ANNEX – Annual Governance Statement

1. Scope of Responsibility

1.1 The Board is accountable for Governance, risk management and internal control. As Chief Executive of the Health Board I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding quality standards, public funds and departmental assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

1.2 The annual report outlines the different ways the organisation has had to work both internally and with partners in response to the unprecedented pressure in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated and assurance has been sought and provided. Where necessary additional information is provided in the Governance Statement, however the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

1.3 I am also responsible for ensuring that the Health Board is administered prudently, economically and with propriety, and that resources are applied effectively and efficiently.

1.4 In fulfilling my responsibilities to the Chief Executive of NHS Wales, I am directly accountable to the Chairman of the Health Board and the Independent Members of the Health Board for the operation of the Health Board and for the implementation of the Board's decisions.

2. Capacity to Manage Risk

2.1 As Chief Executive, I have overall responsibility for risk management within the Health Board for meeting all statutory requirements and adhering to the guidance issued by NHS Wales and the Department of Health and Social Care in respect of governance. The Executive Team has the remit to ensure the adequacy of the structures, processes and responsibilities for identifying and managing key risks facing the organisation, prior to discussion at the Board.

2.2 The Board has considered its risk appetite annually. This clearly articulates the Health Board's view that it does not tolerate unmitigated/unacceptable risks to the quality of service provision.

2.3 The Board held a risk management workshop on 8 March 2022 to review the risk appetite statement, which was aligned to a Board Assurance Framework (BAF) refresh workshop in April 2022 to review the strategic risks as at the end of 2021/22, and identify new ones, taking into account the objectives outlined in the Living Healthy, Staying Well strategy.

2.4 Day to day management of risks is undertaken by individual operational managers and management teams, who are charged with ensuring that risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where risks are identified. There is a process of escalation to Executive Directors, Risk Management Group and Quality, Safety and Experience Committee (which undertakes the role of Risk Committee of the Health Board), as well as the other Health Board Committees who review risks that fall within their remit, for the purposes of providing assurance that risks are robustly mitigated in a timely manner.

2.5 To ensure all staff are aware of their responsibilities for risk management, training is provided incorporating aspects of risk management and senior staff have been trained in the identification and management of clinical risk. In particular the training provides guidance for staff on the actions they can take once they identify a risk from tolerating a risk through to deciding it is so significant that immediate action is required.

2.6 Within the 2021/22 period a total of 1000 staff were provided with risk management training across the full range of staff groups.

2.7 Staff are advised on how to escalate risks but are also reminded that this does not lessen their personal ownership of the risk. The development of local risk registers has served also to promote awareness and understanding of the identification of risks and their management across the Health Board.

2.8 As previously highlighted, the need to plan and respond to the Covid-19 pandemic presented a number of challenges to the organisation. A number of new and emerging risks were identified. Whilst the organisation did have a major incident and business continuity plan in place, as required by the Civil Contingencies Act 2004, the scale and impact of the pandemic has been unprecedented. Significant action has been taken at a national and local level to prepare and respond to the likely impact on the organisation and population. This has also involved working in partnership on the multi-agency response as a key member of the Strategic Co-ordination Group. There does remain a level of uncertainty about the overall impact this will have on the immediate and longer term delivery of services by the organisation, although I am confident that all appropriate action is being taken.

2.9 The organisation continues to work closely with a wide range of partners, including the Welsh Government, as it continues with its response, and planning into the recovery phase. It will be necessary to ensure this is underpinned by robust risk management arrangements and the ability to identify, assess and mitigate risks which may impact on the ability of the organisation to achieve their strategic objectives.

3 Our Governance Framework

3.1 The Board of Directors is the key decision-making body within the Health Board, with responsibility for ensuring the organisation achieves its objectives.

3.2 During the 2021/22 period, Board membership changed, with the addition of two Independent Board members Richard Micklewright and John Gallanders, who joined the Health Board in November 2021 and Lyn Meadows's term of office ended on 31 March 2022.

3.3 In addition, Dr Nick Lyons joined the Board as Executive Medical Director in August 2021 on a substantive basis, having taken over from Professor Arpan Guha, who had undertaken the role of acting Medical Director until August 2021.

3.4 Mark Wilkinson left the Board at the end of August 2021

3.5 The turnover of the Board was embraced by the organisation as an opportunity to refresh and re-energise efforts, whilst taking the Health Board forward, aided by a Kings Fund supported Board Development programme.

