:-			
	Intended outcomes to be captured as well as progress on specific recommendations	November 2018	28.10.19 Closed audits are asked to report evidence of change 5.11.19 MM indicated it was not possible to provide full assurance that the actions were fully robust in terms of outcomes. JAQS decided to leave action open until it can be evidenced as completed. 02.03.20: Lack of capacity in the team has delayed the production of a quarterly progress report. A progress report is planned for April CAESG 04.11.20: Q1&2 report drafted and to be discussed at CEG in November; outcomes to be reported in the annual report which is on the agenda for 24.11.20	Recommended for closure
	Summary of main headlines to be captured for reporting to the Board.	November 2018	28.10.19 Reports as planned will include highlights and outlier status / standards for improvement. For Tier 1 this will be national and local. 5.11.19 Noted would be done going forward, however, JAQS decided to leave action open until it can be evidenced as completed. 02.03.20: Action needs to remain open until the reporting framework is established – potentially following next JAQS meeting provided the annual report received is acceptable. 04.11.20: Monthly escalation report to CEG from October 2020 reporting delays. CEG Triple A report to include this 2020 to report to QSE (Action AG)	

			16.11.20 Outputs from quality governance review, and establishing Chair's reports up to QSE from PSQ, PCE, CEG and OHSG will enable appropriate escalation/reporting to Board through QSE Chair's report.	Recommended for closure
	RAG rating system to be adopted and whether recommendation was implemented and within timeframe	November 2018	28.10.19 Quarterly reporting template will document if the audit is on track or delayed- and any remedial action 5.11.19 Noted would be done going forward, however, JAQS decided to leave action open until it can be evidenced as completed. 02.03.20 as above 04.11.20: as above	
	Trajectory showing whether improvements are being made year on year	November 2018	28.10.19 Needs further discussion to understand a level of reporting that is meaningful 5.11.19 Discussion around what exactly the JAQS needed. Agreed that the action related to annual audits where there were improvements to be made and needed to be reported going forwards to demonstrate learning from audits as part of the audit cycle. 02.03.20 Actions reported nationally to WG (part B) will be tracked and reported through the quarterly reports and annual plan. 04.11.20: Working with Leads to ensure action plans support tacking. Investigating tracking system; this will require additional funding to enable this. Completed actions are reported within the annual report	Recommended for closure
	Indicators to show whether all leads within a particular area are working to the same level	November 2018	28.10.19 Reporting full, partial and no compliance with audit activity by area 5.11.19 The Committee requested that the action more appropriately related to whether audit leads were working to the same audit standards as opposed to compliance against the plan. Action to remain open until there is evidence that it has been addressed.	Recommended for closure

			04.11.20: Annual report includes compliance against standards/national average and comparison to previous year for tier 1 audits.	
	Emphasis to be placed on reflective learning and examining the results of audits in conjunction with performance data in order to provide effective triangulation;	November 2018	28.10.19 Emphasis is being placed on improvement activity and reporting/sharing work. 5.11.19 The Committee decided that this action needs to remain open as the Clinical Audit Report was focussed on activity rather than outcomes and learning. 04.11.20 Annual report includes changes in practice as does the quarterly report; assurance will increase over time.	Recommended for closure
Gill Harris/Adrian Thomas	JAQS 17/5 Clinical Audit Report – GH &AT to discuss highest risk factors outside the meeting.	December 2017	Superseded by discussion and agreement of corporate clinical audit plan at QSG. Revised interim plan includes risk assessment - this will be strengthened going forward (Sept 2019) 28.10.19 Approved plan has risk stratification within it 5.11.19 LR suggested that a Committee action could not be superseded by discussion at an operational group. The Clinical Audit Report in its current form does not identify any risk factors or prioritisation and so the action is to remain open. 10.03.20 This relates to the clinical audit report identifying risk factors with non-compliance and prioritising actions to ensure risk is being addressed appropriately. For Tier 1 audits the Welsh Government returns highlight any areas of significant concern and the action plan addresses these and other priority areas identified by the audit lead. These would then be raised within the audit report currently actions are not reported back in a timely way; this will be addressed in the reporting framework in 2020/21. For example, there has been a recent communication about YGC being an outlier on the 30 day risk adjusted mortality within the	

			national stroke audit and a response with action plan being followed up through the stroke governance group. For Tier 2 audits, when there is significant concern this has been escalated through the governance structure – for example, the consent audit in 2019 was reported to Secondary Care Quality Group with a request from Dr Clark to all Site MDs to produce an action plan for improvement; these have not been forthcoming and the issue has been escalated to QSG. Going forward these will be raised through the new reporting framework. Remains open until there is confidence in the reporting system. 04.11.20: SOP to describe escalation process ensuring the review and improvement plan for WG (Part A&B) are completed. Sign off of improvement plan strengthened to ensure SMART actions. Quarterly reports and escalation reports now developed.	
Gill Harris	JAQS 17/5 Clinical Audit Report – Areas of concern noted around stroke. GH agreed to liaise with MD Radiology re forthcoming report on Stroke.	December 2017	28.10.19 There is an action plan to support the SSNAP audit documented in the report on the agenda for 5.11.19 5.11.19 The Clinical Audit Report includes some actions arising from the SSNAP audit but this is not in the form of an action plan and there is no link back to the previous areas of concern discussed in 2017. 02.03.20 This will need to be actioned in the forthcoming report. Remain open 12.11.20 KC confirmed that in terms of stroke related actions 1) all stroke clinicians are trained and there is training arranged to ensure they now have the competencies to identify patients suitable for referral to Walton for thrombectomy. 2) Concern around delay in thrombolysis with a request to thrombolyse in CT2 scanner at YGC and for Stroke nurses to be able to request CT scans has now been completed.	Recommended for closure

Adrian Thomas	JAQS 17/5 Clinical Audit Report – good news stories to be included in future reports	November 2018	Addressed as part of the update report prepared for March 2019 Audit Committee. This will form part of the reporting system to be developed (QSE reports) 28.10.19 This is within the templates 5.11.19 The Tier 1 report template includes a section on examples of good practice related to this project but this needs to be reflected within the report. The Clinical Audit Report for Quarter 2 does not include elements of good practice identified. Suggest that this remains open until it has been clearly incorporated within the report. 02.03.20 Needs to remain open until reporting framework agreed. Report expected to include good performance 04.11.20: Included in Annual report and Quarterly reporting when highlighted. Comparative data provides some assurance.	Recommended for closure
Adrian Thomas	JAQS 17/6 Clinical Audit Plan – AT to give further consideration to the process around inclusion of individual clinical audits within the plan and review the arrangements for the tracking of clinical audit recs with a view to adopting a similar system to that in place for internal and external audit recs.	November 2018	Further consideration given to the process and outlined as part of the update report prepared for March 2019 Audit Committee. This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources. 28.10.19 This will be part of the business case – outstanding action 02.03.20 Remains outstanding action until digital system in place to support tracking 04.11.20: Identified potential package to use, currently being investigated. Introduced e-recording for Tier 3 – this has been linked to access to medical records providing more clarity around individual audits. Linking to more robust local approval processes.	
Dawn Sharp	JAQS17/7 – Quality Assurance Frameworks and Governance Arrangements –	December 2017	This will be reviewed as part of the development of the clinical audit policy and process.	Recommended for closure

	report to be presented to the December 2017 QSE		28.10.19 Will be picked up as part of the ongoing governance review 5.11.19 The action will remain open until it has been implemented. 04.11.20: Clinical Audit Policy and Process in place. Reporting through Clinical Effectiveness Group. Escalation report to each meeting.	
Actions from JAQS meeting 6.11.18				
Adrian Thomas	JAQS18/9&10 – Clinical Audit and Outcome Review Plan and update reports – ET re-examine the BCU elements of the clinical audit plan and the process going forward including future presentation, tracking and follow up of recommendations arising, with input from Internal Audit as appropriate.	March 2019	Progress report update on agenda for Audit Committee March 2019 This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources. 28.10.19 This will be part of the business case – outstanding action. Need to agree templates; manual collection of information in the interim to populate the reports. 02.03.20 Clinical Audit policy and Procedure now approved; requires additional resources. 04.11.20: this action is duplicated above	Recommended for closure
Actions from JAQS meeting 5.11.19				
Lucy Reid Medwyn Hughes	JAQS19/4.2 Review action log outside of the meeting and confirm their acceptance or otherwise of the status of each action, and recirculate.	December 2019	Review undertaken by joint Chairs. Most of the actions remain open - partly because officers present on 5.11.19 were not party to the previous discussions and so some of them have been interpreted in a different way than was originally intended. Given this the Chairs have agreed that actions remain open until they are satisfied that they have been addressed. Proposal that the QSE Committee reviews the JAQS action log in conjunction with the production of the next Clinical Audit Report as most of them relate to this. QSE would then make a recommendation to the Audit Committee for closure or otherwise.	March 2020

			10.03.20 Clarified the action – QSE should receive regular updates on audit alongside the annual plan and report. The reporting framework within the audit policy is quarterly reports to CAEsG with a copy for information to QSG. QSE should receive a Chair's Report from CAEsG and therefore clinical audit progress can be assessed. However, this will need to be reviewed once the revised governance structure is in place. 12.11.20 JAQS action log reviewed and submitted to JAQS meeting on 24.11.20	Recommended for closure
Melanie Maxwell	JAQS19/7.2 Follow up and respond to comments made on the Clinical Audit Report to provide an amended version.	December 2019	02.03.20 Further loss of staff has hampered ability of team to progress the reporting. However, draft document is in production to be finalised for CAESG in April 2020. 04.11.20: Annual report on JAQS agenda Nov 2020	Recommended for closure
~~David Fearnley~~ Arpan Guha	JAQS19/7.3 Determine whether a priority could be given to undertaking a local respiratory audit in order to provide some level of assurance in absence of	January 2020	02.03.20 No local audit been undertaken due to lack of capacity within the teams. DF in discussion with potential audit lead. Work is needed to provide data collection support in this and other areas. 04.11.20: During the Covid pandemic all national audit was stood down. The respiratory team have been engaged in Covid research and some local audit. BCU funded data collection for the National Covid Audit. There are ongoing discussions across the sites to ensure all audits have an identified lead (all now identified) and the resources required to complete the audit. This will be part of the business case.	Recommended for closure
Lucy Reid Medwyn Hughes	JAQS19/7.5 Prepare a joint note encouraging clinicians' participation in audit	December 2019	10.3.20 A draft has been prepared for circulation as required	Closed
Kate Dunn	JAQS19/10 Arrange date of next meeting	December 2019	Meeting arranged for 24.11.20	closed

16.11.20

Cyfarfod a dyddiad: Meeting and date:	Joint Audit and Quality, Safety & Experience (JAQS) Committee 24th November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Clinical Audit Annual Report 2019-2020
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof Arpan Guha, Acting Executive Medical Director
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell, Senior Associate Medical Director/ Improvement Cymru Clinical Lead
Craffu blaenorol: Prior Scrutiny:	Clinical Effectiveness Group (CEG) (Oct 2020)
Atodiadau Appendices:	Appendix 1 - Clinical Audit Annual Report Appendix 2 - Tier 2 Appendix 2 - Tier 3

Argymhelliad / Recommendation:

The Joint Committee asked to approve the Clinical Audit Annual Report 2019/20.

Please tick as appropriate

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

Sefyllfa / Situation:

The draft Clinical Audit Annual Report 2019/2020 was presented to the Clinical Effectiveness Group in October. It was agreed to submit it to JAQS in November. Due to the Covid 19 pandemic, the standing down of most audits from March – September, and redeployment of audit staff, the annual report was delayed in being finalised for submission

Therefore, the Committee is asked to review the attached Clinical Audit Annual Report 2019/2020 as an overview of clinical audit activity carried out across the Health Board from 1st April 2019 to the 31st March 2020.

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 applicable audits are included in the Tier 1 element of the BCUHB Clinical Audit Plan.

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

- BCUHB priority that the project will support.
- The responsible Corporate Group.

• An assessment of risk (based upon specified criteria).
Assurance is given to the Joint Committee that under each project there is an accountable lead responsible within the Corporate Group. The plan has been updated to ensure changes in leads has been acknowledged.

More recently, the Audit Committee have requested that the audit plan reflects any claims against the Health Board where appropriate. This will be clearly articulated in the next round of audit planning and explicit in the tier 2 audit criteria.

Asesiad / Assessment & Analysis

Strategy Implications
The Annual audit report will reflect all services within BCUHB, mandatory audits taking place with the NCAORP programme, monitoring of Tier 2 audits which are linked to key quality and safety concerns and to ensure improvement in patient care within the Health Board and capturing Tier 3 audit registration, which needs to be encourage further.

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 Effectiveness Group (CEG), 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 2019/20 Clinical Audit Annual report 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) with a current tier 2 risk rating of 12. This has been mitigated by reducing the scope of activity of the corporate team for example introducing a digital solution to register tier 3 audits. There is work in progress to articulate the additional resources required to support a fully functional audit programme.

There is a risk of a lack of assurance for services where there is patchy or non-compliance with the plan. Where these are Tier 1 audits, it is usually due to lack of resources; mitigation might be more localised audits and other sources of assurance. Actions to address this are predominantly with the secondary care Hospital Management Team (HMT) and include ensuring audit leadership is included within robust job planning, embedding audit reporting within the governance structures from speciality to Board; once commenced, quarterly reporting will identify issues earlier for action. Additional resources are likely to be required to support the audit function. Going forward the clinical strategy includes the development of pathways that explicitly links to relevant national audits, will be developed.

Legal and Compliance
The Tier 1 element of the 2019/20 Clinical Audit Annual report relates to mandatory projects as prioritised by Welsh Government within their NCAORP. Reporting on progress will be scheduled for

the Clinical Effectiveness Group (CEG) on a quarterly basis leading to a full annual report in line with the new Clinical Audit Policy.

Impact Assessment

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

- 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

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

Clinical Audit Annual Report 2019 - 2020

British Cardiovascular Society

NPCA National Prostate Cancer Audit

NICOR

VSQIP Vascular Services Quality Improvement Programme

Royal College of Physicians | NACAP

NOGCA National Oesophago-Gastric Cancer Audit

DEMENTIA CCQI National Audit of Dementia

King's College London SSNAP Sentinel Stroke National Audit Programme

National Audit of Care at the End of Life

Report Authors:

Joanne Shillingford: Interim Head of Audit & Clinical Effectiveness
Dr Melanie Maxwell: Senior Associate Medical Director/ Improvement Cymru Clinical Lead

Executive Lead: Prof.Arpan Guha, Acting Executive Medical Director

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APPENDICES

1. INTRODUCTION

Welcome to the Annual Audit report for 2019/20.

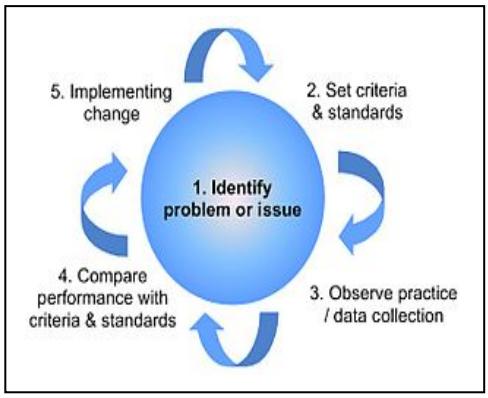
This report provides an overview of clinical audit activity carried out across the Health Board from 1st April 2019 to the 31st March 2020. The Clinical Audit Annual Plan includes mandated projects identified by the National Clinical Audit and Outcomes Review Advisory Committee relevant to BCHUB as well as local priority projects. It highlights where services have improved care compared to previous years and the national position where available, it also recognises where there is more improvement required.

During this year, the corporate governance for the Clinical Effectiveness and Audit Department changed and has now joined the Office of the Medical Director to enable closer links with quality improvement. Trevor Smith, Head of Clinical Audit also decided to leave BCUHB, and we would like to thank him for his contribution to the department and the Health Board over many years. We are altering the way the department works to ensure we are better able to support priority audits within the organisation, and this should accelerate our improvements over the coming years making care safer and of higher quality for our patients.

In March 2020, the new Clinical Audit Policy and Procedure was introduced. This policy sets out the expectations of the Health Board with respect to clinical audit planning, multidisciplinary participation, and acting on the audit findings to maximize effectiveness. Alongside the mandated national audits, our services are expected to develop priority audits based on identified local and BCU priorities, these inform the BCUHB annual audit plan. Implementing this policy will support a culture of best practice in the management and delivery of clinical audit. Unsurprisingly, some of this work has been delayed by the COVID 19 pandemic; progress with implementation will be reported in next year's report.

2. CLINICAL AUDIT ACTIVITY 2019 – 2020

Clinical audit is a cyclical activity with phases of:



- Audit development – using best current evidence to measure against standards of care as described by national clinical guidelines or research finding.
- Data collection - in a standardised way to make sure it can be used to compared either over time within a service, or between similar services.
- Analysis – to provide a report that helps guide the clinical teams to improve care
- Improvement Planning - clinical teams need to review and discuss the reports produced to develop an action plan that delivers improved care. It is also an opportunity to highlight where care has been excellent and share that good practice.

therefore, the audits activity reported will be in different phases throughout the year and we have focussed this report on those audits that are in the improvement planning stage.

2.1 NHS WALES NATIONAL CLINICAL AUDIT AND OUTCOME REVIEW PLAN (NCAORP)

Each year, the Health Board receives notification of the NCAORP. For 2019/20, BCUHB identified 39 relevant projects. Many of these require continuous data collection across years; others are time limited, collecting data at prescribed intervals. These are called Tier 1 projects within BCUHB.

Almost all of these projects, by their nature, relate to secondary care services, and may include information from one or all our acute sites. Unfortunately, we did not achieve full participation by all services and participated in 90% of them.

Partial participation: Three audits were unresolved from previous years within the Respiratory services:

- Chronic Obstructive Pulmonary Disease
- Adult Asthma with submission from Ysbyty Glan Clwyd (YGC) only
- Children & Young People Asthma from Ysbyty Gwynedd (YG). These are continuous audits requiring clinicians to collect the data. The services have continued to be unable to identify resources to participate.

The Fracture Liaison Service has also not submitted data in year – work is ongoing within the service to identify administrative support for this audit.

Completion: For the first time this year, we were able to participate in the data collection for the National Audit of Care at End of Life (NACEL).

Lack of participation is not an acceptable position and needs to be addressed in the coming year.

The nationally mandated projects are expected to complete a 2-stage proforma that summarises their improvement plans and documents any progress in the time between data collection and reporting.

The first part of the form (Part A) should be completed within 4 weeks of the report being published; this identifies those standards or quality statements the Health Board will focus on including any measures where we are an outlier.

The second part (Part B) should be completed within 12 weeks of publication; this describes the actions needed to address Part A, which is the improvement plan.

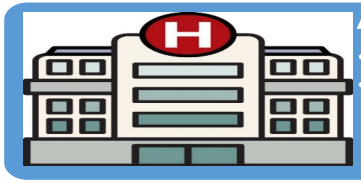
The monitoring of this has not been robust, due to the absence of an effective escalation process; this has recently been developed and is currently being tested and should improve compliance. Going forward, this will be monitored by the Executive Medical Director through an escalation report to the Clinical Effectiveness Group.

Process	Number returned with 4 weeks	Numbers returned >4 weeks	No report received	Total expected:
Part A	5 (15%)	21 (64%)	7 (21%)	33
Part B	8 (24%)	17 (52%)	8 (24%)	33

PROGRESS REPORT - NCAORP

Four audits have delivered the improvement plan in year:

- National Audit of Care at the End of Life (NACEL)
- Cardiac Rhythm Management
- Myocardial Infarction National Audit Project (MINAP)
- National Lung Cancer Audit

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
	 **Acute Care** • National Joint Registry • National Emergency Laparotomy Audit)				
NCAORP /2019/02	National Emergency Laparotomy Audit (NELA) (12 standards)	G	G	All sites have been involved in national Emergency Laparotomy Collaborative A care pathway has been developed	Continue development of pathway to implement Emergency Laparotomy Collaborative 6 Step Care Bundle Lead - 3 NELA Leads by October 2020 Ensure early antibiotic administration for sepsis is low and need to ensure the Preoperative risk assessment is used - Lead - 3 ED consultants (ongoing) Perioperative COTE Specialist Assessment for the over 70s. Due to not meeting the standard this was escalated to CEO as business case. Response was acknowledgement of issue to be considered against all priorities. Critical Care admission guidelines developed and promoted – 3 Critical Care Leads (ongoing)

NCAORP /2019/01	National Joint Registry (NJR) (27 standards)	A	G		No return to Welsh Government Completed for this data quality audit- response required from 3 site Orthopaedic Consultants (Escalated to Secondary Care, Secondary Care Medical Director, Corporate Office)
	 **Long Term Conditions** • National Diabetes Audits (Adult) incl. pregnancy/insulin pumps/footcare • National Paediatric Diabetes Audit • National Respiratory audits (COPD/Asthma (Adult & Child)) • National Early Inflammatory Arthritis Audit				
NCAORP /2019/06	National Diabetes Foot Care Audit (NDFA) (16 standards)	G	G	Case ascertainment during this period was low (8%). Issue have been identified; data is now inputted daily and monitored monthly	NDFA Gold standard of assessment of new cases within 24 hours not deliverable with current 5 day working patterns within BCUHB. 7 day working is not under consideration at present. A business case for funding of additional podiatry posts to secondary care to coordinate the care of acute onset diabetic foot wounds as they present was not agreed. This is still work ongoing at a national level within the All Wales Diabetic Network Group and yet to be signed off for roll out. It sits with the national diabetic foot lead and no timescales as to when this will be rolled out. Significant vascular / diabetic foot pathway escalation within the organisation now underway following a recent CHC report. No outcomes yet.
NCAORP /2019/07	Diabetes Inpatient Audit (NaDia) (9 standards)	R	G	A dedicated Diabetes Pharmacist has been introduced in Wrexham to support improved prescribing Part of the Think Glucose team, co-ordinates and updates diabetes guidelines	Welsh Government reporting form not completed in West due to resource shortage at the time – Lead Diabetologist. Every acute hospital should have a DISN/Diabetes Inpatient team and multi-disciplinary foot care team. In regards to the DISN/Diabetes inpatient team, this has been raised with managers and it is presently on the at risk register for Wrexham. Lack of electronic records and prescribing Informatics (no time scale)

				Locally available electronic patient records for diabetes patients attending YGC, have been available since 2007 and can be accessed by approved medical staff.	Web-linked blood glucose and ketone meters should be actively used to alert the diabetes inpatient team to out of range glucose values and to monitor glucometrics across the trust and at ward level (remote blood glucose monitoring [BGM]). Available in YWM. Being implemented in YGC.
NCAORP /2019/08	Diabetes in Pregnancy Audit Programme (5 standards)	R	A		Welsh Government reporting form not completed – due Jan 2020. Lead - Secondary Care
NCAORP /2019/09	National Core Diabetes Audit: (42 standards)	G	G	The diabetes specification (Gateway) is available for all practices. 69 out of 103 practices are contracted to provide the Gateway Module	No Welsh Government return from East/ Centre Areas Formal evaluation of the model of Diabetes care was published in draft in early 2020 with a view to further sharing across BCU as an example of best practice and to potentially adopting this model as a consistent pan BCU approach. Delayed by Covid – GP Leads (no date given) Monitor the uptake of modules 1-4 of the Diabetes National Enhanced Services (NES). – GP Leads (October 2020) To monitor uptake of the Diabetes Specification Gateway which requires practices to share their NDA outcomes at GP Cluster level to promote good practice and to identify areas for improvement/support within the GP Cluster and the Health Board. – GP Leads (October 2020) To continue to encourage 100% GP practice participation with the National