3.6 As part of the Board Development programme, Kings Fund facilitated evaluation of effectiveness, through an analysis of work carried out against work planned, attendance, quoracy, and annual member surveys covering strategy, performance, risk and assurance, Committee and collective Board performance. The process is designed to comply with best practice requirements such as the Audit Committee Handbook, the UK Corporate Governance Code, the Healthy NHS Board and the Taking It on Trust study, where appropriate.

3.7 The Health Board has incorporated the best practice requirements of the UK Corporate Governance Code in the committee terms of reference and associated infrastructure.

3.8 The Board carries out its roles and responsibilities with the aid of a structured and focussed Annual Board cycle of business, which takes into account the setting of strategy and the monitoring of key risks, performance, governance, and culture and quality issues. Service user and carer engagement is incorporated in the Annual Board cycle.

3.9 Board attendance for the 2021/22 period is set out in more detail within appendix 3. In the reporting period, this averaged a rate of 89% and formal Board meetings were held 9 times during the 2021/22 financial year.

3.10 During the 2021/22 period the Committees of the Board were:

- Audit Committee;
- Quality, Safety and Experience Committee;
- Remuneration and Terms of Service Committee;
- Digital and Information Governance Committee, until October 2021, when it was merged with the Performance, Finance and Information Governance Committee;
- Performance, Finance and Information Governance Committee, from October 2021;
- Strategy, Partnerships and Population Health Committee, until October 2021;
- People, Partnerships and Public Health Committee, from October 2021;
- Mental Health Act Committee, until July 2021;
- Mental Health Capacity and Compliance Committee from, from July 2021;
- Charitable Funds Committee.

3.11 The Health Board Committees and relevant sub committees maintain oversight of the Health Board's statutory and regulatory arrangements with authority delegated from the Board.

3.12 There is crossover of Independent Membership, to enhance the effectiveness of Committee business. Independent Members of the Quality and Finance Committees are also members of the Audit Committee.

3.13 The Board Committees have enabled the Board to focus on its core business whilst receiving regular assurance through written Committee Chair Assurance reports, in line with best practice.

3.14 The effectiveness of the Committees is enhanced by comprehensive work plans as well as the alignment of the Board's meetings and that of its Committees. This ensures timely monitoring of areas of responsibility delegated by the Board to the Committees through receipt of Chair assurance reports and minutes, with an escalation mechanism to the Board, where appropriate. During the 2021/22 period, the Board and its Committees maintained compliance with the UK Corporate Governance Code pertaining to Board Composition, Board Effectiveness and Risk Management.

3.15 The Audit Committee supports the Board in reviewing the effectiveness of the system of internal control, through a structured annual work plan, compliant with the Audit Committee Handbook issued by Welsh Government. The main role of the Committee is to seek assurance that the Health Board's governance and risk management systems are fit for purpose, adequately resourced and effectively deployed.

3.16 To aid this assurance, the Committee's work plan incorporates the review of the organisation's risk management processes, and the corporate risk register. The Audit Committee takes assurance from the Internal and External Audit functions, by setting the annual Internal Audit plan and monitoring its delivery regularly, as well as overseeing the implementation of audit recommendations. The Audit Committee maintains oversight of the work of other committees in respect of the system of internal control.

3.17 The members of the Audit Committee play a key role by independently scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the Health Board's risk register. In addition, the Committee's role includes:

- Monitoring management progress in the implementation of Internal and External Audit recommendations;
- Scrutinising the effectiveness of the counter fraud arrangements, and tracking progress of delivery of the annual work plan of the Local Counter Fraud Specialist's plan;
- Formally reviewing the system of internal control regularly at meetings, by taking assurance on the management of detailed risks on a rotational basis.

3.18 During the 2021/22 period, the Committee received internal audit reports covering a broad range of the Health Board's governance and risk management systems.

3.19 The Audit Committee's 2021/22 annual self-assessment incorporates the views of the internal and external auditors, and the counter fraud function. The overall assessment results indicate that the Committee is discharging its terms of reference and meeting best practice guidelines, as set out in the NHS Audit Committee Handbook.

3.20 Further narrative on the Health Board's quality governance arrangements is in section 10 of this document.

4. Data Quality Assurance

4.1 The Health Board is improving its data quality arrangements to enhance the quality and accuracy of elective waiting time data and other metrics. The Planned Care Transformation Group reviews and monitors live waiting list data for accuracy, performance and targets. The Planned Care Transformation Group also has a system to validate and audit its elective waiting time data weekly and monthly, with random specialty checks carried out to quality-assure the validation process. These arrangements were reviewed by the Internal Auditors during 2021/22 and a 'limited assurance' audit opinion was given. Action Plans are in place to address the gaps identified at pace.

4.2 The risks to the quality and accuracy of this waiting time data is examined weekly to ensure activity is recorded accurately and timely; if issues do arise, remedial action is agreed, implemented and monitored immediately.

4.3 Annual validation of waiting lists also takes place through internal audit and a range of live data quality reports which are being developed to monitor the data quality key performance indicators weekly and monthly.

5. The Purpose of the System of Internal Control

5.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

5.2 The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

6. Risk Assessment

6.1 The organisation has processes to identify and assess risks.

6.2 The risk register is populated at a local/operational level and at a corporate level. The risk register informs the business planning process and is a key consideration in general operational management at service line, clinical business unit and corporate level.

6.3 Strategic risks are identified and assessed in relation to their threat to achievement of the Health Board's strategic objectives. 'Bottom up' risks are identified through local staff incident reporting and risk assessments whilst organisational risks will be identified through business planning, Serious Incidents and People processes, such as recruitment. 'Top down' risk assessment is undertaken through the development and review of the Board Assurance Framework, strategic business planning and contract management.

6.4 Progress was achieved in the year to mitigate key risks relating to the principal objectives of the Health Board. Based on the residual risk score, the top remaining significant risks to the organisation in the 2021/22 period with a significant impact on the system of internal control were:

6.4.1 BAF 21-09 – Infection Prevention and Control: current risk rating: 20

6.4.1.1 Significant progress was made during the course of the year to mitigate this risk, In relation to strengthening the infrastructure to support the prevention of infections.

6.4.1.2 Key examples include the mitigation pertaining to the introduction of appropriate ventilation and 3.6m bed spacing has been completed by the Estates Department as part of Safe Clean Care programme. Assurance for the rest of the mitigations continues to be monitored through the Quality and Safety Experience Committee on an ongoing basis as part of the cycle of business.

6.4.2 BAF 21-10 – Listening and learning: current risk rating: 20

6.4.2.1 Actions around training have been deferred recognising current pressures over the winter period and the directive to prioritise essential clinical services during the pandemic.

6.4.2.2 Internal Audit reviewed the organisation's arrangements for listening and learning and awarded a reasonable assurance audit opinion during the 2021/22 period.

6.4.3 BAF 21-12 – Security Services and
BAF 21-13 – Health and Safety: current risk rating: 20

6.4.3.1 The Health Board has in place key mitigations to address these risks, with detailed assurance updates feeding into the Quality and Safety Experience Committee, including detailed Health and Safety Assurance updates during the financial year, including a progress update on policies (such as The Management of Violence and Aggression) as well as detailed measures to ensure the health and safety of lone workers.

6.4.3.2 In addition, plans are in place to remediate compliance gaps identified by the Health and Safety Executive during the course of the 2021/22 financial year. The details of these can be found in section 19 of this document.

6.4.3.3 The Health Board put in place a series of controls, including working towards compliance with Protect legislation Martyn's Law by 31st March 2022 as well as a Security Policy with appropriate mitigations.

6.4.4 BAF 21-03 – Primary Care sustainable health service:
current risk rating: 20

6.4.4.1 Progress has been made in relation to some of the key mitigations aligned to this risk, with a specific focus on the roll out of Urgent Primary Care Centre pathfinders, with the business case being approved in November 2021. Work is underway to progress the implementation of the Dental Training unit in Bangor. The Partnerships, People and Population Committee continues to maintain oversight of the mitigations aligned to this risk.

6.4.5 BAF 21-04 – Timely Access to Planned Care: current risk rating: 20

6.4.5.1 Manual validation continues across the three sites alongside the completion of the recommendations arising from the Waiting List Management Audit. This risk continues to be monitored by the Performance, Finance and Information Governance Committee.

6.4.6 BAF 21-16 – Digital Estates and Assets :current risk rating: 20

6.4.6.1 The implementation of the Digital Strategy continues, following its launch in 2021, with detailed assurances being monitored by the Partnerships, People and Population Committee via the digital dashboard.