					Diabetes Audit – additional 16 practices participating in 2021 Ensure the DBDG (Diabetes, Planning and Delivery Group) that is currently improving its working function establishes a clinical lead to take all of the above forward. Escalated to Area Directors and Deputy MD for resources (no date)
NCAORP /2019/09	Insulin Pump (16 standards)	G	A	94% compliance with the standards	Ensure measurements are completed Lead Consultant and Primary are in Wrexham. (Ongoing)
NCAORP/ 2019/11	National Paediatric Diabetes Audit (NPDA) (17 standards)	G	G	**YG:** Improved data capture new form and process 7 Care processes have shown improved completion. Twice monthly MDT meeting introduced to discuss complex patients **WMH**: Introduced 'Target Achieving' clinics to see those with high HbA1c. **YGC** – Extra Nurse led clinics to see those with high HbA1c.	Waiting list problems at West for the Retinopathy Screening Service for Wales, remains a concern service awaiting confirmation of this being resolved **YGC-** to improve Psychology support, Health Board has been unsuccessful in recruiting a Paediatrics Psychologist

NCAORP/ 2019/14	NACAP: COPD (18 standards)	R	R	All spirometry requests from the wards are now performed with introduction of testing after discharge Introduced new members of the "Help me Quit" inpatient team, two per site. *Note sites participating were "green" for national comparison and "Amber" for local comparison.*	**YGC** - Implementation of COPD discharge bundles – specialist nurses to contact Ysbyty Gwynedd nurses to share good practice – reformatted but delayed by Covid Lead - Resp. Consultants and Nurses (no date) **West** - Business case being developed for admin. support to contribute to the audit by Business Manager and Matron (No date)
NCAORP /2019/11	NACAP: Adult Asthma (37 measures)	R	R	*Note participating site was "Amber" for national comparison and had no previous local data to compare performance*	**West -** Business case being developed to finance and recruit HCA/Admin support. This will enable contribution to the mandatory audit and an additional role in support of the respiratory specialist nursing team by Business Manager and Matron (No date)

Older People

- Sentinel Stroke National Audit (SSNAP)
- National Audit of Inpatient Falls (NAIF)
- National Hip Fracture Database
- National Audit of Dementia
- National Audit of Breast Cancer in Older people

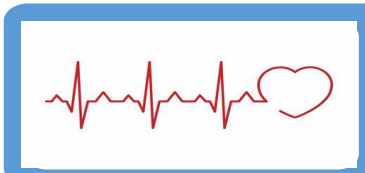
NCAORP /2019/17	National Early Inflammatory Arthritis Audit (NEIAA) (6 standards)	G	No Comparative data available	100% compliance with the standards Peter Maddison Rheumatology Centre medical staff. - Triage that gives priority to all Inflammatory Arthritis (IA) referrals - IA patients seen within 3 weeks in the dedicated Early Synovitis clinic, which is organised to deliver a “one stop” service. The Early Synovitis Clinic has Doctors and Nurse Specialist who diagnose and start treatment along with initial education.	Consultant vacancies remain a concern for sustainability of this service –Lead - Clinical Lead (No date)

NCAORP /2019/19	Stroke Audit (SSNAP) (33 standards)	A	G		Develop an awareness plan for the public in BCU. Lead - Stroke Coordinators (July 2020) Business case written for additional staff / 24/7 service/ Early supportive discharge Lead- Secondary Care Medical Director (awaiting outcome) Each Emergency Department (ED) to comply with the Rapid Computed tomography (CT) protocols Lead – Heads of Nursing for EDs (ongoing) Site Management Teams to ensure ring fenced beds are protected Lead – DMs (ongoing) YGC and YG to resolve the conflict of the General Medicine (GM) rota with the Out of Hours (OOH) thrombolysis rota Lead – Site MDs (ongoing) Education of ED Nursing staff Lead – Stroke Coordinators (March 2020)
NCAORP /2019/21	National Audit of Inpatient Falls (NAIF) (16 standards)	G	No Comparative data available	**YGC** – Appointment of an Ortho- Geriatrician (Dec 2019) **YG -** table top reviews of all inpatient falls with harm and lessons are shared across the site	No plan required at this time – site specific data not available
	National Hip			**WMH:** Nutritional Risk	**WMH** – Further education on importance of nutritional assessment ongoing

NCAORP /2019/20	Fracture Database (NHFD) (29 standards)	A	G	Assessment score was the worst performance in Wales - compliance on orthopaedic inpatients on weekly monitoring Lead – Site Director of Nursing (DoN) (Early Oct - 68%) Delirium testing has improved due to the 4AT screening tool incorporated into the fractured neck of femur pathway	Lead – Site DoN
					Improved access to the Specialist Care provided on the Acute Trauma Ward within 4 hours ensuring prompt admission to this unit and the specialist multi-disciplinary care that it offers. Ongoing discussion with local managers
					Urgent review of the Nursing Staff levels and morale Ongoing discussion with local managers
					Dedicated, ward based discharge/flow support. Ongoing discussion with local managers
				YGC: Additional Consultant and Physician Associate appointed. Collaboration with lead aneasthetists to improve theatre efficiency including "golden patient" ie rapid early treatment. Introduction of trauma surge plan. Appointment of orthogeriatric team has all resulted in improvement.	**YGC** - Neck of Femur bed is now identified each day on trauma ward. Working on improving discharge arrangement Lead – GME Hodgson. (Dec 2019) Delirium Assessment -Team training initialized. Staff competency improved. Regular checks/ auditing to ensure compliance Lead – MDT (Nov 2019)
					Standardising the nutritional forms and make it mandatory for every case Lead – Ward Manager. (Jan 2020)
					Awaiting appointment of fragility nurse since November 2019
					Delirium Assessment -Team training initialized. Staff competency improved. Regular checks/ auditing to ensure compliance Lead – MDT (Nov 2019)

				YG: Appointment of Trauma Coordinator and progress with 'Golden patient' process for Fracture Neck of Femur. Monthly meeting chaired by Dr Alan Bates (Consultant Physician: Care of the Elderly).	Need to improve data collection Lead- not identified (ongoing)
NCAORP /2019/23	National Dementia Audit (15 standards)	G	A	**WMH:** Improve discharge support through better provision of Community Resource Team (CRT) and a Home first programme. The CRT will coordinate with the Frailty team to improve discharge support	Rolling out BCU wide clerking proforma to enhance initial delirium assessment – Compliance to be monitored locally. Lead – Clinical Audit Leads (Dec 2020) **YG-** Increase the involvement of patients and carers in discharge planning; requires a digital solution **YGC** – Enhance use and compliance with " This is Me" documentation to support individualised care Lead – Clinical Lead (Next audit) **WMH** – Education sessions for Junior Doctors Lead – Clinical Leads (Next audit).
NCAORP /2019/24	National Audit of Breast Cancer in Older Patients (NABCOP) (7 standards)	A	No Comparative data available	Data workshop held in January 2019 in order to review and address data requirements. In particular performance status now collected at Multidisciplinary Team (MDT) – local monitoring has shown regular recording	Radiotherapy rates post breast conserving surgery and mastectomy need improving: Audit in progress and revised completion date - aiming to complete & present at November 2020 meeting. Lead – Clinical Audit Lead

 **End of Life Care** • National Audit of Care at End of Life					
NCAORP /2019/205	National Audit of Care at the End of Life (NACEL)	R	No Comparative data available	Established Strategic Delivery Group for Palliative & End of Life Care including representation from third sector. Creation of subgroups/work streams including Operational Delivery Group, Bereavement Quality Group & Academic Group for palliative care & End of Life Care. Round 2 NACEL Participation completed.	Completed Action Plan

 **Heart** • National Audit of Heart Failure • National Audit of Cardiac Rhythm Management • National Audit of Percutaneous Coronary Interventions (NAPCI) • Myocardial Infarction National Audit Programme (MINAP) • National Vascular Register					
NCAORP /2019/26	National Heart Failure Audit (13 standards)	A	A	**YGC:** Additional 2 beds have brought compliance to national average. **WMH:** Agreement now in place for Secondary Care heart failure team to transfer patients admitted with acute heart failure where appropriate to the Cardiology ward with input from Consultant Cardiologist. This should also assist in improving appropriate referral for Cardiology input following discharge.	Business Case is being written to secure permanent funding for the Heart Failure service BCUHB wide. Lead – BCUHB Strategic Manager For Cardiac Service (July 2020) **YGC** - Replacement cardiologist appointed for pacing and Hearth Failure; however this does not fully cover the HF service – no action identified or time line
NCAORP /2019/27	Cardiac Rhythm Management (3 standards)	A	No Comparative data available	**YGC/ WMH**: Data issues are now resolved. Additional consultant appointment has increased activity.	Completed Action Plan

				YGC: ICD/CRT implanter – retraining implemented	
NCAORP /2019/28	PCI Audit (7 standards)	G	G	Meeting all national targets	WAST has revoked access to the required timings that are needed for the audit – Discussion has not resolved this however WAST are providing individual data on request - Lead: Clinical Audit Lead (ongoing)
NCAORP /2019/29	MINAP (6 standards)	A	G	**WMH**: Increased staffing in Echocardiography and additional machine bought to support increase in capacity required. Mortality review completed – no concerns raised. Training for juniors for prescribing in place	Completed Action Plan
				YGC: Additional beds have led to increased specialist input for patients. Data issue for Call to Balloon time resolved – compliance expected	

				YG: Outreach specialist nurses are providing increased specialist input to patients not on cardiac wards. Patients needing PPCI are moved to YGC – echocardiography rates have improved. Case ascertainment was too high suggesting the clinical coding did not reflect patients who are eligible for this audit - awareness raising with clinical team has taken place.	
	National Vascular Registry Audit (23 standards)	G	A	Data submission – funding and recruitment process agreed for data clerk.	Critical Limb Ischaemia review of pathway and audit. Lead - Clinical Service Lead (Nov 2020) Lower limb amputations – review of care pathway and patient outcomes Lead - Clinical Service Lead (Sept 2020) Carotid Endarterectomy – Review of referral pathway and timeframes for the procedure. Lead - Clinical Service Lead (Sep 2020) Abdominal Aortic Aneurysm (AAA) Repair- review the pathway to ensure referral to assessment is less than 8 weeks. Lead -Clinical Service Lead (Sep 2020) Complex AAA Data Submission – Service needs to ensure information is

					complete to enable comparison of outcomes. This will be discussed at the local governance meeting. Lead - Service Manager (Aug 2020) Complex AAA surgery – need to ensure the availability of equipment; working with companies to reduce the delivery time in North Wales. Lead- Clinical Service Lead (Sep 2020) Emergency EVARs – There are not enough interventional radiologists in North Wales ti provide 24/7 cover. Exploring options to outsource out of hours care Lead for recruitment Clinical Service Lead for Radiology (no date)
NCAORP /2019/31	Cardiac Rehabilitation (9 standards)	G	G	Pan BCU Business case was developed for improved and expanded service –lead by GP lead; 3 year plan. **West:** The service underwent redesign in 2018. This has enabled more opportunity for cardiac rehabilitation. The assessment paperwork and data capture has now been redesigned to enable audit but also to support better time management, intervention and monitoring progress.	**Centre**- Need to increase uptake in patients who have had heart attack – set up data feed from MINAP to identify patients and data is now flowing. However no further analysis due to Covid redeployment Tailoring service to patients comorbidity and ability– home exercise programmes/ group programmes/ tele clinics etc; stalled due to Covid restrictions and redeployment Increase innovation to increase the scope of service- part of the Pan BCU business plan. Lead by Clinical Specialist Physiotherapist all actions ongoing.

				The team are utilising more venues allowing staff to assess people in remote areas. **East**: Recruitment to staff vacancies has occurred and funding identified for an additional support worker. Data completeness has been addressed by temporarily increasing administrator hours to improve the cardiac rehabilitation system/pathway. Offering options to patients for improving return of necessary audit data.	

Cancer

- National Lung Cancer Audit
- National Prostate Cancer Audit
- National Oesophageal - Gastric Cancer audit
- National Bowel Cancer Audit

NCAORP /2019/32	National Lung Cancer Audit (8 standards)	G	G	**YGC:** There was concern at low rates of surgery for one group of cancers. A Pan BCU audit was undertaken investigating this and presented to the Cancer Advisory Group (CAG). The recommendation is to explore influences on patients' choice of treatment. **WMH:** Low Systemic anti-cancer treatment (SACT) rates in advanced non–small–cell lung cancer (NSCLC) was identified as a data error.	2018 IMPROVEMENT PLAN COMPLETED Jan 2020 organisational audit report became available – this has not been discussed due to Covid-19 pandemic; this will be on CAG next agenda
NCAORP /2019/33	National Prostate Cancer Audit (11 standards)	G	G		Audit of treatment for patients with low risk localised disease to determine if there is over treatment has been discussed at their CAG and the parameters agreed. First cycle of audit will be completed by March 2021. Lead - Consultant Urologist High 90 day emergency readmission rate following radical prostatectomy was noted. Some of these patients were treated in Wirral due to lack of capacity and data have been requested from them to support a comparison with BCUHB data (due Sept 2020). The information will be presented to CAG and

					then further individual pathways will be reviewed as needed. Lead - Consultant Urologist (Jan 2021)
NCAORP/ 2019/34	National Gastrointestinal Cancer Audit Programme: Oesophago-Gastric Cancer: (13 standards)	G	G	No Action Plan developed as compliant with all standards	
	National Gastrointestinal Cancer Audit Programme: Bowel Cancer (15 standards)	G	A	Report was discussed at the Colorectal CAG in March 2020. Radiotherapy rates have been reviewed and found to be consistent; this will be monitored through the annual report.	Re-audit of colorectal emergency admissions/surgery led by primary care due Dec 2021. Colorectal surgeons contributing to robot business case with view to implementing robotic surgery when robot arrives in North Wales. (Lead Secondary Care Medical Director dependent on HB time scales)

Women & Children

- National Neonatal Audit Programme
- National Maternity & Perinatal Audit (NMPA)

NCAORP /2019/35	National Neonatal Audit Programme (NNAP) (13 standards)	A	G	**West:** Morning consultant ward round on SCBU were introduced; parents encouraged to attend. (Covid 19 has impacted on this)	**West** – Failure to recruit Ophthalmologist for Retinopathy of Prematurity Screening means babies need to travel to YGC. Investigating digital solution (RETCAM). Lead Surgical Dept . No date as yet.
				Centre: initiated telephone update to parents who cannot easily travel to the unit to enable consultation within 24 hours. Monitoring suggests achieving this KPI is now above the national average.Achieved Baby Friendly Initiative stage 1 (BFI) to improve breast feeding rates.	Centre – Work ongoing to stage 2 BFI all training for medical and nursing staff completed. Need an increase in BFI lead hours to support improvement work. Lead - Consultant and Senior Staff nurse. (ongoing)
				East: Unit also working to BFI stage 2 to support improved rates of breast feeding.	**East** – Issues with poor documentation. Weekly quality assurance of system now in place and started feedback at the relevant meetings; improvement seen. Virtual teaching session planned. Lead - Consultant and Senior Staff nurse. (ongoing)

NCAORP /2019/36	National Maternity & Perinatal Audit (13 standards)	G	G	Following a review of Post- Partum Haemorrhage (PPH) patients the first line uterotonic medicine used was changed in line with other units.	BCU was reported as an outlier for Post Partum Haemorrhage – re-audit to be completed following changes made Lead by Obs Cymru - (ongoing)
				There is a weekly "Putting things Right" meeting when any late preterm &term admissions to the neonatal unit are discussed to understand the reasons for admission and identify learning – admissions are on a downward trajectory	A report with recommendations for improving the birth environment in primary care is being presented to the Quality and Safety Group in August 2020 to request Executive sponsorship for the engagement. Lead-Consultant Midwife.
				Women are given opportunity to discuss their birth experience and any barriers they perceived through an Afterthoughts clinic or Maternity Voices Group this has led to a review identifying improvements for primary care.	There are a number of babies born not in the planned place of birth. This is reported as an incident and an action plan specific to the Maternity Unit needs to be in place to address this. Lead – Consultant Midwife. No date recorded – commenced in 2019.

				Key performance indicators- breast feeding at birth, 10 days and 6 weeks have all increased. Bi-monthly trend monitoring in place and a strategic plan to improve this has been developed. Smoking Cessation services have been disrupted during the Covid 19 pandemic but Help me Quit services have remote contact available	

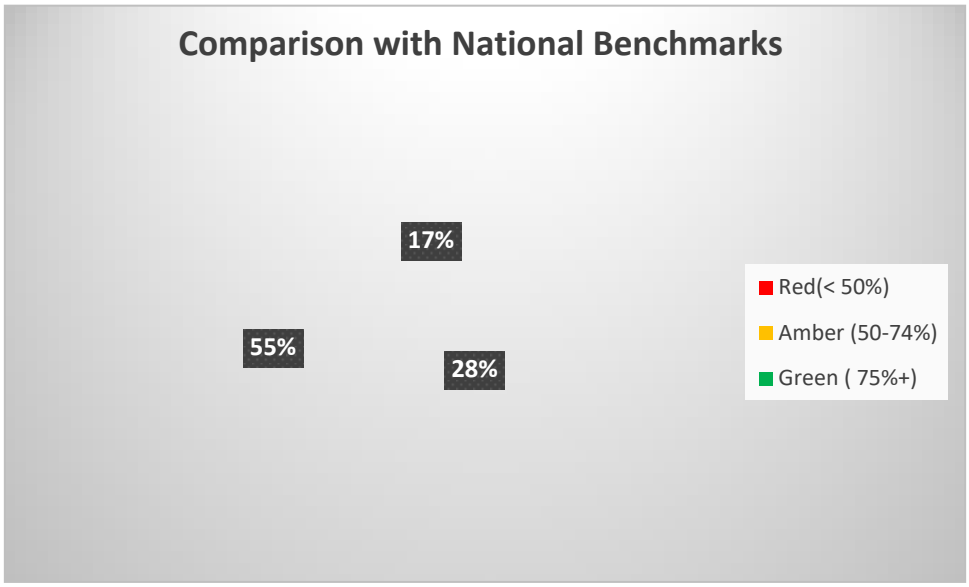
Keys:

Comparison to National Benchmark:	
	Partial or non-participation or, the measures where BCU is at, or above the benchmark is less than 50% of the opportunities to achieve the measures or standards ie. if there are 10 measures/standards in the audit. There are 3 opportunities to achieve each standard when applied to the acute sites in BCU so the denominator is 3X10 = 30 Suppose the sites achieve the national averages or standards in the following way: YG achieves 3/10: YGC achieves 4/10: WMH achieves 3/10 then across BCU there were 10 (3+4+3)/30 opportunities to meet or surpass the national average - 33% compliance has been achieved.
	The measures where BCU is at, or above the benchmark is 50-74% of the opportunities to achieve the measures or standards. Using the methodology above
	The measures where BCU is at, or above the benchmark is 75% or more of the opportunities to achieve the measures or standards. Using the methodology above

Comparison to Last BCUHB Report:	
	Partial or non-participation or, The measures or standards where BCU has maintain or improved compared to the last report is less than 50% of the opportunities to do so. ie. if there are 10 measures/standards in the audit. There are 3 opportunities to improve or maintain the score from the previous report when applied to the acute sites in BCU so the denominator is 3X10 = 30 Suppose the sites achieve the same or improved scores in the following way: YG achieves 3/10: YGC achieves 4/10: WMH achieves 3/10 then across BCU there were 10 (3+4+3)/30 opportunities to meet or surpass the previous score; across BCU 33% improvement has been achieved.
	The measures where BCU has maintain or improved is 50-74% of the opportunities to do so using the methodology above.
	The measures where BCU has maintain or improved is 75% or more of the opportunities to do so using the methodology above.

Actions	
	Cause for concern. No progress to completion reported. Needs evidence of action
	Delayed, some action in progress; date may be reported as “ongoing”
	Progressing on schedule

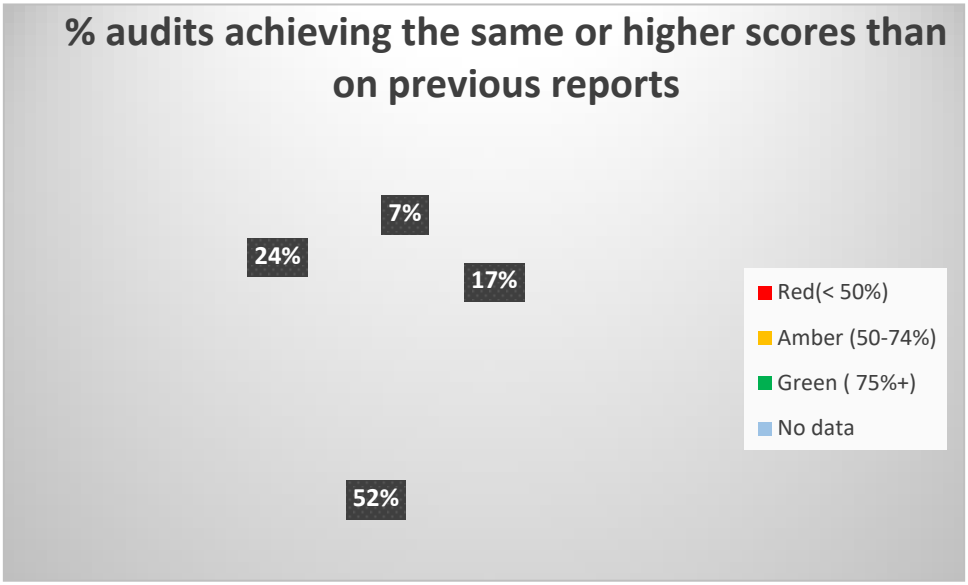
In comparison to the national benchmarks reported, just over half of BCUHB tier I audits are at or above the national benchmarks for 75% or more of the measures included:



Audits of concern are:

- Diabetes in Pregnancy (poor compliance with standards)
- Diabetes inpatient care (poor compliance with standards)
- Adult Asthma (partial participation)
- Adult COPD (partial participation)
- National Audit of Care at End of Life (non participation) (resolved).

When compared to previous reports just over half of the audits showed maintenance or improvement against the prevous audit for 75% or more of measures:



Audits of concern are:

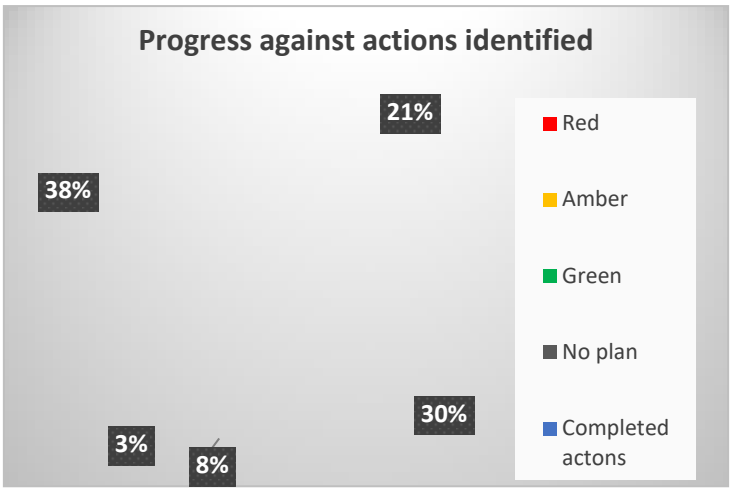
- Adult Asthma (partial participation)
- Adult COPD (partial participation)

Audits with limited improvement and not showing high levels of compliance are:

- Diabetes in pregnancy
- Heart Failure

The improvement plans require more work as not all actions are clearly articulated and many are recorded as “ongoing”. This is being addressed through a strengthened quality assurance process prior to sign off within the Health Board. Actions will be written to enable monitoring and tracking.

118 Actions were identified within the improvement plans of which 46 were completed (39%). There have been significant delays in some actions because of the response to Covid 19 with redeployment of staff and lack of the resources required for improvement.



Five audits had no or incompletely developed plans:

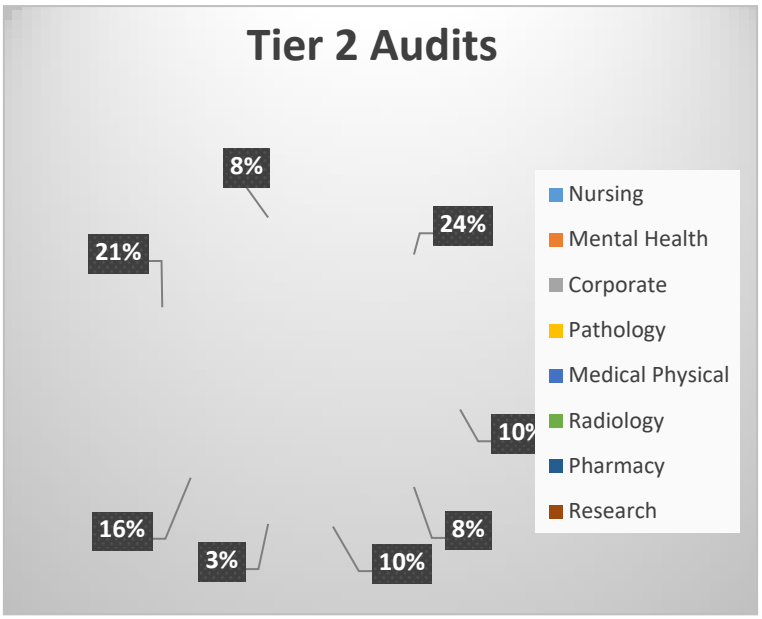
- National Joint Registry (all sites)
- Diabetes Inpatient audit (West)
- Diabetes in pregnancy audit (Primary care – BCUHB)
- National Core Diabetes Audit (East & Centre)
- National Audit of Inpatient Falls (no site specific data available at time of writing)

One audit had no plan as fully compliant with the standards; this is permissible on the Welsh Government return:

- National Gastrointestinal Cancer Audit Programme: Oesophago-Gastric Cancer

2.2 BCUHB PRIORITY AUDITS

Executives and Divisional Management Teams identify local priority audits that are part of the annual audit plan – these are called Tier 2 audits. These projects are all risk assessed against organisational objectives. In 2019/20, we identified 38 audits to be started within the year of which 10 are considered ongoing as they relate to continued accreditation internally or externally. A number of these assure compliance within the diagnostic services and have multiple components. For example, the blood science departments delivered 168 audits this year to provide assurance with the Blood Safety and Quality Regulations; these have action plans and ongoing monitoring in place to ensure ongoing compliance (See Appendix 2 Tier 2 activity)

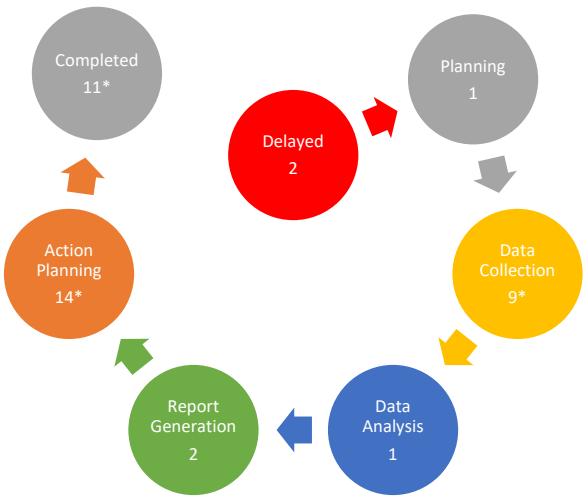


Like the Tier 1 audits, these are also in various phases of the audit cycle and some of these are ongoing across years. Whilst the Covid 19 pandemic has had an impact on the progress in some cases, only two have delayed starting and will be part of the 2020/21 action plan:

The Enhanced Care Policy approval and implementation was delayed – the audit is to ensure it is embedded in practice and so will moved to later in 2020. (Medium risk)

Assessment of the Homecare Service compliance with the Royal Pharmaceutical Society Professional Standards for Homecare. Again redeployment of staff and other resource issues has delayed this quarter 4 audit. (High Risk – compliance with legal standards).

Progress against the 2019/20 Tier 2 action plan:



NB: *Ongoing audits are included in data collection (3); action planning (2); completed (5)

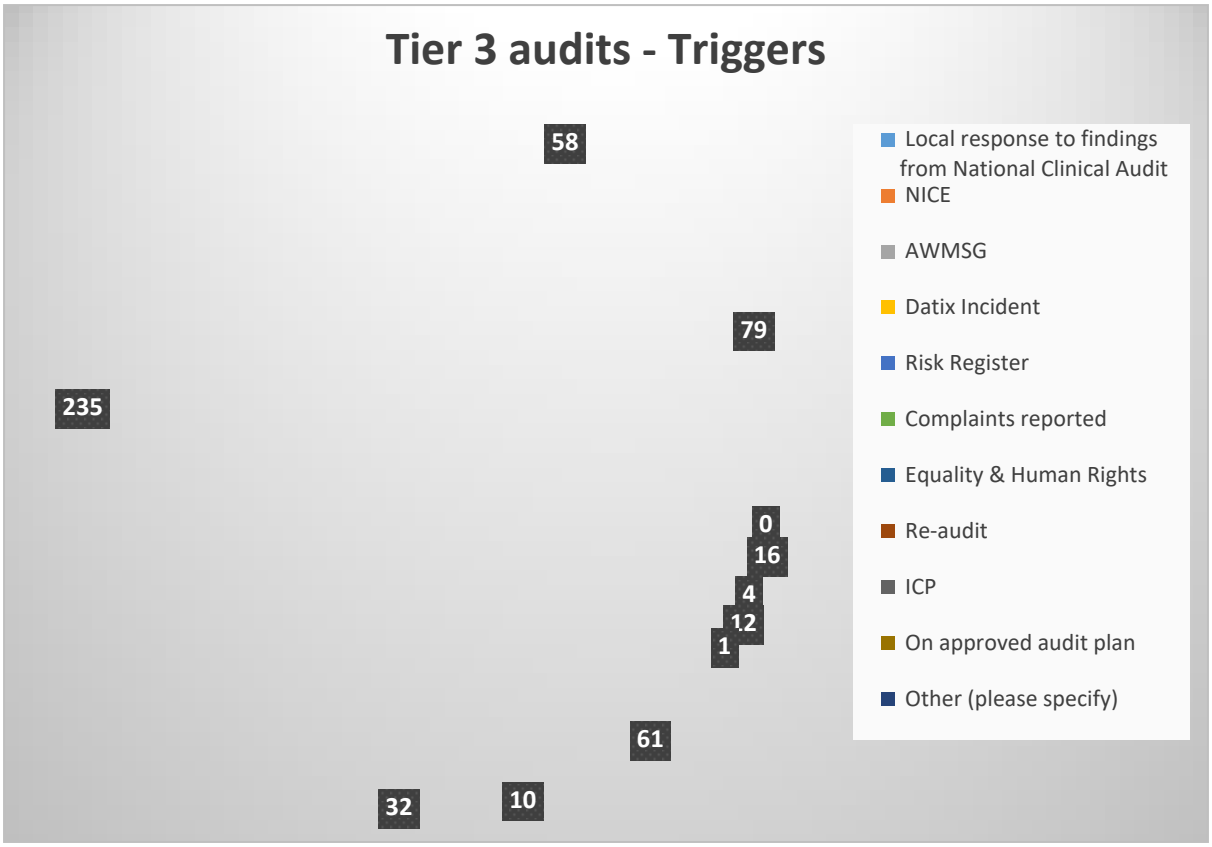
11 projects have completed in year (29%) of which 5 are continuous (ongoing). The six non-continuous projects were all risk assessed as critical or high.

Examples of outputs from this year's audits have been:

- Revision of the IV Morphine guideline. This also includes The IV Morphine competencies and assessment document and a new IV Morphine treatment sheet.
- An audit of compliance with the Human Tissues Act standards for post mortems has shown compliance is maintained. This form part of the site accreditation.
- In addition, standards for human tissue storage for stem cell therapy) has shown compliance against the standards
- Radiology audits have shown good levels of compliance with Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} and Patient Identification in each radiology service.
- An internal end of life audit was completed to support work related to the HASCAS action plan. This audit found the use of outdated paperwork in one of the ICU sites. This is now standardised across all sites and in line with the Critical Care Network guidance; updated national guidance is currently in development and once available this will be revisited.
- The All Wales Medication and Safety audits have shown improving compliance with completion and standards within the audit in Centre medicine reconciliation has improved as has omission of medicines. In the East there has been enhanced pharmacy support within the admissions area and medicine storage is being reviewed. Information on this audit is available internally on the IRIS system to ensure ward managers are aware of the results and can take action.
- In total, 168 audits were completed across BCUHB Blood Science departments in 2019/20 (an increase of 25% compared to 134 audits completed 2018/19). Actions identified during BSQR are completed within agreed timeframes, with actions recorded and monitored in Qpulse (Quality Management Software).

2.3 LOCALLY INITIATED PROJECTS

Locally initiated audits are undertaken within specialties and departments by local agreement. There is a corporate database where these are registered along with service evaluations and on completion the auditor is expected to provide a report. On receipt of this the audit is considered closed. During this year 442 projects were registered of which 78 were completed (17.6%). This is a mixture of audits – checking quality or safety issues in specialities where there is no national priority audit, ensuring actions from a Tier 1 audit are completed or a localised risk or assurance issue such as compliance with national guidance. However, many are undertaken for "local interest" or educational purposes and we need to consider their value given the limited resources we have for audit. (Appendix 3 – Tier 3 activity 2019/20).



NB: Some audits have multiple triggers and so the total above is greater than the 442 registered audits.

The "other" category on the chart captures all other reasons not listed on the registration form used such as education needs (MSc and/or dissertation work) or other evidence based guidelines

2.4 AUDITS IN PRIMARY CARE

There are primary care audits within the NCAORP programme relating to topics such as chronic obstructive pulmonary disease and aspects of diabetes care.
However, local audit activity specific to individual GP practices or GP Clusters is not currently registered within the corporate department. Discussions took place with the previous Head of Clinical Audit to encourage engagement from Primary Care, and this will need further development going forward.

3. RECOMMENDATIONS:

1. The Clinical Audit Policy and Process needs to be robustly implemented. It is not acceptable that Tier 1 mandated audits are not completed. All NCAORP audits must be completed as a matter of priority within the relevant services. Actions plans will be developed with Divisional Leads and monitored and escalated where necessary to ensure data collection is in place.

2. Where appropriate, Clinical Audit leads will be appointed to coordinate audit across BCUHB in line with the work undertaken by the corporate Clinical Advisory Group, ensuring appropriate returns are provided for submission to Welsh Government by all relevant services. Whilst it is acceptable to not have a return where services are fully compliant by Welsh Government; this is not in the spirit of continuous improvement and all audits should have an associated improvement plan. This needs to be progressed by the corporate Clinical Audit and Effectiveness Dept.

3. The Annual audit report will reflect all services within BCUHB; discussion needs to be held with primary care to understand what audit is in place out with the NCAORP programme and encourage use of Tier 3 audit registration.

4. The performance management of audit activity will ensure:
    a. Auditors write action plans that are deliverable and clearly articulate the responsible person and time scale
    b. The sign off process for the action plans needs to be enforced. The developing a standard operating procedure (SOP) covering levels of approval from site leads through to corporate leads. In the short term this might lead to delays returning information to Welsh Government. However, the quality will be much improved.
    c. This will be supported by the recent introduction of an escalation paper to the Clinical Effectiveness Group and support the introduction of quarterly monitoring of actions.

    This is work in progress and will be overseen by the Senior Associate Medical Director, with Executive Medical Director oversight

5. There needs to be an investment in audit across BCUHB to enable data collection and whilst ideally this would be digital, it is likely to require administrative support in the short term. A business case is being prepared to set out these requirements. This will be taken forward by the Office of the Medical Director.

6. There needs to be the ability to track the action plans developed by the auditors to identify barriers to change and support implementation as well as providing robust assurance to the Board. This is currently being investigated.

7. There needs to be stronger local ownership and governance around audit. Resources need to be focussed on Tier 1 & 2 audits in advance of any local audit within a service. Tier 3 projects now need to register on the website to enable access to medical records; this should provide a better overview of the projects planned. There is little incentive to complete these audits and report them centrally – information on completion and the impact of these audits is therefore largely unknown outside the specialty. However, specialities should promote sharing findings across BCUHB.

Aopendix 2

Tier 2 Activity 2019/20

Project Ref Number	Project Title	Which BCUHB priority does this support?	Risk Assessment *(see key below)*	Responsible Corporate Group	Stage of project cycle	Progress with actions
Acute/19/01	Ward Manager Weekly Audit	Highly reliable clinical care	Critical	Secondary Care Quality Group	Ongoing	The new metrics for ward managers (weekly audit) has only just been launched (started 01/07) and super cedes the previous methodology.
Acute/19/02	Shine Tool (Emergency Department Safety Checklist)	Reduce patient harms	Critical	Secondary Care Quality Group	Action Plan ongoing	Reported November 2019. Action plan had been agreed. Awaiting confirmation of action Plan completion.
Acute/19/03	Outlier Matrix	Reduce patient harms	High	Secondary Care Quality Group	Action Plan ongoing	Reported November 2019. Action plan had been agreed. Awaiting confirmation of action Plan completion.
Acute/19/04	Oxygen Competencies	Highly reliable clinical care. Reduce patient harms	High	Medical Gases Committee	Action Plan ongoing	An improvement plan has been in place for the oxygen competency and compliance against safety notice that Debra Hickman has requested to be updated by sites. This therefore will be submitted by Secondary Care when completed.
Acute/19/05	IV Morphine (compliance against guidelines and record keeping)	Highly reliable clinical care. Reduce patient harms	High	PAG / Safe Medication Steering Group	Completed	Guideline completed in draft, to be presented to next Medicines management Sub group for approval IV Morphine Competencies and Assessment document completed and approved at PAG. IV Morphine Treatment Sheet completed in draft to be presented to Medicines Management sub group.
Acute/19/06	Enhanced Care	Highly reliable clinical care	Medium	Secondary Care Quality Group	Delayed	There was a delay in QSG approving the Policy Document. This has only just been rolled out, so to audit would be too early and audit will be conducted when Policy embedded in practice. To be completed by end of October 2020
CORP/OMD/Consent/19/01	Obtaining Written Patient Informed Consent within Secondary Care – A Retrospective Re-audit of Consent forms	Highly reliable clinical care. Reduce patient harms	Critical	Consent and Capacity Strategic Working Group	Action Plan ongoing	Last report was agreed at Consent and Capacity Strategic Working Group in March 2019. Patient Safety Issue circulated in May 2019. Local Action plans have been requested from Secondary Care AMD's.
CORP/19/20-02	Record Keeping	Highly reliable clinical care. Reduce patient harms	Critical	Awaiting confirmation	Action Plan ongoing	East, West & Central reports were completed and results shared with Q&S (West), Clinical Improvement & Audit Groups (CIAG) Central & East for local action.
CORP 19/20-03	Medications Transcription and eDischarge (MTeD)	Highly reliable clinical care. Reduce patient harms	High	Medicines Management Improvement Group	Draft report	Report drafted and awaiting confirmation of action plan. Continued roll-out of MTeD is being supported through Business Plan development.
CORP/04/19	Ward Accreditation Monthly Metrics	Highly reliable clinical care. Reduce patient harms	Critical	Senior Nursing Team	Ongoing	Ongoing and continuous metrics to support Ward Accreditation visits. Actions from the metrics are held locally for improvement, wards are expected to display data for their metrics and actions required on the ward. BCU review is via the Ward Accreditation visit.
CORP/19/013	HASCAS End of Life Audit	Highly reliable care.	Critical	HASCAS & Ockenden Improvement Group	Action Plan ongoing	All three action points are now to be taken up by newly formed BCUHB Strategic Delivery Group for Palliative & EoLC, supported where necessary through Operational Delivery and Academic Sub-Groups, to ensure ongoing review and completion of project action plan.

HASCAS/19/1	Safe Discharges to and from Care Homes.	Highly reliable clinical care. Care closer to home.	High	Corporate Nursing	Action plan ongoing	The reportable actions have not progressed due to Pandemic . However to support the Pandemic Home first Bureaus have been set up, which provide coordination of safe discharges from hospital to home, which could also mean a care home. Care home support has also been provided through the daily calls where they can gain access to MDT advice and support. The Key actions have also been circulated again to Nurse Directors to seek further updates or achievement of targets. It is proposed that a task & finish group be convened to review progress and implementation of key actions.
Corp/19/039	Re-audit of routine enquiry into domestic abuse during pregnancy and the postnatal period.	Highly reliable clinical care. Reduce patient harms	Medium	Safeguarding, in partnership with Womens Services	Report writing	Areas of low and non-compliance with Routine Enquiry Domestic Abuse have been highlighted and targeted activities put in these areas. VAWDASV Training continues to be delivered virtually as this is mandatory for all midwives The audit findings have been reported within the Annual Safeguarding Report 2019/2020. Communication – the audit findings have been shared at Women's QSE and Women's Divisional Group. Findings have been discussed in safeguarding supervision sessions with acute and community midwives and this will be ongoing during 2020.
HTA/HA/2019	Auditing compliance with the Human Tissue Act - Human application	Highly reliable clinical care.	Critical	Pathology Management and Stem Cell Service	Monitoring compliance	Original audit registration was for Human application, but this has been changed to storage only following changes within the stem cell service. Completed audits as per current HTA requirements. Monitoring compliance with HTA standards.
HTA/PM/2019	Auditing compliance with the Human Tissue Act - Post Mortem Sector	Highly reliable clinical care.	Critical	NWMCS Quality Committee	Completed	Rolling audit schedule monitoring compliance with HTA standards for the post mortem sector. Compliance maintained. Next HTA assessment due Spring 2021.
BSQR/2019	Auditing compliance with the Blood Safety and Quality Regulations	Highly reliable clinical care. Reduce patient harms	Critical	NWMCS Quality Committee	Completed	In total, 168 audits were completed across BCUHB Blood Science departments in 2019/20 (an increase of 25% compared to 134 audits completed 2018/19). Actions identified during BSQR are completed within agreed timeframes, with actions recorded and monitored in Qpulse.
ISO15189/2019	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.	Highly reliable clinical care. Reduce patient harms	Critical	NWMCS Quality Committee	Ongoing	Agreed improvement actions completed from 2018/19 annual audit review.Blood Sciences audit calendar completed 31st March 2020. Actions for 2019/20 review to be discussed during annual management review meeting date TBC.
P&MM/19/01	Antimicrobial Point Prevalence Audit (Inpatients)	Reduce patient harms	High	Antimicrobial Steering Group	Action Plan ongoing	Work plan actions ongoing for the "Antimicrobial consumption and prescribing goals: BCUHB Operational delivery plan 2020/21".

P&MM/19/02	All Wales Inpatient Medication Safety Audit	Reduce patient harms	High	Safer Medicines Steering Group	Action plan ongoing	**Centre:** 1. Improve completion rates of the audit tool in YGC - Monthly tracking of audit completion implemented. 2. Improve medicines reconciliation rates and missed doses of medicines in community hospital through targeted support from pharmacy team - Targeted support to LLGH wards implemented on a sequential basis. Actions agreed with ward managers and implemented. Increased data collection and feedback to wards implemented. 3. Undertake focused audit of delayed and missed doses of medicines - Audit complete with review of results in underway. **West:** Monthly data collection by pharmacy ward teams (sample size 10 patients/ward)-data input for medicine reconciliation rate, medicine allergy status documentation, medication omissions, VTE risk assessment and medication storage. Data to be inputted electronically and results viewed on IRIS dashboard. Exception reporting via Quality & Safety, Medication Steering Group. 2019/20: Data available on IRIS dashboard. Data collection sample size reduced during Covid pandemic surge. Awaiting automated data results reports from IT. **East:** 1. Monthly tracking of audit completion. Current ward list on IRIS needs to be updated (several wards no longer exist). 2. Enhanced pharmacy support on admissions areas. Medicines storage capacity being reviewed. 3. Critical medicines list produced. Improved Datix reporting of missed dosing. Targeted audits. NB: interpretation of trends made difficult due to ward moves and repurposing of wards during Covid pandemic.
P&MM/19/03	Safe and Secure Handling of Medicines in Clinical Areas	Reduce patient harms	High	Safer Medicines Steering Group	Report writing	The audit has been completed and the three sites are pulling the data together into a single report; with suggested completion date at end of July 2020.
P&MM/19/04	Controlled Drugs: storage, handling and record keeping in pharmacies and clinical areas	Reduce patient harms	Critical	Controlled Drugs Local Intelligence Network	Ongoing	**West:** CD audits completed in all acute, community hospitals and Mental Health. 6 monthly Controlled Drugs Audits are undertaken by the ward pharmacist team, monitored by the pharmacist team leader and compliance reported to Pharmacy Patient Safety Lead & CDLin meetings. Safe Storage of Medicines clinical area walkabouts includes aspects of CD structural legalities, safe storage and record keeping incorporating daily CD checks-all ward areas & theatres assessed during Jan/Feb 2020. All areas achieved 100% compliance with the standard for controlled drugs cupboard being locked and secure. All areas achieved green status compliance with controlled drug cupboard meets legal criteria.Datix incidents involving CDs reviewed and managed regularly. Datix themes are reported to SMMIRG (Safe Medicines Management & Incidents Review Group) and reported to CDLIN quarterly. **Centre:** All areas with CD storage now audited 4 monthly. 4 monthly CD audit checks compliance increased from 67% to 87% at 28th Feb 2020, despite transition to increased frequency of auditing during this period. Active plan in place for those out of date. Individual incidents arising are datixed and managed accordingly. Incidents escalated to appropriate group as necessary. **East:** CD audits completed in all acute, area and MHLD wards at Wrexham Maelor. Encompasses structural legalities, storage and handling, record keeping and also patient safety aspects, highlighted by the NPSA. No major issues identified. Minor issues discussed with nurse in charge. In addition annual PSN 030 – Safe Storage of Medicines includes aspects of CD storage and daily CD checks. Report to be submitted to QSG for August. Main finding relevant to CDs: some CD cupboards within anaesthetic rooms not structurally compliant, which has been escalated. Datix incidents involving CDs reviewed and managed regularly. These are collated and reported to CDLIN quarterly.

P&MM/19/05	Assessment of BCUHB Homecare Service compliance with the Royal Pharmaceutical Society Professional Standards for Homecare	Highly reliable clinical care. Care closer to home.	High	Pharmacy and Medicines Management: Secondary Care Group	Delayed	Delayed by three months due to resource challenges in Homecare team having been effectively halved from four staff to two since last Autumn and subsequent delays due to COVID redeployment.
P&MM/19/06	Antipsychotic Prescribing (Primary Care) in people aged 65 years or over, as a percentage of all patients aged 65 years or over.	Reduce patient harms	High	Pharmacy and Medicines Management: Heads of Primary Care and Community Hospitals	Action Plan ongoing	The baseline data for a number of GP practices but significantly less data for the end of year data in March 2020. It is also in QAIF this year but since COVID this work has been extended for another 12 months. Clearly our team won't be able to complete this by 13th July. We have a number of staff shielding and also we are having to work remotely focusing on safe, timely access to medicines and clinical review. Our thoughts were: 1. We focus on a 2020/21 audit – data capture July /August 2020 and then again in February/March 2021 COVID 19 permitting. 2. A possible extension to the 2019/2020 data of 2-3months to gather data and to give time for write up
P&MM/19/07	Adherence to Prescription Writing Standards. MHLD Inpatients	Reduce patient harms	High	Mental Health Medicines Management Group	Action Plan to be agreed	The audit has been completed in June 2020. Due to COVID, the presentation was cancelled Presentation date to be rearranaged and will involve development of an action plan in September 2020.
IP&C/19/01	Hand Hygiene audits	Quality and Safety. Reduction in healthcare associated infections	High	Local IPG. Infection Prevention Strategic Group (IPSG)	Ongoing	**West:** Audits not completed Nov and Dec 2019 due to staffing. Recovery plan to implement HH Action Plan training on Acute Site and Roadshow Workshops in Community to improve scores. Unable to carry out Audits in March 2020 due to COVID-19. Resume community roadshow activity when area activity back to normal. Weekly IP visits to community hospital are being carried out to each site, with good feedback. **YGC:** Record maintained of every individual observed and actions taken if required standard not met. Hand sanitizer stations in public areas increased across the sites. Hand hygiene awareness week May 2019. Significant focus on hand hygiene and environmental risk factors as part of Covid19 response and return to business as usual. Hand Hygiene practice reviewed on every Quality Visit to a clinical area. Ward/area/clinic specific action plan is then developed in response to this and progress with the action plans reported via exception reporting to Local Infection prevention group. **East:** Hand Hygiene – issues of significance for escalation is included in the directorate exception reports presented by the Heads of Nursing at the Local Infection Prevention Group meetings. Audits not completed March 2020 due to staffing and due to the impact of COVID-19 on the team. Resource in the team has since allowed the IPT to re-establish the audits. However this data relies solely on the IPT, and the Clinical Service Lead has previously requested through the Local Infection Prevention Group that Matrons contribute to the collection of this data. Data for community hospitals and Mental Health and Learning Disabilities is extremely limited. The introduction of IP/PPE champions as part of the COVID education campaign in the East and daily peer reviews will support this data collection going forward to include in the area and MH&LDs.

IP&C/19/02	Decontamination Audits	Quality & Safety. Reduction in healthcare associated infections	Critical	Exceptions to Strategic Decontamination Group then IPSG	Ongoing	The governance mechanism put in place as per the agreement at the decontamination group meeting, was a program of unannounced visits to cover all departments carrying out decontamination processes. This was set for July 2019 – March 2020. The majority of the visits were carried out. There were no significant issues for escalation identified during the visits that took place up to March 2020.
SALT/19/01	International Dysphagia Diet Standardisation Initiative (IDDSI) Implementation	Highly reliable clinical care. Care closer to home. Deliver what matters most.	Medium	Therapies and Clinical Support Services (Central Area)	Data analysis	Data collection has been completed. Analysis and report delayed by COVID.
Diet/19/03	Dietetic NG audit *(Following PSA008)*	Highly reliable clinical care. Reduce patient harms	High	Therapies and Clinical Services (Central Area).	Ongoing	In view of the COVID pandemic, the audit was halted somewhat. Data collection resumed 1st July 2020. Data collected when a new naso-gastric feeding tube is placed to determine safety of placement and management. This data is collected on a department wide spreadsheet and analysed quarterly. A report is sent to the artificial nutrition patient safety group (led by Dr Tehan). However in view of COVID, these meetings have been halted currently (suggested to restart soon).
Research 19/01	Audit and monitoring of hosted studies (for high and medium risk categoried studies)	Highly reliable clinical care. Reduce patient harms	Low	Research senior management team group	Ongoing	Ongoing program of audits of hosted studies. During the period April 2019 to March 2020, two hosted research audits were completed.Study specific corrective and preventative actions agreed. There are study specific action plans. All recommended actions are closed.This is a rolling program, with new hosted studies being selected on an ongoing basis based on risk and recruitment rates.
Research 19/02	Audit and monitoring of sponsored studies	Highly reliable clinical care. Reduce patient harms	Low	Research senior management team group	Ongoing	Ongoing program of monitoring visits for Sponsored studies. During the period April 2019 to March 2020, seven monitoring visits for Sponsored research were completed and three site initiation visits. These are study specific action plans. Monitoring visits were completed. Completion of corrective and preventative actions are ongoing.
Research 19/03	Research policies and SOPS	Reduce patient harms	Low	Research senior management team group	Ongoing	We have an ongoing program of audits for Sponsored and hosted research. During the period April 2019 and March 2020, Nine studies were audited and monitored and three site initiation visits took place. Study specific corrective and preventative actions agreed. Completion of corrective and preventative actions are ongoing.
Research 19/04	Computer systems validation and data	Reduce patient harms	Low	Research senior management team group	Planning	Over the period April 2019 to March 2020 there were no specific BCUHB computer systems involving R&D research that required system validation. Should this be required, it would be prioritised for audit over the next financial year.
IRR/2019	BCU Ionising Radiation Protection Regulations compliance audits (Minimum 2 a year performed by head of Quality & Governace and Medical physics expert at any site or department in BCU where imaging takes place)	Highly reliable clinical care. Reduce patient harms	Critical	Overarching Radiation Protection Committee	Ongoing	Audits completed for the following: • CT scanning – January 2020 • Interventional Radiology December 2019 • Holywell community February 2020 • Llandudno and bone densitometry scanning March 2020 Actions progressed with some delays due to Covid 19.
IRMER/PI/2019	Radiology Ionising Radiation (Medical Exposure) Regulations { IR(ME)R} compliance Audit - Patient Identification completed annually for each radiology service	Highly reliable clinical care. Reduce patient harms	Critical	NWMCS Quality Committee		

IRMER/RPD/2019	Radiology Ionising Radiation (Medical Exposure) Regulations { IR(ME)R} compliance Audit - Recording of Patient Dose completed annually for each radiology service	Highly reliable clinical care. Reduce patient harms	Critical	NWMCS Quality Committee	Completed	All sites completed audit before end of March with each site collecting the data over a defined period during the later part of 2019. All results presented to the local Radiology audit meetings and shared at the radiation governance meeting. High level compliance on all three sites.
IRMER/PS/2019	Radiology Ionising Radiation (Medical Exposure) Regulations { IR(ME)R} compliance Audit - Pregnancy Status completed annually for each radiology service	Highly reliable clinical care. Reduce patient harms	Critical	NWMCS Quality Committee		
IRMER/RP/2019	Radiology Ionising Radiation (Medical Exposure) Regulations { IR(ME)R} compliance Audit - Recording of Practitioner completed annually for each radiology service	Highly reliable clinical care. Reduce patient harms	Critical	NWMCS Quality Committee		
QSI/2019	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	Highly reliable clinical care. Reduce patient harms	Critical	NWMCS Quality Committee	Ongoing	Tier 2 plan ran to 31st March 2020. A total of 14 audits were registered under this section which is 4 short of the planned number. All are at various stages of completion. The reason for not meeting the required number is due to pressures on service delivery. The pressures were highlighted as a risk of 20 in the risk register. All are at various stages including some that are completed. This includes 2 that are part of national audits. A recovery plan is being developed to ensure all audits are completed and actions implemented

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.

Appendix 3:

Tier 3 Audits	West	Central	East	Total	Completed
Acute Medicine	4	11	3	**18**	2
Adult Mental Health	1	4	2	**7**	1
Anaesthetics/Critical care	4	8	2	**14**	1
Audiology	2	1	0	**3**	0
Breast Surgery	2	2	0	**4**	0
Cancer Centre	0	2	0	**2**	0
Cardiology	4	4	0	**8**	1
Clinical Haematology	2	0	0	**2**	0
Clinical Oncology	2	2	0	**4**	0
Corporate Nursing	1	0	0	**1**	0
Dental	1	1	0	**2**	0
Dietetics	1	4	1	**6**	0
Elderly Medicine	1	3	1	**5**	2
Emergency Department	3	4	0	**7**	0
Endocrinology/Diabetes	1	6	3	**10**	4
ENT	4	3	1	**8**	3
Gastroenterology	0	4	0	**4**	1
General Surgery	15	15	1	**31**	9
Gynaecology	4	5	4	**13**	3
Learning Disability Services	1	1	0	**2**	0
Medical oncology	0	2	0	**2**	0
Neonatal Medicine	0	3	1	**4**	0
Neurology	0	1	1	**2**	0
Obstetrics	10	17	7	**34**	1
Occupational Therapy	0	2	0	**2**	0
Older persons Mental Health	0	1	0	**1**	0
Ophthalmology	4	0	3	**7**	1
Paediatrics	10	11	4	**25**	3
Pain medicine	1	1	0	**2**	0
Palliative Care Medicine/Palliative Care	1	2	0	**3**	1
Pharmacy	4	11	1	**16**	0
Physiotherapy	2	1	1	**4**	0
Radiology	4	5	7	**16**	4
Respiratory	2	5	0	**7**	3
Rheumatology	0	2	2	**4**	0
Sexual Health/HIV services	1	1	2	**4**	0
Speech Language Therapy	0	0	1	**1**	1
Trauma Orthopaedics	14	19	13	**46**	19
Urology	11	3	4	**18**	3
Vascular surgery	2	4	1	**7**	1
Other (specify)	15	49	14	**78**	14
(blank)	8	0	0	**8**	0
	142	**220**	**80**	**442**	-
Projects completed:	20	37	21	-	**78**

Cyfarfod a dyddiad: Meeting and date:	Joint Audit and Quality, Safety & Experience (QSE) Committee 24th November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Delivering Effective Clinical Audit
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof Arpan Guha – Acting Executive Medical Director
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell – Senior Associate Medical Director/ Clinical Lead Improvement Cymru
Craffu blaenorol: Prior Scrutiny:	Prof Arpan Guha – Acting Executive Medical Director
Atodiadau Appendices:	Appendix 1: Logic Model for Clinical Effectiveness

Argymhelliad / Recommendation:

The Joint Committee is asked to discuss whether they agree the proposed actions will provide an effective clinical audit function that will support quality improvement leading to safe, high quality care whilst providing the assurance required by the Joint Committee.

Please tick as appropriate

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

Sefyllfa / Situation:

The clinical audit function in BCUHB has been an area of concern for some time, providing limited assurance that services recognise and value the role of clinical audit in delivering the clinical effectiveness agenda through adherence to evidence based practices and supporting better patient outcomes.

This paper reviews the progress made against the model previously presented (2019) recognising that this has been hampered by the Covid19 pandemic (see appendix 1). It reviews the outstanding actions and any additional changes required. The committee is asked to discuss this document and provide support in principle for the planned improvements and activity.

Cefndir / Background:

"Audit is not concerned primarily with fault or discrepancy finding, but with the examination of working practice to improve effectiveness".[1]

Clinical audit is integral to improving quality, safety and delivery for patient care in Wales. Audit provides an invaluable insight into the quality of care being provided and monitors how well improvements are being taken forward. All organisations should have annual clinical audit programmes in place which include both national, and local audits that address their priorities.[2]

To support an effective clinical audit function a logic model was presented to QSE and Audit Committee in 2018/19 (see appendix 1). There were 3 main themes:

- An appropriate plan that supported key quality and safety issues and aligned with the quality improvement strategy
- Sufficient resources to support delivery of the plan
- Ownership & leadership so staff understand the need for audit and are participating in the delivery of the plan.

Progress against this model and outstanding actions are highlighted below:

Asesiad / Assessment & Analysis

PLAN

PROGRESS:

1. 2020/21 plan agreed at QSE but delayed
2. Draft quarterly update report to CEG (Nov 2020)
3. Monthly escalation report to CEG for overdue action plans (Nov 2020)
4. Annual Audit report 2019/20 drafted (Nov JAQS)

NEXT STEPS:

1. Plan requires more information about audit objectives to enable robust scrutiny
2. Ensure tier 2 audits reflect all priorities including claims (financial risk)
3. Ensure work to expected business cycle for 2021/22
4. Capture tier 2 primary care activity

RESOURCES

PROGRESS:

1. Clinical Audit policy and procedure agreed to focus resources effectively.
2. Introduced electronic registration for Tier 3 audits linked to access to case records
3. Linked audit activity to the Quality Improvement hub - shared resources

NEXT STEPS:

1. Business case for developing audit capacity, both corporately and within the divisions. (Interim Head of Clincial Effectiveness appointed)
2. identify software to enable action plan monitoring.
3. Work with new governance structures to ensure changes are fit for purpose

LEADERSHIP

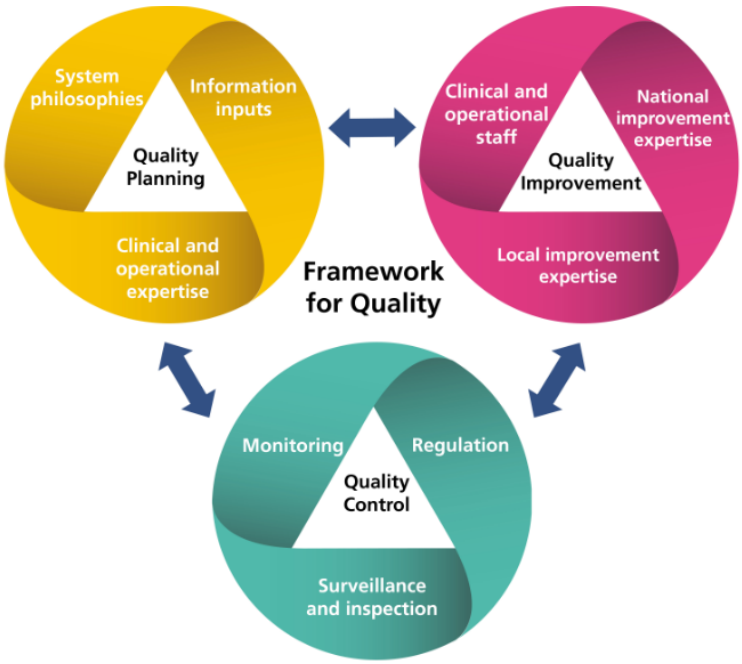
PROGRESS:

1. Escalation process developed to promote timely review and action planning.
2. Sign off process re-developed to ensure action plans are appropriate and deliverable. (from September 2020)
3. 4. E alerts to ensure divisions are aware of registered tier 3 audits; enabling tighter control on audit activity

NEXT STEPS:

1. Ensure all tier 1 audits have an idenfied site and or BCU wide lead (as required).
2. Implement the developed polices, procedures and processes
3. Ensure Divisions are sighted on the audit programme through the quarlerly review process
4. Work with management teams to ensure Clinical Leads and auditors have adequate time to particpate fully.

Strategy Implications:



Clinical Audit is an integral part of a quality framework:

Control – audit describes whether there is reliable care delivering to the standards required. It can also provide the assurance that service changes have been embedded in practice.

Planning – audit identifies gaps in service quality that need attention; these can be aligned with the quality strategy to support prioritisation.

Improvement – audit can provide the measurement needed to monitor change. It can tell you when the change is embedded enabling you to move the focus of improvement elsewhere.

Within BCU, a group are meeting to re-develop the quality strategy. This will align to the new quality governance structures and will encompass a safety strategy, a clinical effectiveness strategy and a patient experience strategy. Clinical audit will be one of the key drivers in the clinical effectiveness strategy.

Options considered
Not applicable to this paper

Financial Implications
This paper does not include financial costs.

Clinical audit needs to be included in the digital strategy, so that data requirements are captured as part of clinical care wherever possible. This will enable real-time monitoring for clinical pathways and also support better understanding of key outcomes; this is the long term ambition. In the interim, a business plan is in development that will support delivery of the audit policy, with the focus being additional resources within the divisions rather than the corporate team. There is work in progress to identify suitable software to support audit tracking and action plan monitoring. In addition, we need to ensure clinical staff have enough time to complete audit including driving any changes identified within their work timetables. For secondary care doctors, there is an expectation that Supporting Professional Activities (SPA) time will be identified to support this; however for those leading audit, third SPA time may be required. However, GPs and other clinical professionals need agreed time within their role to enable them to participate.

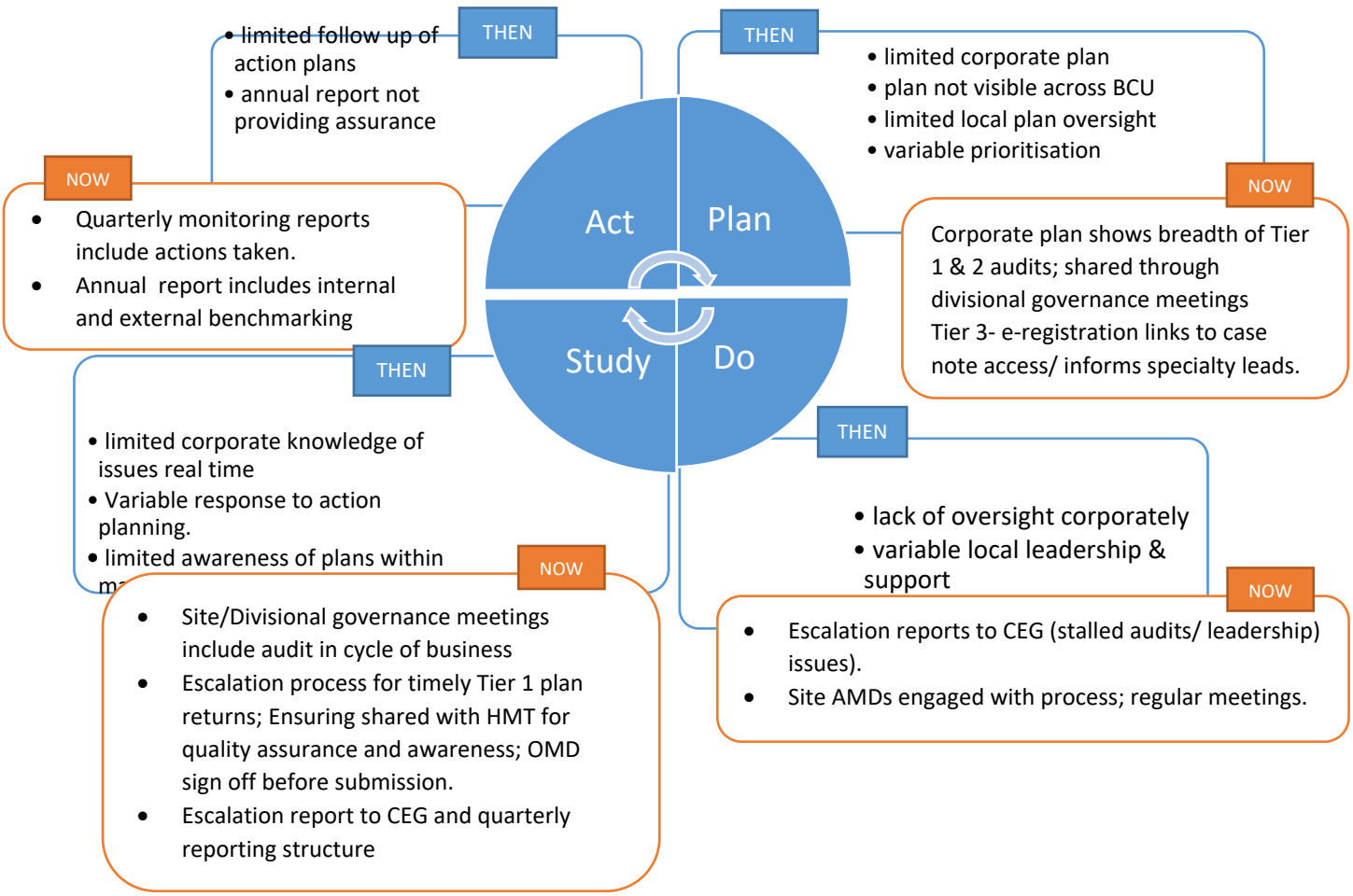
Risk Analysis

The Tier 1 element of the Clinical Audit Plan relates to mandatory projects within the national programme as prioritised by Welsh Government. 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) with a current tier 2 risk rating of 12. This has been mitigated by reducing the scope of activity of the corporate team for example introducing a digital

solution to register tier 3 audits. There is work in progress to articulate the additional resources required to support a fully functional audit programme.

There is a risk of a lack of assurance for services where there is patchy or non-compliance with the plan. When these are Tier 1 audits, it is usually due to lack of resources i.e. clinical time to capture the complex and /or continuous data, and delivering any associated improvements; mitigation might be more localised audits and other sources of assurance.

There has been progress in the last 12-18 months:



There is work predominantly with the secondary care Hospital Management Team (HMT) to embed audit reporting within the governance structures from speciality to Board; quarterly reporting and escalation reports to Clinical Effectiveness Group will identify issues earlier for action. Going forward the clinical strategy includes the development of pathways that explicitly links to relevant national audits.

The logic diagram still remains fit for purpose and over the coming months the focus will be on improving the leadership element:

At a system level, the quality strategy will encompass the clinical effectiveness strategy and so reaffirm the role of audit. The change in governance structures provides a thread in the performance management of audit through the site and divisional clinical effectiveness meeting, to the Clinical Effectiveness Group; this group should then be able to provide robust assurance to the Quality, Safety and Experience Committee. This will be achieved through enhanced monitoring reports that will provide more timely information on improvement with the internal and external benchmarking and service improvements; whilst giving audit and related improvement more visibility, holding

people to account when there are unresolved issues highlighted through the escalation/exception reports.

This will need to be underpinned by additional resources; an interim Head of Service has been employed to who will be writing the business case as a priority within the next 10 weeks.

Legal and Compliance

NHS organisations in Wales are expected to participate in clinical audit as part of the requirements of Standard 3.3 of the Health and Care Standards 2015, which requires healthcare organisations to have a cycle of continuous quality improvement that includes clinical audit.

Compliance with participation in the National clinical audit programme is documented within the Annual report for the committee and through exception reporting and quarterly clinical audit update reports to Clinical Effectiveness Group (from October 2020).

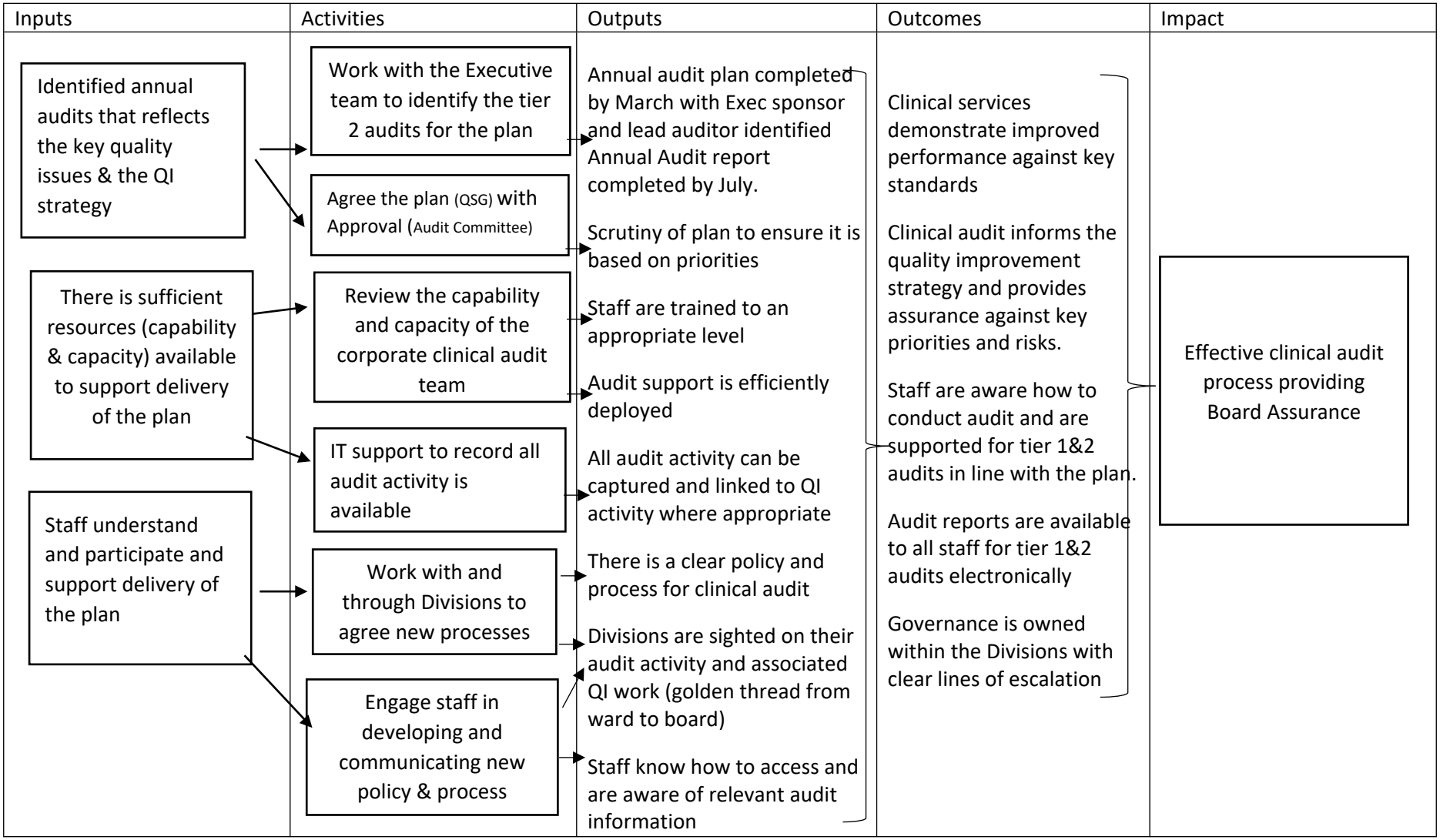
Impact Assessment

An equality impact assessment was undertaken in developing the clinical audit policy. Improving the effectiveness of clinical audit highlights no additional equality issues.

References

1. Dickens P. (1994). In: Welsh Assembly Government. (2003). *An introduction to clinical audit.* Wales
2. Welsh Government governance e – manual http://www.wales.nhs.uk/governance-emanual/clinical-governance
3. Delivering Best Practice in Clinical Audit https://www.hqip.org.uk/resource/best-practice-in-clinical-audit/

Appendix 1: Logic Diagram: Effective Clinical Audit (2019)



Cyfarfod a dyddiad: Meeting and date:	Joint Audit and Quality Safety & Experience (QSE) Committee 24th November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Progress update on the Risk Management Strategy & Policy
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans Interim Director of Governance
Awdur yr Adroddiad Report Author:	David Tita – Head of Risk Management Justine Parry - Assistant Director of Information Governance & Risk
Craffu blaenorol: Prior Scrutiny:	Approved by the Interim Director of Governance
Atodiadau Appendices:	N/A

Argymhelliad / Recommendation:

The Joint Audit and QSE Committee is asked to:

1. Review the report.
2. Note the progress implementing the Health Board`s new Risk Management Strategy & Policy.

Please tick as appropriate

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

Sefyllfa / Situation:

The Health Board is currently on a risk management improvement journey that is marked by the recent ratification and implementation of a new Risk Management Strategy. The new strategy that came into effect on 1st October 2020, is underpinned by a number of significant changes including the introduction of a Risk Management Vision Statement, a clearer Risk Appetite Statement, a Board Assurance Framework and the move from the five to three tier risk management approach or model.

This paper highlights the Health Board`s risk management trajectory, key challenges and progress that has been made.

Cefndir / Background:

The implementation of the new strategy has been split up into individual actions including: evaluation, monitoring and review of progress, accountability and oversight. These are being monitored as part of an annual improvement plan with oversight by the Risk Management Group.

Placing risks into tiers denotes the level at which oversight and scrutiny will be provided, the responsibility for effectively mitigating and managing risks remains with the local service where the risk was identified and is being held. The three tier approach reinforces the Health Board`s

commitment to continuously improve its risk management system and reflects the principles and values of Good Governance.

The three tier risk management approach establishes the oversight of risks that have been through the appropriate check and challenge governance approach will be managed at:

1. Tier 1 for risks scored 15 and above.
2. Tier 2 for risks scored 9-12.
3. Tier 3 for risks scored 1-8.

As part of the process to reduce the tiers all Services, Departments and Divisions across the Health Board have reviewed and updated their risks. Currently there are 1073 risks open on risk registers across BCU; 633 (58.99%) of them align with the new scoring matrix while 440 (41.01%) risks are currently being reviewed by the Corporate Risk Team and the Divisional Governance Teams.

Work is on-going to address anomalies where risk scores indicate that a risk should be overseen by a different tier.

- 121 risks scoring 15 and above are still be held at Tier 3.
- 277 risks scoring 9-12 are being held at Tier 3 while.
- 42 risks scoring 15 and above are being held at Tier 2.

The Corporate Risk Team is working with Governance Teams to address these anomalies, which will be resolved by 31st January 2021.

Continuous support: The Corporate Risk Team will continue to contact, support and work with risk owners and leads in ensuring that all their risks are reviewed/updated, re-scored and align with the three tier risk management approach as defined in the Health Board`s new Risk Management Strategy and Policy.

Effective governance: Local and Divisional Governance Teams should constructively challenge risk owners and leads who present risk register reports with risks which do not align with the three tier approach.

a. **Robust staff engagement and Leadership**: Staff engagement and buy-in are critical drivers in enabling services and divisions to ensure that risk scoring is evidence-based, intelligence-led and underpinned by the 5x5 matrix. A discussion on key risks in the service should be incorporated into 1:1 meetings with supervisors ensuring that supervisees demonstrate robust evidence of frequently and effectively identifying, assessing, adding, reviewing, updating, mitigating and managing risks under their remit. Building on this work a discussion on risks is included in the standard agendas for performance meetings, in the newly approved Performance and Accountability Framework.

b. **Staff training, capacity building** and development in risk management are central to the Health Board`s approach to embed best practice, a culture which enables effective risk management to flourish and will be critical in developing staff awareness, knowledge-base, skills and confidence in risk management and in engineering appropriate risk scoring. The Health Board recently contracted an external risk specialist who delivered six risk management training sessions to 100 staff across all services and divisions. Two other risk management training programmes (virtual and eLearning) designed to align with staff roles and responsibilities are being finalised by the Corporate Risk Team and will be delivered to

staff across the Health Board in the coming months. Training in risk management is fundamentally important to the Health Board`s strategic approach to improving and invigorating its risk management footprint. The plan is to train 600 -1000 staff over the next 12 months, however this will be dependent on any further affects from the Covid-19 Pandemic.

Implementation of the Risk Management Annual Improvement Plan has some slippage, this was reviewed at the Risk Management Group meeting on 23rd October 2020. Minor adjustments to the plan delivery timescales and trajectory were agreed.

The Corporate Risk Team have designed a Risk Management Self-assessment tool which was recently piloted at Ysbyty Glan Clwyd (YGC), with the anticipation that the pilot will be further extended to the Mental Health and Learning Disabilities Division, Area East and Ysbyty Gwynedd. The results of the pilot are encouraging and point to the fact that this tool can serve as an early warning system in alerting services/divisions to emerging risks and thus support them in timely mitigating and resolving such risks. The plan will be to roll out this Self-assessment tool to all services and divisions in 2021/22, provide a strong level of assurance to the Board and Committees as well as design any locally-led owned action plans in driving improvements, embedding best practice and transforming our risk management landscape and culture.

Board Assurance Framework (BAF)

Work is underway to implement a BAF narrative document that describes the assurances in place for managing the Health Board's strategic risks. Aligned to the five strategic priorities for the Health Board, work is on-going with the Executive Team to align the Principal Risks affecting the achievement of these priority areas, and the first draft of the Framework is currently being populated.

It is anticipated that the revised reporting framework for the Principal risks and the revised Corporate (Tier 1) high level operational risks will be submitted to the Audit Committee in December 2020 for approval, with onward submission to the Board for formal ratification and future management arrangements in January 2021.

Asesiad / Assessment & Analysis

Strategy Implications
The implementation of the new Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Options considered
Not applicable.

Financial Implications
There are no financial implications with the implementation of the new Risk Management Strategy and Policy.

Risk Analysis
There is a risk (Risk ID 3739) that the new Risk Management Strategy and Policy may not be timely and robustly implemented because of the reasons highlighted in this report. This risk is currently scored at 8 due to the controls and mitigations in place, whilst also recognising the re-distribution of the workload within the risk team and the use of virtual tools in delivering support and training to staff across the Health Board.

Legal and Compliance
There are no legal and compliance issues associated with the delivery of the new Risk Management Strategy and Policy.

Impact Assessment
All elements which constitute Equality Impact Assessment have been taken into consideration as an EqIA document was crafted in the light of the new Risk Management Strategy and Policy being written.

Cyfarfod a dyddiad: Meeting and date:	Joint Audit, Quality, Safety and Experience Committee 24th November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Audit Reviews
Cyfarwyddwr Cyfrifol: Responsible Director:	Debra Hickman, Acting Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Authors:	Dawn Sharp, Acting Board Secretary Debra Hickman, Acting Executive Director of Nursing and Midwifery
Craffu blaenorol: Prior Scrutiny:	Acting Board Secretary, Acting Executive Director of Nursing and Midwifery
Atodiadau Appendices:	Appendix 1 – Briefing Note by the Acting Executive Director of Nursing and Midwifery Appendix 2 – Extract from Team Central in respect of the Fall and Operating Theatres Audit Reviews

Argymhelliad / Recommendation:

The Joint Committee is asked to receive the update.

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 Audit Committee has established a process whereby it is now asked other relevant Committees to review Limited Assurance reports around nine months or so after publication. The purpose of this is not a reiteration of the original report but a report by the Executive detailing the progress of the actions taken to address the weaknesses identified and whether the implementation of these actions has had the intended outcome. If not, what other actions are being taken.

A number of report fall within the remit of the Quality, Safety and Experience (QSE) Committee. The Chair of that Committee has reviewed the list and has selected two reviews for discussion at this meeting (which will help alleviate some of the business currently listed for QSE) namely:-

- Implementing the Falls Policy; and
- Operating Theatres Review

Cefndir / Background:

Attached as Appendix 1 is a briefing note prepared by the Acting Executive Director of Nursing and Midwifery which set out the position in relation to the falls report. The Interim Head of Planned Care Improvement will be in attendance at the meeting to provide an oral update in respect of the Operating Theatres Review.

Appendix 2 sets out the current status of recommendations arising from each report which are tracked by Team Central Audit Tool with progress updates reported to Audit Committee at each meeting.

Asesiad / Assessment & Analysis

Strategy Implications

This report is purely administrative. There are no associated strategic implications.

Financial Implications

This report is purely administrative. There are no associated financial implications.

Risk Analysis

This report is purely administrative. There are no associated risk implications other than those that were included in the relevant audit reports.

Legal and Compliance

There are no legal or compliance issues other than those identified within the audit reports.

Impact Assessment

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

Title of Limited Report	Source	Date on Audit Cover	Audit Plan	Audit Committee received	No. of Outstanding Recs	No. Outstanding Recs Exceeding Imp. Date	Notes
Implementing the Falls Policy	IA	Mar-19	2018/19	Mar-19	0	0	x5 recommendations in total. One Rec has been followed up / closed by Internal Audit. The remainder are awaiting audit follow up
Operating Theatres Review BCUHB	AW	Aug-19	2018/19	Sep-19	2	1	Following a review of Nursing Directorate recommendations held with the Executive Director of Nursing/Deputy Chief Executive, Audit Wales and Internal Audit on 04/08/2020, it was agreed that the outstanding recommendations under the Operating Theatres Review would be closed and consolidated (with the exception of one recommendation (R4) which is standalone) into a single new recommendation (see BCU-AW-2020-001 / Operating Theatres Review (Consolidated)).

Project Code	Project Name	Rec State	Rec Title	Recommendation	Priority	Response	Estimated Implementation Date	Number of Revisions	Revised Implementation Date	Actual Implementation Date	Last Status Update	Owner	Final Approver
BCU-1819-25	Implementing the Falls strategy	Implemented - Final Client Approved	Evidence of reporting progress since the launch of the falls policy	Regular reporting on falls management is consistent with the established requirements set-out in the Policy and defined groups accountable for implementing and monitoring.	Medium	The revised TOR for the Falls group now identifies quarterly meetings for the group. Minutes of the Inpatient group will be sent to QSG following each meeting along with a summary report on activity. Monthly falls performance reports to QSG will be provided through the three Area, three acute site and one MH&LD divisional exceptions reports to QSG. The In-patient Strategic Falls group acknowledges that attendance has deteriorated which has slowed the progression that could be made within inpatient falls prevention and management. Attempts have been made to encourage an increase in availability to attend these meetings. The Chair of the group will escalate this in writing to the Executive Director of Nursing (Executive lead) and agree a response. Furthermore the leadership of the group, the level of funded organisational subject expertise to support the group and its Terms of Reference will be reviewed by the Executive lead.	31/01/2019	1	14/03/2019	12/04/2019	Divisional reports of issues of significance reported monthly to QSG Chair of inpatient falls group has written to Director of Nursing on the 4th March 2019 to request support in regard to attendance from divisions and review the leadership and terms of reference of the group.	Gareth Evans,Area Director Clinical Services (central)	Deborah Carter,Associate Director Of Quality Assurance
BCU-1819-25	Implementing the Falls strategy	Implemented - Final Client Approved	Evidence of reporting progress since the launch of the falls policy	Policy requirement is reviewed to ensure it is both achievable and suitable. Also falls management training is included as mandatory for all relevant staff within ESR.	High	Training of staff in the area of falls prevention awareness is mandatory for ward based staff. It is the remit of clinical divisions to ensure that the mandatory training falls prevention awareness module on ESR (000 Preventing Falls in Hospitals) is cascaded and made available to all relevant staff. It is currently available on the ESR catalogue and will also be easily found via signposting from the BCUHB Intranet Falls Prevention Homepage once it is launched. Compliance reporting was initially difficult following the change from e-learning to ESR as the portal of access to the training. The Falls group will review the access to the training and its ability to reportcompliance. The group will review the suitability of the module as a form of training and make a recommendation to the Executive lead as to possible other approaches, such as face to face training which have not been achievable to date due to lack of funding/ resources to support this model. To achieve this, Executive support will be required to establish a framework similar to that of other major harms prevention teams such as Infection Prevention and Tissue Viability.	31/03/2019	2	31/10/2019	30/09/2019	Falls training is mandatory for all nursing and HCSW staff across the Health Board. The Falls Policy was reviewed in 2018 and is being further reviewed as part of the all Wales documentation.	Diane Read,Head Of Transforming Nursing Care	Gill Harris,Executive Director Nursing And Midwifery
BCU-1819-25	Implementing the Falls strategy	Implemented - Final Client Approved	Review the DATIX reporting system and the reporting of patient falls	Compliance with Health Board Falls Management Policy - Section 8.3.2 - "A post falls root cause analysis template action record must be completed for all falls which cause harm".	High	As part of the review of the NU06 policy and attached documents, it will be discussed whether the falls prevention specific RCA attached to this policy is surplus to requirements within the RIDDOR framework as other RCA tools have been seen to be used, thus fulfilling the reporting framework. Compliance with RCA completion will form part of the reporting schedule identified in recommendation ISS.1 above.	31/03/2019	2	26/11/2019	30/09/2019	All Falls with harm are subject to a Root Cause Analysis (RCA) and are then discussed as part of a desk top review.	Diane Read,Head Of Transforming Nursing Care	Gill Harris,Executive Director Nursing And Midwifery
BCU-1819-25	Implementing the Falls strategy	Closed - Verified	Review the DATIX reporting system and the reporting of patient falls	Further development and co-ordination of the intranet as a key repository for all staff.	Low	The Falls Prevention Homepage on the BCUHB intranet was under construction at time of audit, the intranet navigation regarding Falls Prevention was not efficient or comprehensive at the time. This is still an ongoing project in collaboration with the Integrated Care Coordinator, with a work stream action plan and end date of 31st December 2018. This will correlate with the 90 Day unscheduled care plan and allow a launch and awareness campaign of the Falls Prevention Homepage in January 2019.	31/01/2019	0		11/02/2019	Follow up comments from IA: The Quality Improvment Corporate Nursing Lead, provided link to the falls homepage (Attached).http://howis.wales.nhs.uk/sites plus/861/page/73628Attached screen shots of the current dashboard and the planned new dashboard. The ward dashboard that is currently in use by all wards in BCU HB display data re number of falls with harm and falls without harm as well date and time of day.The falls collaborative faculty will be updating the Falls prevention Homepage and promoting through the launches planned for December 2019.Attached email showing the number of views for the homepage following it being made active."	Gareth Evans,Area Director Clinical Services (central)	Gill Harris,Executive Director Nursing And Midwifery
BCU-1819-25	Implementing the Falls strategy	Implemented - Final Client Approved	Evidence that staff are completing the patient falls pathway	Improved awareness to staff with regards to the importance of the completion of the documentation as well as the consequences.	High	Clinical divisions must ensure completion of the appropriate documentation within the Falls Prevention Pathway and provide assurance through regula auditing of documentation in line with wider appropriate record keeping standards. Failure to maintain adequate falls assessment and management records should be captured as part of any serious fall SIR reports and reported as exception under the divisional reporting schedule to QSG as per recommendation ISS.1 above. The strategic falls group will seek assurance form clinical divisions of lessons learnt in relation to poor record keeping following audit reports and /or SIR reports.	31/01/2019	2	31/12/2019	30/09/2019	Falls are monitored via the Ward quality dashboard and included as part of the ward accreditation process which incorporates documentation audits. Monthly ward accreditation metrics monitor compliance and quality of completion. Wards are assessed as Bronze, Silver, Gold, White or Red for each of these areas and support mechanisms put in place.	Diane Read,Head Of Transforming Nursing Care	Gill Harris,Executive Director Nursing And Midwifery

Project Code	Project Name	Rec State	Rec Title	Recommendation	Priority	Response	Est Imp. Date	No. of Revisions	Revised Imp. Date	Actual Imp. Date	Last Status Update	Owner	Final Approver
BCU-AW-2020-001	Operating Theatres Review (Consolidated)	Pending	R1	By April 2021, develop a single Health Board-wide operating theatre plan which takes account of emerging clinical strategy and pathways and the need to recover waiting list performance which deteriorated as a result of Covid. The theatre plan will need to reflect: an increase in capacity requirements, and possible repatriation of externally commissioned services new and proposed clinical pathways theatre estate and workforce requirements opportunity to re-engineer pre-operative assessment processes, and ensure that the service is consistent across North Wales a need to strengthen productivity, whilst also considering covid safety requirements.	High	The Health Board will develop a single Health Board-wide operating theatre plan which takes account of emerging clinical strategy and pathways and the need to recover waiting list performance which deteriorated as a result of Covid. The theatre plan will reflect: an increase in capacity requirements, and possible repatriation of externally commissioned services new and proposed clinical pathways theatre estate and workforce requirements opportunity to re-engineer pre-operative assessment processes, and ensure that the service is consistent across North Wales a need to strengthen productivity, whilst also considering covid safety requirements.	30/04/2021					Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R1 (West)	Develop and commence a time-bound plan to improve surgical productivity, prioritising those specialties where patient waits or productivity gain is highest.	High	The Directorate has committed to a programme of further improvement with focus on productivity at specialty level. Specialty level reports have been developed reviewing all key indicators. In addition benchmarking is undertaken via BCU Theatre Performance reporting information. Specialty performance is also discussed at monthly Surgical Turnaround meetings which are chaired by Site Medical Director, and weekly Theatre Planning Cell which is chaired by Theatre Manager	31/03/2020	5	31/12/2020		the organisation is continuing to deliver essential services and is now moving to re-instate routine services through the re-start programme, once these have been re-established, work will commence on surgical productivity in the light of the Covid guidelines on patient and staff safety.	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Started	R4	Modernise the day of surgery admission unit in Wrexham Maelor to ensure patient flow and to minimise the impact of unscheduled care and medical outliers	High	Plans developed, agreed and a business case submitted to planning department for 2019/20 investment.	31/03/2020	4	30/09/2020		the day case theatre has been used during the covid pandemic, plans are underway to re-establish these theatres, linking into the surge and winter planning	Andrew Kent,Head Of Planned Care Improvement (interim)	Gavin MacDonald,Interim Chief Operating Officer
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R5	Where there are differences in process across the three hospital sites in respect of the surgical pathway, the Health Board should ensure that such differences are acceptable and that	High	A system wide approach to this will be addressed through the SPPTG. Sharing of best practice has become common place, and will continue.	31/03/2020	7	30/11/2020		A number of pathways have been established during and post covid which will standardise the surgical pathways. the main specialties are: General surgery, urology, ophthalmology, vascular	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R2a (West)	Monitor patient experience through the roll out of patient experience surveys and take action to address any issues but also feedback positive responses to staff.	High	This has now been addressed at Ysbyty Gwynedd via the patient experience team, this incorporates the feedback for Tudno ward (surgical day ward). First results should be available September 2019 and outcomes will be shared across the BCU.	07/10/2019	1	29/11/2019	14/11/2019	The patient experience of theatres is now incorporated into the patient pathway experience and is co-ordinated through the patient experience team, any positive or negative patient experiences are then feedback through into the theatre process where trends are monitored and corrective action taken	Andrew Kent,Head Of Planned Care Improvement (interim)	Deborah Carter,Associate Director Of Quality Assurance
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R2a (Centre)	Monitor patient experience through the roll out of patient experience surveys and take action to address any issues but also feedback positive responses to staff.	High	Patient experience team working closely with central management team to capture experiences at various stages of Surgical pathway. Day of Surgery arrivals, POAC, wards. This is also monitored through Datix incident and complaints/concerns within the directorate.	31/12/2019	0		10/02/2020	there is now monthly feedback from the patient liaison team, this is feedback to the theatre team where any improvements or communication issues are discussed and addressed	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R2 (East)	Monitor patient experience through the roll out of patient experience surveys and take action to address any issues but also feedback positive responses to staff.	High	Work started to repeat the survey this year - and the same survey will be used across all 3 sites to give a consistent approach.	31/12/2019	0		10/02/2020	this has now been implemented and all relevant information on patient satisfaction is feed back to the theatre team as appropiate	Andrew Kent,Head Of Planned Care Improvement (interim)	Deborah Carter,Associate Director Of Quality Assurance

BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R3a	Improve patient experience by standardising pre-operative processes across the Health Board to ensure equity of access for all patients.	High	There still remain variations in practice across the three sites. The Wrexham pre op model was previously presented to Nursing Director for Secondary Care with a recommendation was made that this model be used across the 3 depts. Also a scoping exercise was completed April 2018 by Service Improvement team to compare practice and highlight differences. We will continue to work across all 3 sites and expand on not only the Pre op documentation has been standardised across the Health Board since 2016 but also best practice.	31/03/2020	4	31/12/2020	26/08/2020	a pan north wales approach to pre-operative care has been introduced during and following the covid pandemic	Andrew Kent,Head Of Planned Care Improvement (interim)	Gavin MacDonald,Interim Chief Operating Officer
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R4b (West)	Focus on improving debriefings as this is the area of most concern identified by improving monitoring of the whole process of WHO implementation.	High	Debriefings are undertaken as and when required. Each member of the team are aware that they can request debrief if they feel necessary. Any untoward event automatically instigates debrief to ensure all relevant information is captured and staff wellbeing established.	07/10/2019	1	27/03/2020	28/11/2019	All sites have implemented WHO checklists with regular audits being undertaken and feeding into secondary care quality group	Andrew Kent,Head Of Planned Care Improvement (interim)	Deborah Carter,Associate Director Of Quality Assurance
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R4b (Centre)	Focus on improving debriefings as this is the area of most concern identified by improving monitoring of the whole process of WHO implementation.	High	Debriefing is carried out when an untoward event or incident occurs, or as requested by any member of the surgical teams. This is in line with the All Wales Theatre Managers group position. Theatre Manager is planning to visit other health boards outside of Wales.	07/10/2019	0		28/11/2019	All sites have implemented WHO checklists with regular audits being undertaken and feeding into secondary care quality group.	Andrew Kent,Head Of Planned Care Improvement (interim)	Deborah Carter,Associate Director Of Quality Assurance
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R4b (East)	Focus on improving debriefings as this is the area of most concern identified by improving monitoring of the whole process of WHO implementation.	High	The All Wales position is that debrief will occur where an untoward event has happened during the list. Any staff member can ask for debrief following an event which has affected them.	07/10/2019	1	31/01/2020	28/11/2019	All sites have implemented WHO checklists with regular audits being undertaken and feeding into secondary care quality group	Andrew Kent,Head Of Planned Care Improvement (interim)	Deborah Carter,Associate Director Of Quality Assurance
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R1 (Centre)	Develop and commence a time-bound plan to improve surgical productivity, prioritising those specialties where patient waits or productivity gain is highest.	High	A plan for 2019/20 is in place through the Surgical Patient pathway transformation group. There is a specific improvement focus on Orthopaedics, scheduling and implementation of PACU	31/03/2020	4	31/12/2020		the organisation continues to deliver essential services and has commenced a re-start programme for routine services, once established a productivity piece will be introduced based on the covid guidelines ensuring patient and staff safety	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R1 (East)	Develop and commence a time-bound plan to improve surgical productivity, prioritising those specialties where patient waits or productivity gain is highest.	High	A plan for 2019/20 has been developed and is attached. This is monitored weekly at our planning cells and monthly at SPPTG	31/03/2020	4	31/12/2020		Essential services are continuing and in September we are commencing further activity as part of the re-start programme, productivity will be reviewed in light of the new covid guidelines	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R2 (West)	Prepare and publish an operating theatres workforce development plan. This should be based on capacity and demand modelling and workforce demographics	High	We currently have a workforce plan for theatre West, this is in addition to the annual WFP which takes into account turnover rate and demographics all theatre staffing is based on AFPP guidelines taking into account capacity and planning. The plan has been accepted by the West Finance and Performance Committee. The plan will be reviewed twice annually to ensure it aligns to revised demand modelling projections	31/03/2020	6	30/11/2020		this work has been paused during the Covid pandemic. Q3/Q4 plans are being established and review of the workforce plan will be undertaken	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R2 (Centre)	Prepare and publish an operating theatres workforce development plan. This should be based on capacity and demand modelling and workforce demographics	High	Site-specific recruitment and retention plan developed.(See attached.) Task and finish group established, Theatre managers, vocational education manager, deputy director Nursingimprove recruitment opportunities and training opportunities for existing staff.	31/03/2020	3	31/08/2020	26/08/2020	Due to the COVID-19 outbreak, all routine operations have been suspended, therefore this work has paused	Andrew Kent,Head Of Planned Care Improvement (interim)	Gavin MacDonald,Interim Chief Operating Officer

BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R2 (East)	Prepare and publish an operating theatres workforce development plan. This should be based on capacity and demand modelling and workforce demographics	High	Task and finish group established with Theatre Managers, Vocational Education Manager and Deputy Director of Nursing to consider alternative options for training and increasing the number of learners in theatre.	31/03/2020	3	31/08/2020		Due to the COVID-19 outbreak, all routine operations have been suspended, therefore this work has paused	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R3 (West)	Develop a long-term plan for theatre estate to support improved surgical productivity and align this to clinical strategy and specialty level plans where these are available.	High	The clinical services strategy will take cognisance of the work required to improve efficiencies and productivity across the theatre estate. Localised plans are in development which will inform the more strategic approach: The future development of Llandudno Theatres is part of the Llandudno Re-development Group. In addition a Llandudno Stakeholders working group to be established to maximise the use of the site. Development and expansion of Ysbyty Gwynedd Theatre Capacity is included within Orthopaedic Plan	31/03/2020	3	31/08/2020		Due to the COVID-19 outbreak, all routine operations have been suspended, therefore this work has paused	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R3 (Centre)	Develop a long-term plan for theatre estate to support improved surgical productivity and align this to clinical strategy and specialty level plans where these are available.	High	The clinical services strategy will take cognisance of the work required to improve efficiencies and productivity across the theatre estate. Localised plans are in development which will inform the more strategic approach: 3 year Orthopaedic plan to be developed including Theatre and ward.	31/03/2020	6	31/10/2020		this work had paused due to covid. however the q3/4 plan is due in September, which will allow a strategic review of theatre estate and capacity	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R3 (Centre)	Develop a long-term plan for theatre estate to support improved surgical productivity and align this to clinical strategy and specialty level plans where these are available.	High	The clinical services strategy will take cognisance of the work required to improve efficiencies and productivity across the theatre estate. Localised plans are in development which will inform the more strategic approach: 3 year Orthopaedic plan to be developed including Theatre and ward.	31/03/2020	6	31/10/2020		this work had paused due to covid. however the q3/4 plan is due in September, which will allow a strategic review of theatre estate and capacity	Paul Andrew,Theatre Manager (central)	Gill Harris,Executive Director Nursing And Midwifery
BCU-WAO-2019-007	Operating Theatres Review	Closed - Not Verified	R3 (East)	Develop a long-term plan for theatre estate to support improved surgical productivity and align this to clinical strategy and specialty level plans where these are available.	High	The clinical services strategy will take cognisance of the work required to improve efficiencies and productivity across the theatre estate. Localised plans are in development which will inform the more strategic approach: Specialty service reviews at Health Board level are ongoing. The Site redevelopment of Wrexham Maelor will take into consideration those review outcomes. Theatres will form part of the WMH site redevelopment	31/03/2020	3	30/10/2020		a longer term plan of theatre capacity is being reviewed after the submission of the q3/4 activity	Andrew Kent,Head Of Planned Care Improvement (interim)	Gill Harris,Executive Director Nursing And Midwifery

Cyfarfod a dyddiad: Meeting and date:	Joint Audit and Quality Safety & Experience Committee (JAQS) 24th November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Governance Self-Assessment Action Plan
Cyfarwyddwr Cyfrifol: Responsible Director:	Debra Hickman, Acting Executive Director of Nursing and Midwfiery
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience Anne Hall, Head of Quality Assurance Erika Dennis, Senior Quality Assurance Manager
Craffu blaenorol: Prior Scrutiny:	Review by responsible director and executive director
Atodiadau Appendices:	1. Quality Governance Self-Assessment Action Plan

Argymhelliad / Recommendation:

The Joint Committee is asked to note the enclosed update of the Quality Governance Self-Assessment Action Plan.

Please tick as appropriate

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

Sefyllfa / Situation:

Following submission of the Quality Governance Self-Assessment to Welsh Government on 07 January 2020, an action plan (attached) was developed that recorded each action identified in the submission and a lead officer and target date.

This update is being provided for assurance to the Joint Committee that ongoing delivery and monitoring is continuing

Cefndir / Background:

Following well publicised events at Cwm Taf Morgannwg University Health Board, the Royal College of Obstetricians & Gynaecologists (RCOG) was commissioned by the Welsh Government to undertake an external review to investigate the care provided by the health board's maternity services. The review took place on 15-17 January 2019, and at the request of Welsh Government, the resulting report and its findings/recommendations informed a local benchmarking exercise involving health boards across Wales. Each health board was asked to consider its own maternity services in the context of the recommendations of the report and to provide assurances on the safety

of those services. The Women's Directorate in the Health Board undertook this benchmarking exercise and submitted the outcome to Welsh Government in May 2019. Some areas for ongoing improvement were identified and have been taken forward as part of the Directorate's learning culture and service development.

In November 2019 Healthcare Inspectorate Wales and the Wales Audit Office issued a report titled 'A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board'. The Minister for Health and Social Services requested that all Health Boards and NHS Trusts in Wales assess themselves against the recommendations of the review and provide plans for future review of their arrangements and/or the necessary action to be undertaken. The self-assessment was required to include a narrative of current arrangements and the current level of assurance as high, medium or low.

The Board held an extraordinary workshop session in December 2019 as part of its process for determining its self-assessment response. The approved version of the response was submitted to Welsh Government on 07 January 2020 and reported to the Quality, Safety & Experience (QSE) Committee that month.

The self-assessment response sets out the Health Board's current position across 7 areas:

- Strategic focus on quality, patient safety and risk
- Leadership of quality and patient safety
- Organisational scrutiny of quality and patient safety
- Arrangements for quality and patient safety at directorate level
- Identification and management of risk
- Management of incidents, concerns and complaints
- Organisational culture and learning

Levels of assurance, based on the current position, were allocated, based on the following definitions: 'a self-assessment of 'high' indicates substantial assurance on the effectiveness of the quality governance arrangement in question, with few or no matters requiring attention. 'Medium' indicates reasonable assurance, with some matters requiring management attention. 'Low' indicates limited or no assurance, with more significant matters requiring management attention'.

Asesiad / Assessment & Analysis

The achievement of the actions in this plan will help strengthen governance arrangements within the Health Board. The Corporate Quality Assurance Teams continues to monitor this plan and collate evidence against each completed action (which is being stored in a central file directory)

The Joint Committee is asked note this update.

It is proposed that updates continue to be provided to the QSE Committee until such times as the actions are complete, a full evidence repository if collated and the Committee assured.

Appendix 1

BCUHB Quality Governance Self-Assessment Action Plan

[For the purposes of the following table, a self-assessment of 'high' indicates substantial assurance on the effectiveness of the quality governance arrangement in question, with few or no matters requiring attention. 'Medium' indicates reasonable assurance, with some matters requiring management attention. 'Low' indicates limited or no assurance, with more significant matters requiring management attention]

Recommendation 1 - Organisational quality priorities and outcomes to support quality and patient safety are agreed and reflected within an updated version of the Health Board's Quality Strategy/Plan.			
Action	**Lead**	**Deadline**	**Update**
Strategic Focus on Quality, Patient Safety and Risk [baseline level of assurance – Medium] 1a. Production of an updated QIS: The QIS is currently being reviewed and is undergoing an Internal Audit Review. The findings from the Audit will be used to shape the revised QIS alongside the agreed priorities for the Health Board. Timeline for approval – workshop proposed for February 2020, then QSE and approval at May 2020 Board.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	Development of the QIS has been on hold due to the need to respond to the Covid-19 pandemic. A plan for resuming this work and producing an updated QIS is due for presentation at QSG in summer 2020 with a view to a new strategy being in place for 2021-2024 Quality Strategy 2021 -2024 Task and Finish Group in place to

			include Patient Safety Strategy and Patient Carer Experience Strategy Task and Finish Groups. Includes a development, engagement and implementation plan.
1b. Production of a Clinical Strategy: A detailed timeline for the Clinical Strategy is being developed. Timescales – agreed priority by end of march 2021 – agreed signed off process how going forward by Boar d	Arpan Guha, Interim Executive Medical Director	31/03/2021	The timeline and further development of the Clinical Strategy has been disrupted by Covid-19. This work will be picked up again as part of the return to business as usual. Three focussed engagement sessions have commenced using the 3 D approach. Agreed as a priority. Agreed process to be approved by the Board.
1c. Production of Communication Plan: Alongside the development of the QIS, Clinical Strategy and Annual Plan will be a communication plan, which will ensure effective dissemination across the Health Board.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	The development of the Communication Plan will follow the timeline of the key strategic documents to which it is linked This work will be picked up again as part of the return to business as usual. See 1A update

Recommendation 2 - The Board has a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically: **i. The Board Assurance Framework (BAF) reflects the objectives set out in the current Integrated Medium Term Plan (IMTP)/annual plan and the organisation's quality priorities.** **ii. The Risk Management Strategy reflects the oversight arrangements for the BAF, the Quality and Patient Safety (Clinical) Governance Framework and any changes to the management of risk within the organisation.** **iii. The Quality and Patient Safety Governance Framework supports the priorities set out in the Quality Strategy/Plan and align to the Values and Behaviours Framework.** **Terms of reference for the relevant Board committees, including those for Audit, Quality and Safety and Risk, and at divisional /group levels, reflect the latest governance arrangements cited within the relevant strategies and frameworks**			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – low/medium] 2a. Once ratified by the Board, monitor implementation of updated Risk Management Strategy and audit key performance indicators, formally reporting results to the Risk Management Group.	Justine Parry, Assistant Director of Information Governance and Risk	30/09/2020	The Risk Management Strategy and associated procedural documents and protocols have been updated, and the new strategy ratified by the Board on the 23rd July 2020.

			The Health Board has also streamlined its risk management process, clearly defining its risk management process and framework, moving from a 5 to 3 tier risk management approach from 1st October 2020. Training has been and will continue to be delivered to staff across the Health Board as part of developing and building local capacity, knowledge and awareness of effective risk management in supporting and embedding a positive risk aware culture. Risk Management Strategy KPIs will commence formal reporting to the Risk Management Group during October 2020 with assurance provided to the Audit Committee as part of the RMG Chairs Assurance Report. Risk Management KPIs include: **Compliance:** This will measure whether the Health Board is compliant with its own risk management strategy and policy

			by evaluating the following components:- • % of risks in the Directorate reviewed in line with the Risk Management Strategy and Policy; • % of risks which are in date and/or out of date; • % of actions linked to Directorate risks which have been completed within set timescales. **Maturity:** This measure will focus on evaluating the completeness of risks on risk registers across the Health Board and will concentrate on the following aspects: - 92.97% of risks with risk lead/manager and specialty amongst other key fields appropriately completed. **ACTION COMPLETE**
2b. Provide Chairs' Assurance Report from the Risk Management Group on progress and outcomes to the Audit Committee.	Justine Parry, Assistant Director of Information Governance and Risk	30/09/2020	See 2a above – linked to launch of new Strategy. The RMG Chair`s assurance report provides confidence to the Audit Committee of the work the

			group is doing in reviewing, monitoring and ensuring the effective implementation of robust systems, processes and governance arrangements across the Health Board in engineering and embedding an excellent risk management culture as part of Good Governance. The Risk Management Strategy V5.0 approved on the 23rd July 2020 was launched on 1st October 2020 with the move from the 5 to 3 tiers. The new strategy provides an overarching perspective on the Health Board`s vision, philosophy and approach to risk management across. Please see embedded document for details on the Chair`s assurance report.  RMG Meeting - Chair`s Assurance Re Action **COMPLETE**
2c. Deliver training to key individuals and groups across whole Health Board to provide consistent approach for the management of risk, the	Justine Parry, Assistant Director of	30/09/2020	As part of embedding its new Risk Management Strategy, the Health Board recently sourced the

hierarchy for training will be developed alongside strong monitoring arrangements.	Information Governance and Risk		services of an external risk management specialist to deliver six risk virtual management training sessions to senior managers across the organisation. The corporate risk team will continue to deliver this training through the rest of the year and this will be reinforced further training resources around `How to add a new risk onto Datix` and updating of the corporate induction pack to include components on risk management. Monitoring of this training will continue and has been incorporated into the Risk Management Training Plan. Risk reporting, monitoring, scrutiny, escalation, de-escalation, governance, accountability and oversight are key strands of the new strategy and clearly defined reporting and monitoring arrangements in place. Action **COMPLETE**
2d. Ensure the RM Group meets at least 4 times during the year.	Justine Parry, Assistant Director of	30/09/2020	The Risk Management Group has a clearly defined Terms of

	Information Governance and Risk		Reference and Cycle of Business which define that it needs to meet more than 4 times a year. The cycle of business provides a framework on Divisional rotatory risk reporting on how Divisions are effectively mitigating and managing their risks. Action **COMPLETE**
2e. Ensure all risks within DATIX are realigned to the new 3-tier model.	Justine Parry, Assistant Director of Information Governance and Risk	30/09/2020	As defined in the new Risk Management Strategy, the Health Board has moved from a 5 to 3 risk management model. Risk owners have reviewed, updated and re-scored their risks on Datix in readiness for the switch to the 3 tier which took place on 1st October 2020. All risks on Datix are now aligned to the 3 tier approach as defined in our new Risk Management Strategy. Work is ongoing in supporting Divisions to continue to review and appropriately score all their risks Action **COMPLETE**

2f. Principal risks to be presented to the Board at a further workshop to agree and review in line with the current CRAF arrangements.	Dawn Sharp, Acting Board Secretary	30/09/2020 New proposed timescale 31 January 2021	The BAF has now been developed and iscussions are underway with the Executives to agree the format and frequency of reporting. This will be presented to the Audit Committee in December for approval with subsequent ratification by the Board in January 2021. This proposal links the BAF (please see embedded draft) and the high level operational risks (CRR) as both registers can talk to and inform each other. The Corporate risk team has also made some suggestions and recommendations to Chairs of Committees on the best way forward with reviewing and re-writing the current CRR where applicable. Embedded are copies of the recommendations that have been made by the Corporate risk team to Chairs of committees.

			 DIGC CRR Chair`s Report v2.1.doc  F&P CRR Chair`s Report v2.1.doc  QSE CRR Chair`s Report v2.2.doc  SPPH CRR Chair`s Report v2.1.doc  BAF 2020-21-MASTER - d
2g. Ensure the new approach to the BAF will align to the organisational priorities from a risk and quality perspective.	Justine Parry, Assistant Director of Information Governance and Risk	30/09/2020 New proposed timescale 31 January 2021	Following on from previous Executive workshops and Board workshops, a new BAF has been designed following a Risk Management Board Workshop held on 22nd September 2020 during which the Health Board`s Strategic Priorities were identified, articulated and defined. Principal risks which could inhibit the achievement of the Strategic Priorities have also been identified and are being finalised with each Executive and incorporated into the BAF. See BAF 2020-21-Master document in 2f as evidence.
2h. Develop Patient Safety Strategy and review all other pillars of the Quality and Patient Safety	Matthew Joyes, Acting Associate	31/03/2021	Development of the QIS has been on hold due to the need to

Governance Framework to ensure full alignment with the work programme to strengthen governance across the organisation.	Director of Quality Assurance		respond to the Covid-19 pandemic. A plan for resuming this work and producing an updated QIS is due for presentation at QSG in summer 2020 with a view to a new strategy being in place for 2021-2024 See action in 1A
2i. Undertake Governance Review led by the Deputy CEO: This review will seek to ensure that there is clear alignment and escalation of risks to the Board as appropriate and reflect the latest governance arrangements as cited within the relevant strategies and frameworks.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	The governance review has been on hold as a result of Covid-19, but is now being picked up again. Executive Team discussion on future structures and groups took place on 26.5.20. A revised paper on QSE sub-structure is being presented in August 2020 with a six-month implementation period. Paper to QSE 3 July 2020, were asked to recommend proposed QSG Split reporting into QSE, with a proposal of 4 groups to replace QSG. Paper back to QSE on 28 August 2020 where the committee agreed the recommendations in the paper, which 4 groups would report into QSE with a range of new meeting templates that

			includes use of a Triple A Report, and proposed plan for phase 2. Sub group review discussed 12 October 2020 with newly appointed Interim Corporate Governance Director. Phase 2 Sub-group review has commenced in November 2020. TOR in place.
Recommendation 3 - There is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: ***i. The role of Executive Clinical Directors and divisional/group Clinical Directors in relation to quality and patient safety is clearly defined*** ***ii. The roles, responsibilities, accountability and governance in relation to quality and patient safety within the divisions/groups/directorates is clear*** ***There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.***			
Action	**Lead**	**Deadline**	**Update**
[Leadership of Quality and Patient Safety. Baseline level of assurance – Low] 3a. Establish Clinical Leads for new pathways and networks: In addition to Clinical Directors, Lead Consultants and Lead Clinicians, the Health Board will be establishing Clinical Leads for the	Arpan Guha, Acting Executive Medical Director	31/12/2020 New proposed timescale 31 March 2021	Executive Team discussion took place on 20.5.20 regarding the future model of clinical engagement, capitalising on the success of the Clinical Advisory

new pathways and networks as part of the new digitally enabled clinical strategy.			Group established as part of the Covid-19 response. The CAG has demonstrated how clinical input and leadership can augment the (Covid-19) clinical pathway development process, and how this might be optimised for business as usual in future. Broadening the membership of CAG's successor group, and utilisation of key individuals such as Cluster Leads, will provide enhanced options for identifying Clinical Leads for pathways and networks.
3b. Governance Review being led by Deputy CEO to clarify and make recommendations to strengthen any arrangements where felt appropriate; this will include the composition of the local governance teams across BCUHB.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	The governance review has been on hold as a result of Covid-19, but is now being picked up. The overarching structure element is being considered first; composition of local governance teams will follow during the next stage. Work is underway now to align governance teams under corporate management. Governance leads proposal for change out for consultation. Acute and MHLD governance teams will re-align from 01 December 2020. Additional work being done with Area divisions to progress. Formal

			consultation underway in Women' division – likely to be complete by end 2020.
3c. Learning from the HIW review of Maternity Services and Birth Centres to be used to strengthen internal processes.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/12/2020	This work has been paused due to Covid-19. A review of HIW processes is due to start in September 2020. The Health Board will also consider the findings of the national maternity review due at the end of the year.
3d. Governance review to further support work already undertaken by assessing if failings and gaps identified within Cwm Taf exist within BCUHB and ensure that where these are identified strengthened and improved. This will include the use of data and dashboards for and how these are reported through to the Board.	Matthew Joyes, Acting Associate Director of Quality Assurance (quality governance) and Simon Evans-Evans, Interim Corporate Governance Director (corporate governance)	31/12/2020	The Governance review work was been paused as a result of Covid-19. However this work has now restarted and is being facilitated by the appointment of an Interim Director of Governance. The review is expected to be concluded by the end of the year. The QSG meeting has been aligned to the three quality domains allowing greater scope for discussion and scrutiny. Goverance teams are in the process of being re-aligned to corporate leadership. A new Quality Dashboard is in development. Quality Dashboard Development Task & Finish

			Group, Project Plan. Pilot 2 November 2020 (go live). Roll out across the Health Board planned for January/February 2021. A Concerns (Patient Safety and Experience) performance dashboard is in place.
Recommendation 4 - The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety Governance Framework and key corporate risks for quality and patient safety. This should include assessment of ensuring sub-groups/committees have sufficient support to function effectively; the content, analysis, clarity and transparency of information presented to the committee and the quality framework in place is used to improve oversight of quality and patient safety across the whole organisation.			
Action	**Lead**	**Deadline**	**Update**
[***Organisational scrutiny of quality and patient safety.*** ***Baseline level of assurance – Low/Medium]*** 4a. Governance Review will provide further opportunity to ensure fitness for purpose of the overall structure, reporting and escalation. Following the review implementation of the recommendations of the will be monitored by QSE.	Simon Evans-Evans, Interim Corporate Governance Director	31/12/2020	The Governance review work was been paused as a result of Covid-19. However this work has now restarted and is being facilitated by the appointment of an Interim Director of Governance. The review is expected to be concluded by the end of the year.

4b. Function and remit of QSE Committee, and cycle of business, to be reviewed to ensure that the Committee is operating effectively and sufficient focus is given to the quality, safety and experience priorities for the organisation. This will also provide an opportunity for the CBMG to reflect on the reporting arrangements across the different committees to ensure sufficient clarity and oversight at Board level.	Simon Evans-Evans, Interim Corporate Governance Director	31/12/2020	The Governance review work was been paused as a result of Covid-19. However this work has now restarted and is being facilitated by the appointment of an Interim Director of Governance. The review is expected to be concluded by the end of the year.
4c. Broadening of the visibility of the QPSE dashboard as well as other metrics within the internal viewing system IRIS to be undertaken alongside the development of the Clinical Strategy.	Matthew Joyes, Acting Associate Director of Quality Assurance	30/09/2020 New proposed timescale 31 March 2021	This work, together with the development of the Clinical Strategy, had been paused due to Covid-19. A new Quality Dashboard is in development. Pilot Launch 2nd November 2020. See 3d update
Recommendation 5 - Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Medium] 5a. Ensure that the Board Development and Workshop programme is strengthened to include all elements within the IM role e.g. Consultant Interviews. And consider feedback from the work	Dawn Sharp, Acting Board Secretary	31/12/2020	Ongoing Board Development and Workshop programme in place, which has been modified in terms of delivery to take account of Covid restrictions. The current

with the King's Fund which will further support the development programme for IMs			programme will come to an end during Q4 and discussions are underway with Kings Fund to agree a continuation of the programme particularly in view of Board turnover during the year. In terms of Consultant Interviews training and support this has been facilitated by Workforce colleagues outside of the Board Development programme with additional support provided with the move to virtual platforms.
Recommendation 6 - There is sufficient focus and resources given to gathering, analysing, monitoring and learning from user/patient experience across the organisation. This must include use of real-time user/ patient feedback.			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Medium] 6a. Greater emphasis to be placed on the "learning element of listening to patients and services users" throughout 2020 as described in the Patient Experience Strategy, this will include the "You said, We did" approach.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	A refresh of the Patient and Carer Experience Strategy was paused in March due to Covid-19. This has now recommenced and a new strategy is expected to be in place to cover 2021-2024 aligned with the Quality Strategy and Patient Safety Strategy. Launch on 31st March 2021

6b. Review the processes for concerns (incidents, complaints, claims, etc.) - the Community Health Council will be a key part of this work.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/01/2020	The review of the complaints and incidents processes commenced during early 2020, but was paused in March due to Covid-19. This is now being taken forward again with an implementation date of January 2021. Review of processes is included in the Patient Safety Experience Department Delivery Plan in place. See 1a update. Implementation date on track for January 2021
6c. Hold a workshop planned jointly with the CHC, to strengthen how the complaints and patient experience teams within the Health Board, and the CHC, work more closely together.	Matthew Joyes, Acting Associate Director of Quality Assurance	28/02/2020	Complete. The workshop with the CHC was held and following internal review a new senior complaints lead has been appointed to maintain oversight of all CHC complaints develop relationships. **ACTION COMPLETE**

Recommendation 7 - There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Low] 7a. Embed arrangements following adoption of revised Clinical Audit Policy.	Melanie Maxwell, Senior Associate Medical Director	31/12/2020	The Clinical Audit Policy was approved by the Audit Committee; arrangements will be embedded as part of the return to business as usual. To be discussed under Any Other Urgent Business for Clinical Effectiveness meeting on 15 October 2020
7b. Review the clinical audit plan and reporting arrangements, including identification of outliers and learning, to ensure that it is outcome focussed and facilitates quality improvement activities across the organisation – monitor progress through the governance reporting structure going forwards.	Melanie Maxwell, Senior Associate Medical Director	31/12/2020	This work has been paused due to Covid-19. To be mentioned under Any Other Urgent Business for Clinical Effectiveness meeting on 15 October 2020- to be discussed with Chair and member of the group.

Recommendation 8 - The organisation has clear lines of accountability and responsibility for quality and patient safety within divisions/groups/directorates.			
Action	**Lead**	**Deadline**	**Update**
[***Arrangements for quality and safety at directorate level.*** ***Baseline level of assurance – Low/Medium]*** 8a. Complete work to formally identify a Clinical Director for each speciality - as part of the governance review, ensure that reporting lines and structures are fully considered and recommendations to strengthen/improve made.	Arpan Guha, Acting Executive Medical Director	31/12/2020 Proposed new date 31st March 2021	This work was paused due to Covid-19. Work recommenced November 2021.
Recommendation 9 - The form and function of the divisional/group/directorate quality and safety and governance groups and Board committees have: ***i. Clear remits, appropriate membership and are held at appropriate frequently.*** ***ii. Sufficient focus, analysis and scrutiny of information in relation to quality and patient safety issues and actions.*** ***iii. Clarity of the role and decision-making powers of the committees.***			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Low/Medium] 9a. Implement actions from the governance review (see section 4 above), where necessary in order to further strengthen this governance element.	Simon Evans-Evans, Interim Corporate Governance Director	31/03/2021	This work was paused due to Covid-19. See section 4 above. See section 4 above for updates

Recommendation 10 - The organisation has clear and comprehensive risk management systems at divisional/group/directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers and the management of those risks. This must be reflected in the risk strategy.			
Action	**Lead**	**Deadline**	**Update**
[Identification and management of risk. Baseline level of assurance – Low/Medium] 10a. Move to Enterprise Risk Management model and from a 5 Tier model to a 3 Tier version, to strengthen escalation and de-escalation processes.	Justine Parry, Assistant Director of Information Governance and Risk	31/09/2020	The new Risk Management Strategy supports an enterprise risk management approach as it moves from silo to an integrated organisational-wide model to effectively manage. It underlines the fact that BCU is committed to implementing an integrated, dynamic, inclusive, comprehensive, risk-based approach to the delivery of its core operational and business activities. A risk-based approach will enable the Health Board to avoid unwelcome surprises by drawing and triangulating intelligence from multiple sources in implementing a dynamic, enterprise-wide perspective to the timely assessment, mitigation and management of emerging risks. The risk management process as defined in the new strategy draws

			inspiration from established risk management standards such as ISO 31000:2018 in highlighting the Health Board`s risk management process from `Ward to Board`. It provides high level assurance to key stakeholders through the use of tools like Self-assessments, Audits, KPIs reporting, regularly reports to Quality & Safety and Governance meetings, committees and the Board. Staff are encouraged, trained and empowered to take local ownership and leadership for the effective risk management within their Services and Divisions. This will strengthen engagement, local ownership/decision making, streamline the process, encourage, joined-up, integration and greater visibility of identified risks through the governance arrangements. At the heart of the new Strategy is the implementation of Enterprise Risk Management (ERM) across BCU as staff will embed effective risk management through priority and

			objective setting, raising productivity, performance, better decision-making and ensuring financial viability. **ACTION COMPLETE**
10b. Implement and monitor revised Risk Management Policy.	Justine Parry, Assistant Director of Information Governance and Risk	31/09/2020	See section 2a (KPI's to monitor policy). In addition to clearly defined KPIs as highlighted in 2a above for monitoring the new Strategy: - - A suite of guidance and supporting documents have also been crafted and are available on the risk management intranet page to assist staff with reviewing, updating and re-scoring their. - A CQC-style Risk Management Self-assessment tool has also been developed and piloted at the YGC with the aim of supporting staff in undertaking self- evaluation of how they are doing with regards to risk management. The Corporate Risk Team will

			work with Divisions to develop their action plans to address any areas of short fall and monitor through to completion. See below embedded example. - The new Strategy advocates for a performance management approach to risk management and defines effective risk management as a tool for continuous improvements in patient care. DRAFT Risk Self Assessment Form - v **ACTION COMPLETE**
Recommendation 11 - The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning.			
Action	**Lead**	**Deadline**	**Update**
[Management of incidents, concerns and complaints. ***Baseline level of assurance – Medium]***			

11a. Ensure the Patient Safety Strategy strengthens reporting arrangements and focus on learning from all opportunities.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	See section 2. This work was put on hold due to Covid-19. This has now recommenced and a new strategy is expected to be in place to cover 2021-2024 aligned with the Quality Strategy and Patient and Carer Experience Strategy. See update in 1a
11b. Ensure the Listening and Learning from Patient Experience Report and CLIC (Concerns, Litigation, Inspections, Claims) Report are reviewed and improved in order to provide the QSE Committee with further improved data and analysis, and a link to improvement activity	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2020	Complete. A new format Patient Safety Report and Patient and Carer Experience Report for QSE are both in place. Q4 reports were submitted to QSE and Q1 and Q2 reports for 2020/21 have been produced. **ACTION COMPLETE**
11c. Ensure that the review of concerns/incidents/complaints/claims also includes a focus on HIW and CHC inspections/ visits as well as a link into risk management structures/ BAF in order to further strengthen triangulation	Matthew Joyes, Acting Associate Director of Quality Assurance	31/12/2020	The reports mentioned above in 11b contain HIW and CHC information following integration of the corporate teams under the Acting Associate Director of Quality Assurance. New PE and PS reports do include CHC etc. New Quality Assurance Report to PSQ on 13 November 2020, now bi-monthly.

			New business cycle for PCE and PSQ addresses this action.
Recommendation 12 - The organisation ensures staff receive appropriate training in the investigation and management of concerns (including incidents). In addition, staff are empowered to take ownership of concerns and take forward improvement actions and learning.			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Medium] 12a. Enhance the training programme for concerns with the introduction of a modular series of training and a passport scheme	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	This work was put on hold due to Covid-19. New training will be in place to support the new processes being implemented from January 2021. This training will link into the Ombudsman Complaints Standards Authority training programme.
Recommendation 13 - The organisation has an agreed Values and Behaviours Framework that is regularly reviewed, has been developed with staff and has a clear engagement programme for its implementation.			
Action	**Lead**	**Deadline**	**Update**
[Organisational learning and culture. Baseline level of assurance – Medium] 13a. Ensure continued focus on delivery of the organisational and Divisional Improvement plans.	Debra Hickman, Acting Executive Director of Nursing	31/03/2021	Lead amended from Sue Green to Debra Hickman. This action links to the Quality Strategy development- See action 1a

13b. Deploy a single improvement system across the organisation	Debra Hickman, Acting Executive Director of Nursing	31/03/2021	Lead amended from Sue Green to Debra Hickman. This action links to the Quality Strategy development- See action 1a
Recommendation 14 - The organisation has a strong approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken within the organisation and across the NHS.			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Low/Medium] 14a. Establish clinical summits (chaired by the Executive Medical Director) with clinical leaders and the executive team, to review the quality of the main pathways (e.g. looking at safety, national clinical audit data, outcomes and experience measures) as a key aspect of delivering a new digitally enabled clinical strategy.	Interim Executive Medical Director	31/03/2021	This work has paused due to Covid-19. See sections 7 and 11. Work has restarted in November 2020
14b. Ensure national clinical audits are explicitly embedded in the new clinical strategy and pathways – and used to benchmark the Health Board so that organisational learning can be improved.	Melanie Maxwell, Senior Associate Medical Director	31/03/2021	See section 7

Cyfarfod a dyddiad: **Meeting and date:**	Joint Audit, Quality, Safety and Experience Committee 24th November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Governance arrangements during COVID
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dawn Sharp, Acting Board Secretary
Awdur yr Adroddiad **Report Authors:**	Dawn Sharp, Acting Board Secretary Dave Harries, Head of Internal Audit
Craffu blaenorol: **Prior Scrutiny:**	Acting Board Secretary
Atodiadau **Appendices:**	Appendix 1 – Internal Audit Report on Governance arrangements during COVID Appendix 2 – Guidance Note issued by Welsh Government in respect of discharging Board Committee responsibilities during COVID response phase.

Argymhelliad / Recommendation:

The Joint Committee is asked to note:-
(1) the Internal Audit report and in particular the priority considerations for the future;
(2) that these priority considerations are being actively via Team Central and reported to the Audit Committee;
(3) the Guidance as issued by Welsh Government in respect of discharging Board Committee responsibilities during COVID-19 response phase.

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 note the contents of the attached internal audit report as presented to the Audit Committee in September 2020 together with the guidance note document as issued by Welsh Government in respect of discharging Board Committee responsibilities during COVID-19 response phase.

Cefndir / Background:

The attached Internal Audit review was requested by the Acting Director of Finance to assess the adjusted financial and overall governance arrangements that were put in place to enable the Health

Board to maintain appropriate governance whilst enabling its senior leadership team to respond to the then rapidly developing emergency.

The review was completed during July 2020 and involved meeting key members and officers of the Health Board as well as reviewing associated documentation supplied, where available. Internal Audit worked closely with Audit Wales to avoid unnecessary duplication with their work, sharing information where relevant and undertaking a number of meetings together.

Members are asked to note that the Guidance document as issued by Welsh Government in respect of discharging Board Committee responsibilities during COVID-19 response phase has been previously considered by both Audit Committee and the Quality, Safety and Experience Committees.

Asesiad / Assessment & Analysis

Strategy Implications

This report is purely administrative. There are no associated strategic implications.

Financial Implications

This report is purely administrative. There are no associated financial implications.

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

There are no legal or compliance issues other than those identified within the report.

Impact Assessment

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

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

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

Governance Arrangements during the Covid-19 Pandemic

Advisory Review Final Report

2020/21

Betsi Cadwaladr University Health Board

Audit and Assurance Services

Private and Confidential

Contents

Review reference:	BCU-2021-39
Report status:	Final
Fieldwork commencement:	22nd June 2020
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Draft report issued:	12th August 2020
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Auditors:	Head of Internal Audit Deputy Head of Internal Audit Audit Manager - Capital
Executive sign off:	Acting Director of Finance Acting Board Secretary
Distribution:	Acting Director of Finance Acting Board Secretary Chief Finance Officer – Central Area
Committee:	Audit Committee

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

Please note:
This advisory review report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee. Advisory review reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction

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

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

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

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

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

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

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

2. Executive Summary

Main Observations

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

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

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

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

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

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

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

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

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

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

Priority Considerations for the Future

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

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

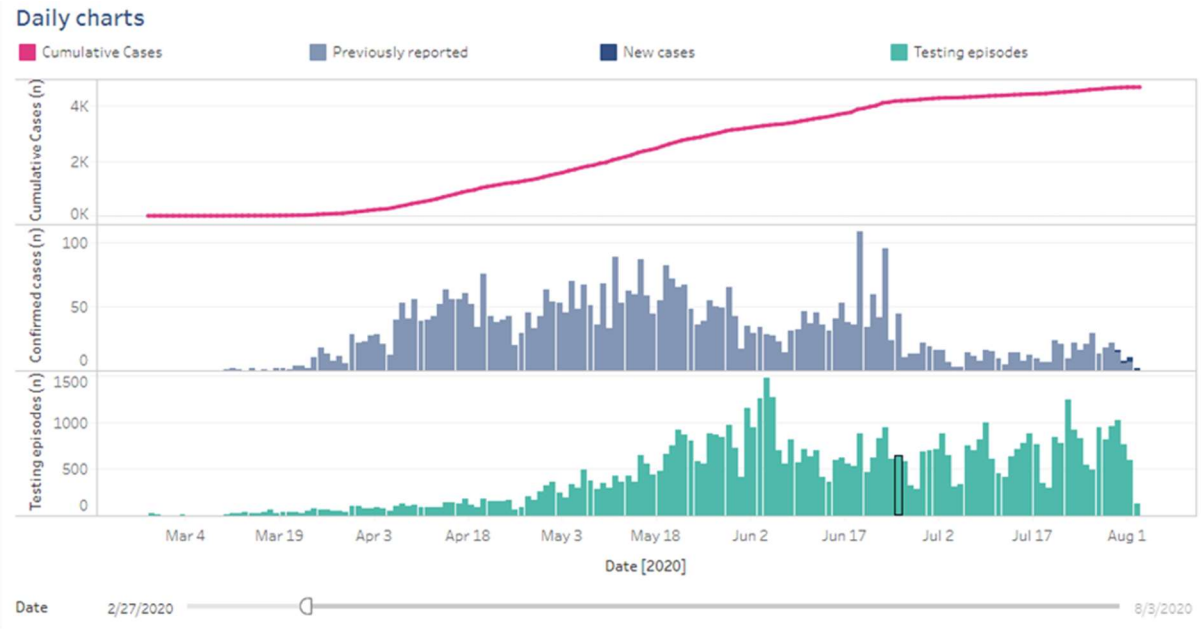
- Documenting all decisions taken in accordance with published guidance, with a clear audit trail;
- Updating all business continuity plans throughout the Health Board, to reflect changes required as a result of the pandemic;
- Ensure all COVID-19 risks are recorded in accordance with the Risk Management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

3. Background and Context

Overview of the Impact of the Pandemic on the Health Board

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

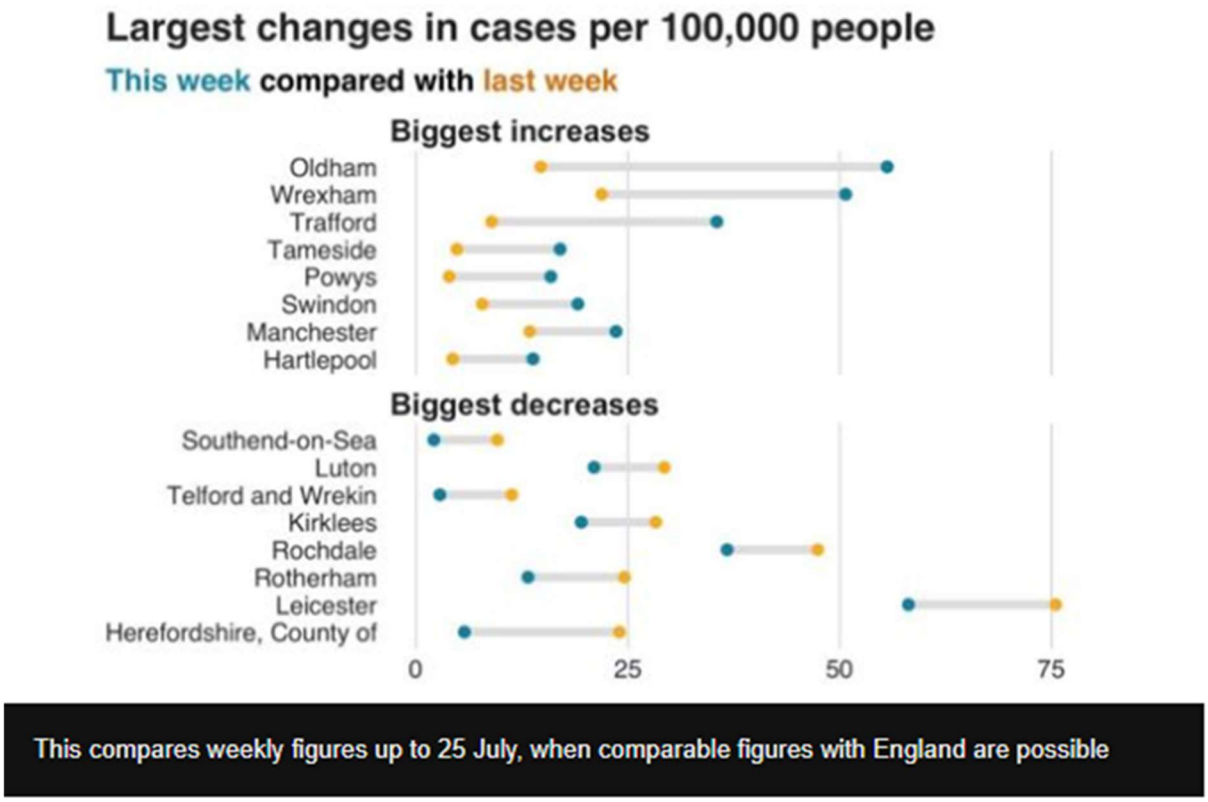
Image 1: Betsi Cadwaladr University Health Board Daily Reports



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

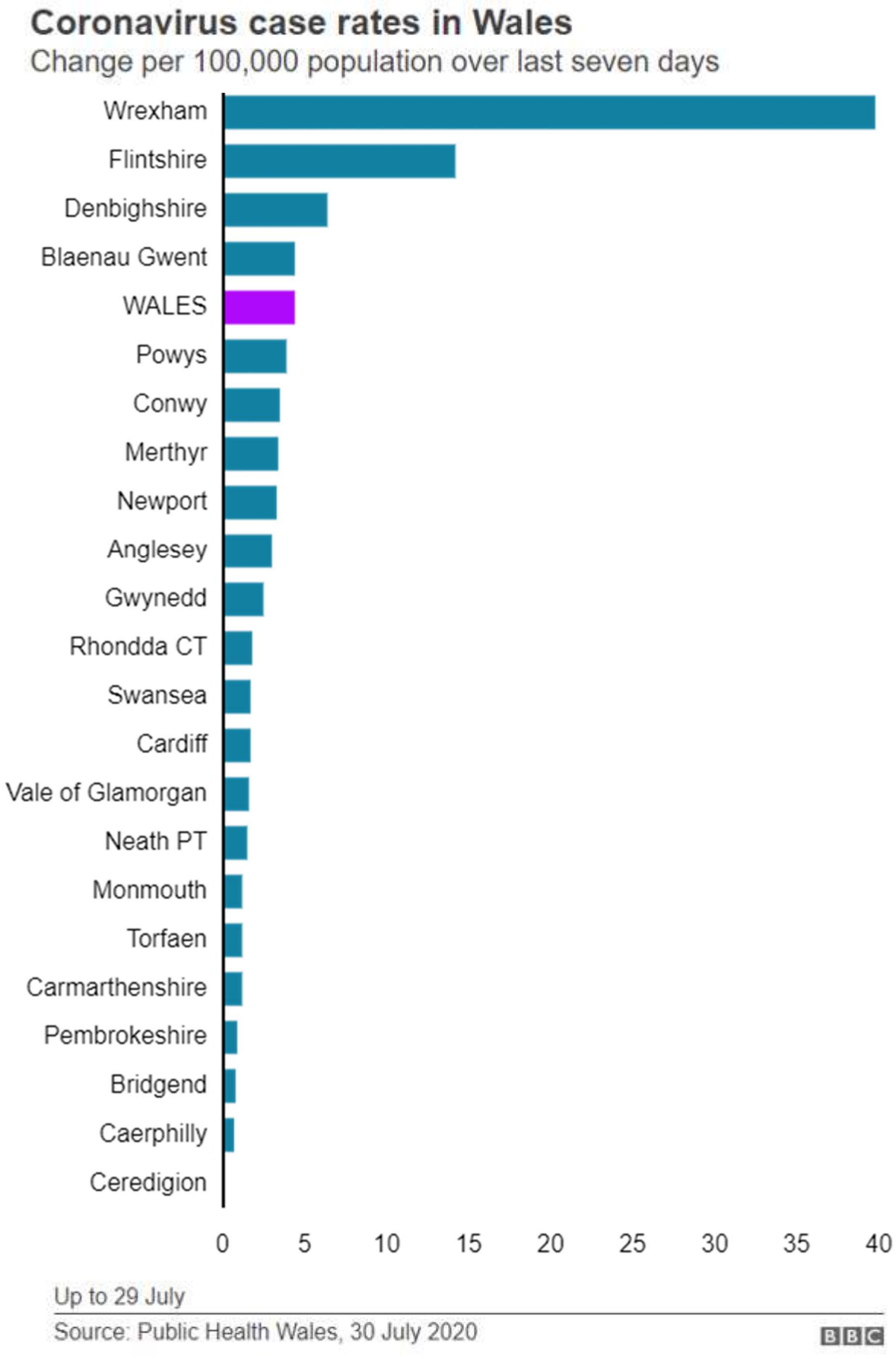
Following the onset of the pandemic across Wales, the Health Board continues to experience high levels of the virus in comparison to England (image 2) and above the Wales average (image 3).

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



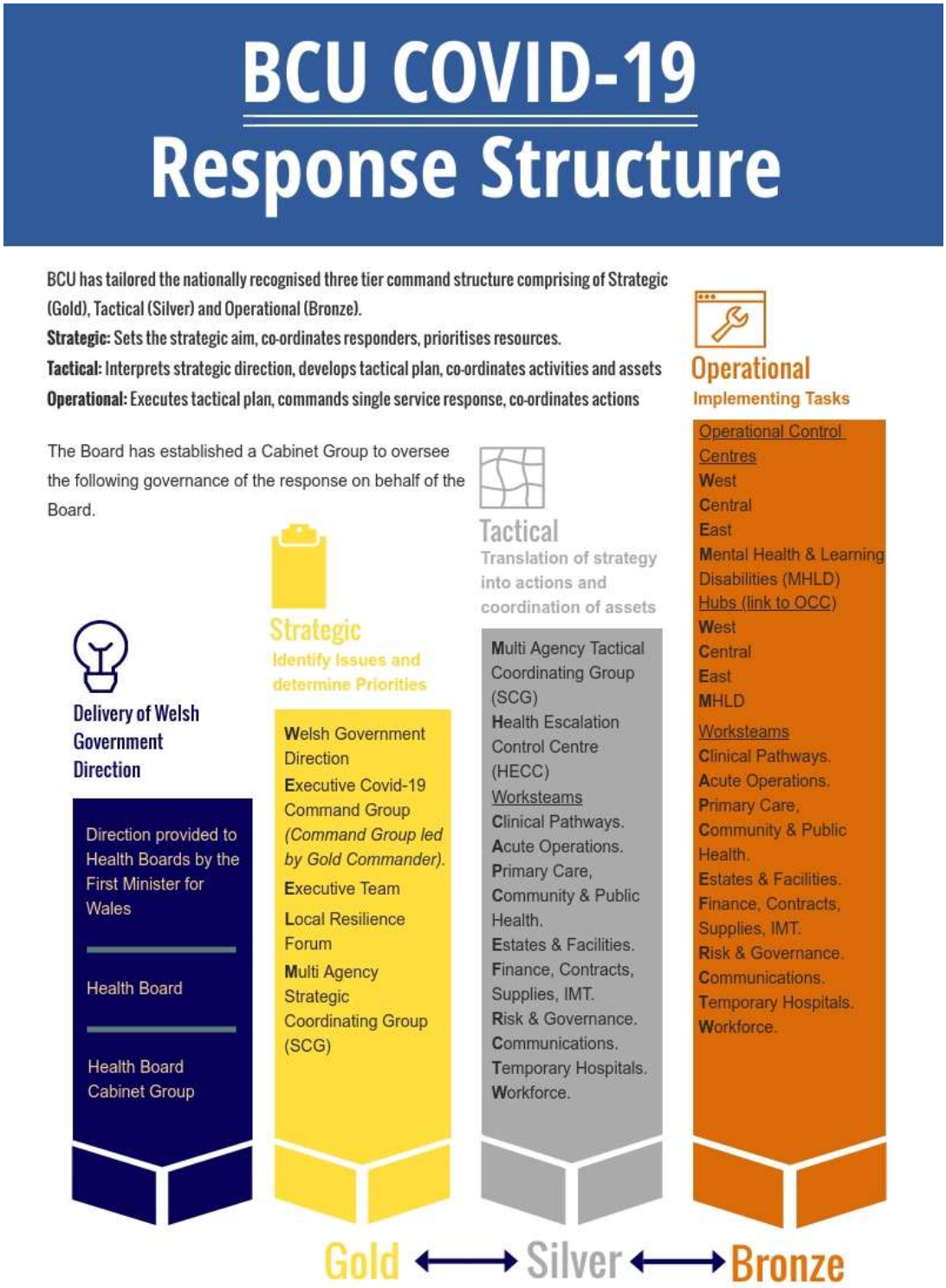
Source: https://www.bbc.co.uk/news/uk-wales-53592767 (Image 2 & 3)

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



Command and Control Structure

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



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

Adjusted Governance Arrangements

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

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

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

4. Detailed Findings

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

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

Strategic Governance

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

Financial Governance

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

Other Governance Areas

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

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

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

Strategic Governance

Board and Committee Meetings

What we found

Our review identified the following:

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

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

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

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

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

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

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

What we found

Our review identified the following:

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

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

What could be done differently in the future

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

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

Risk Management

What we found

Our review identified the following:

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

What could be done differently in the future

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

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

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

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

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

Financial Governance

Annual Accounts and Reporting

What we found

Our review identified the following:

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

What could be done differently in the future

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

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

Authorised Signatories/ Electronic Approval Hierarchy / Delegated limits

What we found

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

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

What could be done differently in the future

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

Financial Systems and Processes

What we found

Our review identified the following:

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

What could be done differently in the future

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

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

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

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

Covid-19 Expenditure (Revenue and Capital)

What we found

Our review identified the following:

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

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

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

What could be done differently in the future

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

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

Workforce

What we found

Our review identified the following:

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

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

What could be done differently in the future

We suggest the following considerations as the organisation looks forward:

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

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

Budget and Savings

What we found

Our review identified the following:

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

What could be done differently in the future

We suggest the following consideration as the organisation looks forward:

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

Other Areas of Governance

Partnership Arrangements

What we found

Our review identified the following:

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

What could be done differently in the future

We suggest the following considerations as the organisation looks forward:

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

Cross-Border Flows and Long Term Agreements

What we found

Our review identified the following:

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

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

Future consideration

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

Charitable Funds

What we found

Our review identified the following:

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

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

What could be done differently in the future

We suggest the following consideration as the organisation looks forward:

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

Counter Fraud arrangements

What we found

Our review identified the following:

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

What could be done differently in the future

We have no suggestions as the organisation looks forward.

Information Governance

What we found

Our review identified the following:

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

What could be done differently in the future

We advise that guidance is developed setting out:

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

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

Appendix One – Guidance, Principles and Scope

Guidance and Principles

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

The Principles are:

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

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

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

Scope of this Advisory Review

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

This review focused on the following Principles:

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

In particular, we undertook interviews and review of documentation:

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

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

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

The potential risks considered in this review are as follows:

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

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

Appendix Two – What we did

We undertook the following review activity:

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

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

Guidance Note : Discharging Board Committee Responsibilities during COVID-19 response phase

Introduction

The NHS in Wales is currently facing unprecedented and increasing pressure in planning and providing services to meet the needs of those who are affected by COVID-19. Alongside this is the need for organisations to balance continuing to provide and commission life-saving and life impacting essential services. As a result of the pressure placed on the NHS bodies and the Welsh Government response to managing the impact of the pandemic it has been necessary to adapt governance arrangements. The Welsh Government in its response (dated 26 March 2020) to a letter received on behalf of the Board Secretaries Group, agreed the Governance Principles that are designed to help focus consideration of governance matters over the coming weeks and months (see below).

Governance Principles:

- ***Public interest and patient safety –*** *We will always act in the best interests of the population of Wales and will ensure every decision we take sits in this context taking in to account the national public health emergency that (COVID-19) presents.*
- ***Staff wellbeing and deployment –*** *we will protect and support our staff in the best ways we can. We will deploy our knowledge and assets where there are identified greatest needs.*
- ***Good governance and risk management –*** *we will maintain the principles of good governance and risk management ensuring decisions and actions are taken in the best interest of the public, our staff and stakeholders ensuring risk and impact is appropriately considered.*
- ***Delegation and Escalation –*** *any changes to our delegation and escalation frameworks will be made using these principles, will be documented for future record and will be continually reviewed as the situation unfolds. Boards and other governing for a will retain appropriate oversight, acknowledging different arrangements may need to be in place for designated officers, deputies and decisions.*
- ***Departures –*** *where it is necessary to depart from existing standards, policies or practices to make rapid but effective decisions – these decisions will be documented appropriately. Departures are likely, but not exclusively, to occur in areas such as standing orders (for example in ow the Board operates), Board and executive scheme of delegation, consultations, recruitment, training and procurement, audit and revalidation.*
- ***One Wales –*** *we will act in the best interest of all of Wales ensuring where possible resources and partnerships are maximised and consistency is achieved where it is*

appropriate to do so. We will support our own organisation and the wider NHS to recover as quickly as possible from the national public health emergency that COVID-19 presents returning to business as usual as early as is safe to do so.

- ***Communication and transparency*** *– we will communicate openly and transparently always with the public interest in mind accepting our normal arrangements may need to be adapted, for example Board and Board Committee meetings being held in public.*

The purpose of this guidance note is to assist the Board in discharging their responsibilities during this time, paying particular attention to the role of the Quality and Safety Committee and Audit Committee.

Background

NHS Boards are required to establish a number of Committees, including a Quality and Safety and an Audit Committee in accordance with the Model Standing Orders for NHS organisations in Wales.[1] In responding to the pandemic, NHS organisations in Wales have revised their arrangements, standing down some board committees and partnership forums, and reviewing the remit of others. Two committees which will continue to meet in all organisations are the Quality and Patient Safety Committee and the Audit Committee, operating where required, through revised arrangements.

Assessment of Board and Committee Roles in Responding to the Pandemic

Whilst the Quality and Patient Safety (Q&PS) and Audit Committees may operate with more focused agendas as the organisation responds to the pandemic a number of areas will still require their attention which are not directly COVID-19 related. Organisations should consider their current governance arrangements including the operation and frequency of the Board and appropriate committees.

It may be sensible for the Board to consider an integrated approach to assurance that limits the amount of management time needed, particularly on those with clinical responsibility where the impact of COVID-19 will be most felt.

As the organisation moves into the recovery and re-activation phase it will be necessary to consider the currency of previous audits and reviews as it is recognised that some services/activities will inevitably change in the long term as a result of the different ways of working that have been established. In the interests of openness and transparency it will be necessary to ensure there is a log of Committee activity pre-Crises to ensure this does not get overlooked and there is a clear audit trail.

Some areas for the Board to consider for the Q&PS Committee and Audit Committee to discharge include:

[1] *Model Standing Orders,* Welsh Government, September 2019, http://www.wales.nhs.uk/governance-emanual/standing-orders

Quality and Safety Committee

Workforce and volunteers

- Safety and use of temporary staff/staff working in unfamiliar environments (including field hospitals)/with unfamiliar patient mix and use of volunteers
- Sickness absence levels/need for staff to self-isolate and impact on safer staffing
- Capacity of other non-patient areas, e.g. pathology with regard to COVID-19 and non-COVID workloads
- Health and well-being of staff (in the absence of a Workforce Committee this may fall to the Quality and Safety Committee or the Board may decide they wish to maintain oversight of this area).

Equipment, Medicines, Supplies and Facilities Management

- Availability of appropriate PPE, its procurement, deployment, staff training, guidance and communication.
- Availability of equipment and consumables - procurement, deployment, risk assessment and training requirements , monitoring supplies and stocks,
- Medicines management - access to critical medicines, community access etc.
- Cleaning and hygiene – cleaning regimes for all areas, potential impact on other hospital acquired infections, ability of staff to shower and change as appropriate at the end of their shift etc.

Safety, Quality and Clinical Effectiveness

- Maintaining an oversight and monitoring of the organisations ability to provide/ commission essential services and agree action where there are significant risks to delivery.
- Serious incident management – to include any changes to the arrangements for reporting and managing incidents, monitoring and tracking themes as a result of COVID-19
- Responding to patient safety alerts and notices and other improvement actions needed, including any requirements from inspections in line with advice from Healthcare Inspectorate Wales and other regulatory bodies.
- Mortality reviews – maintain oversight of mortality reviews for those deaths where there may be a concern or unusual circumstances. Committees should ensure immediate ‘make safes’ are put in place and learning shared across the organisation in the usual way
- Triggers for clinical harm reviews of those on waiting lists – how will these be identified and will there be any change to the pre-COVID arrangements?
- Understanding position regarding the organisations clinical audit programme (Note – National Programme suspended)
- Arrangements for approving amendments to policies, procedures and protocols – how will this be managed during the phases of the response?
- How is the organisation keeping a track of the published guidance? Are there arrangements for evaluating and ensuring an appropriate response?

- Is the Committee clear regarding the expectations of staff regarding following guidance and maintaining parameters of clinical practice?
- Potential risk to patients if unable to fulfil assessment of specialling needs leading to potential increased Deprivation of Liberty concerns e.g. if clinical areas are locked to maintain patient safety.
- Ensuring that services delivered in surge facilities such as field hospitals have clear operating procedures in place and in line with the organisation's clinical/quality governance arrangements

Patient Experience

- Patient Experience and Concerns Reporting – arrangements for managing and responding during response, recovery and re-activation phases.
- Consideration of issues and concerns which may be raised by the Community Health Council.
- Impact on patients due to their ability to access essential services such as end of life and palliative care, pain control, value based decision making.
- Concerns and mitigation regarding ability to ensure Welsh language, other language and needs as a result of protected characteristics are met.
- DNACPR and ensuring its appropriate use.
- Impact on patients and their families regarding visiting policies, ability to ensure supplies of clothing and basic toiletries, provide for hygiene and nutrition needs, provide comfort towards end of life, pastoral needs etc.

Capacity

- Ability to meet demand of COVID and patients requiring essential services
- Status and utilisation of surge capacity
- Plans for use during response, recovery and re-activation phase.
- Status of life saving and life enhancing services
- Performance split between COVID- and non-COVID patients.

Annual Reporting

- Agree Annual Quality Statement for approval by the Board before 30 September 2020.
- Receive Annual Putting Things Right Report
- Receive information regarding annual reports/programmes which have been suspended (e.g. National Clinical Audit Programme) and arrangements for receiving exception reports if required.

**Decision Making and Delegation of Powers/Risk Management and Assurance*

See below in Audit Committee Section. The Q&PS Committee will need to consider matters which fall within their Terms of Reference and decision making powers.

Audit Committee

Annual Reporting

Revised timescales were issued in the Welsh Government letter dated 26 March 2020 (see References section below). This will inform the work of the Committee during the annual reporting period.

- Review and recommend the annual accounts for adoption and approval by the Board
- Review the Annual Governance Statement to ensure it is an accurate reflection of the position for 2019/20 and up to the date of approval, prior to signature by the Chief Executive/Accountable Officer – ensure the impact of the need to respond to COVID-19 is clear.
- Review the Remuneration Report and recommend for approval by the Board
- Review the Annual Report and accountability statements in accordance with revised timetable issued by Welsh Government and recommend for approval by the Board

Note: Whilst it is for each organisation to agree the level of assurance required and content of reports consideration should be given to the potential impact of diverting resources to prepare reports which will add limited value to the response, recovery and reactivation of services.

Internal Audit

The Chair may benefit from holding a discussion with the Head of Internal Audit and Board Secretary to help inform the activity of the Committee during the response, recovery and reactivation phase. The Committee will be required to:

- Receive the Annual Audit Opinion of the Head of Internal Audit and Annual Internal Audit Report which will inform the Annual Governance Statement
- Assess the status of the Annual Internal Audit Plan 2019/20 and the potential impact on the 2020/21 Plan
- Review and agree a revised plan for 2020/21 with the Head of Internal Audit. This will need to remain fluid as it is not clear at this stage when the programme will be able to commence or what revisions will be required to cover both supporting recovery and reflecting the revised risk profile of the organisation.
- Agree the arrangements for tracking internal audit actions during the period. The Committee may wish to focus on:
  - Reports which received a Limited Assurance or No Assurance Rating
  - Actions assessed as high priority where the “action by date” has passed
- As the organisation moves into the recovery and reactivation phase consider whether previous reports and resulting actions still remain relevant
- Assess whether any decisions/ways of working which were established during the response phase would benefit from an Internal Audit Review to provide assurance to the organisation.

Audit Wales

As indicated for Internal Audit it is suggested that Chair holds a discussion with the Audit Wales Partner and Board Secretary to inform the activity of the Committee during the response, recovery and reactivation phase. Annual Reports and Structured Assessment reports for 2019 were published before the COVID-19 pandemic was declared. The Auditor General for Wales has advised on the Audit Wales website[2] that whilst delivering his statutory responsibilities, he wants to ensure that audit work does not have a detrimental impact on audited bodies and their staff at a time when the public service is stretched and focused on more important matters.

Arrangements will be put in place to ensure delivery of the statutory end of year duties in accordance with the revised accounting timetable.

*Risk Management and Assurance**

Although the Committee should not be directly involved in the process of risk management, the organisation's risk management system will underlie the assurance system and the Committee needs to review the risk management processes in exercising its functions in relation to this system of assurance[3].

- It is likely that the organisations risk appetite will be higher than in the pre-crises phase to ensure the organisation is able to respond effectively and at pace. This may be evidenced in the speed that decisions have been arrived at for example.
- The Committee should seek assurance that risks have been assessed and evidenced transparently including disproportionate impact on other areas.
- What level of assurance is available from external sources for the risks and what is the level of confidence that can be gained from this as it is likely their programmes have also been impacted? Is there confidence in the sources of internal assurance during this time to help mitigate against the impact on sources of external assurance?
- As the organisation moves into the recovery and reactivation phase it will be necessary to further consider the risk appetite and tolerance of the organisation. Whilst accepting that it unlikely to be appropriate to revert back to the position before the pandemic it is important to ensure that any changes have been considered and agreed by the Board and arrangements are in place to manage appropriately.

*Decision Making and Delegation of Powers**

The Governance Principles recognise there may be changes to the delegation and escalation frameworks, together with departures from existing standards, policies or practice to make rapid but effective decisions. They also recognise the need to document such departures for future record and to ensure their continual review as the situation unfolds.

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[2] https://www.audit.wales/news/covid-19

[3] Welsh Government Audit Committee Handbook , June 2012, http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf

- Committee has a role to consider any variation in Standing Orders, approving these where it considers appropriate and providing a formal report to the Board.
- Assess robustness of the arrangements for recording decisions and arrangements for ensuring business continuity if individuals are not able to discharge their responsibilities.
- Receive information regarding any variation from Schemes of Delegation/Organisational Policies and Procedures/Standard Operating Procedures

* Note –The Audit Committee together with the Quality and Patient Safety Committee will have a role in advising the Board regarding the appropriateness of this risk management arrangements, decision making and the delegation of powers.

Financial Control and Management

The HFMA have published COVID-19 Financial Governance Considerations[4] which advises of areas which will require consideration such as review of scheme of delegation, authorised signatory arrangements, coding of expenditure etc. The Audit Committee will have a role in:

- Receiving information on the changes to control procedures and delegations which have been necessary to ensure the organisation is able to respond
- Receiving information relating to the arrangements for recording any deviations
- Receiving information regarding these deviations – this may be a list of contracts entered into which have not been subject to the full procurement controls
- Review losses and special payments
- Assurance that there where appropriate legal advice has been sought prior to entering into agreements

Counter Fraud

The Local Counter Fraud Specialist (LCFS) is the main point of contact and will advise regarding reports which should be received by Audit Committees during this time.

The fraud threat posed during emergency situations is higher than at other times and organisations should put in appropriate controls to mitigate where possible.

The UK government are issuing information regarding safeguards which should be put in place[5] and alerts are also being issued in Wales

[4] COVID-19 Financial Governance Considerations, Healthcare Financial Management Association (HFMA), https://www.hfma.org.uk/docs/default-source/publications/covid19-financial-governance-implications.pdf?sfvrsn=0

[5] Fraud control in Emergency Management:COVID-19 UK Government response, Government Counter Fraud Function, https://www.gov.uk/government/publications/fraud-control-in-emergency-management-covid-19-uk-government-guide

The Audit Committee should consider the arrangements for undertaking post-event assurance to look for fraud and ensure access to fraud investigation resources. This should be undertaken as soon as practicable and the Committee should receive the findings.

Recommendation

NHS organisations should consider the information and guidance provided in this document to inform the arrangements for their Board Committees during the COVID-19 response phase. They will also need to consider the relevance as they move into the recovery/reactivation phase.

Further guidance will be issued if required.

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