6.4.7 BAF 21-01 – Emergency Care: current risk rating: 20

6.4.7.1 The Quality, Safety and Experience Committee approved the increase of the current rating for this risk from 16 to 20 in November 2021, due to increased pressures on unscheduled care.

6.4.7.2 Implementation of the Unscheduled Care improvement plan continues, including ongoing ward based improvement work with a specific focus on improving patient flow and timely discharges.

6.4.7.3 Key mitigations against this risk continue to be monitored by the Quality Safety and Experience Committee with additional bi-monthly reports submitted to the Performance, Finance and Information Governance Committee for the purposes of providing assurance on unscheduled care strategic developments.

7. The Risk and Control Framework

7.1 The Health Board has in place a process for the identification, assessment, and management of risks. This is a systematic approach which assesses the consequences and likelihood of each risk event, associated mitigations and allows for the identification of risks which could be considered unacceptable to the organisation.

7.2 The Health Board has a dynamic, agile, comprehensive and structured approach in place to identify, assess, control, mitigate and effectively manage risks to the achievement of its operational and strategic objectives. The Health Board`s approach to risk management is informed by a robust risk management framework, architecture, including processes and systems which draw inspiration from best practice and ISO 3100:2018 in supporting staff to continuously scan the horizon for emerging risks, mitigate and appropriate manage them. The Health Board`s Board agreed a new Risk Management Strategy for the organisation in 2020 which was launched on 1st October 2020.

7.3 During the 2021/22 period, the Risk Management Group continued to strengthen its core business activities in order to leverage better advice, assurance and provide effective recommendations to the Executive Team on appropriate escalation and management of risks. The Group also has responsibility to ensure that the Health Board has robust systems, processes and governance arrangements in place to facilitate effective mitigation, management and embedding of best practice in risk management across the organisation. As of October 2021, this group is chaired by the Executive Medical Director; prior to this, the role was undertaken by the Executive Director of Nursing and Midwifery/Deputy CEO.

7.4 Whilst the Risk Management Strategy sets out a framework for underpinning the Health Board`s overarching approach, vision and arrangements for management at all levels across all its Services, Departments and Divisions, it also informs the appropriate management of Covid-19 related risks, thereby ensuring prompt and timely escalation and de-escalation of risks. A simplified Covid-19 Response Guidance on Risk Management was designed to facilitate the timely identification, assessment, mitigation, management and escalation/de-escalation of Covid-19 risks. This guidance included the requirements under the Civil Contingencies Act 2004 (as amended) (CCA) and Good practice guidance for Category 1 responders individually and collectively as part of a Local Resilience "Community" to adopt a proactive, dynamic risk-based approach to managing Covid-19 and related risks.

7.5 The Health Board is working closely with a wide range of partners, including the Welsh Government as it continues with its response, and planning into the recovery phase. It will be necessary to ensure this is underpinned by robust, integrated risk management arrangements and the ability to identify, assess and mitigate risks, which may affect the ability of the Health Board to achieve their strategic objectives.

7.6 The risk and control framework incorporates a range of supporting systems and associated policies that provide a structured and consistent approach to the management of risk.

7.7 These include, amongst others:

- Risk Management Strategy and policy;
- Standards of Business Conduct;
- Waiting list management;
- Raising Concerns Policy and Procedure (Whistleblowing);
- Incidents and Serious Incident Management Policy;
- Complaints and Concerns Resolution Policy;
- Claims Management Policy;
- Being Open Policy;
- Standing Financial Instructions, Standing Orders and Scheme of Reserved Delegation.

7.8 During the course of the 2021/22 period, the Standing Orders and Scheme of Reserved Delegation were applied in the manner that acknowledged that in unprecedented times, there are limitations on Boards and Committees being able to physically meet where this is not necessary and can be achieved by other means. In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. As a result of the public health risk linked to the pandemic there have been limitations on public gatherings and it has not therefore been possible to allow the public to attend meetings of the Board and committees in person for the duration of the financial period As part of efforts to conduct business in an open and transparent manner during this time, the following actions were taken:

- Use of technology in order to hold virtual meetings, including the provision of Welsh / English translation. From May, Board meetings were recorded and made available to the public online, with subsequent meetings being live-streamed;
- Publication of agendas and papers as far in advance as possible with reference to Standing Orders;
- Increased use of verbal reporting captured in the meeting minutes;
- Publication of a set of minutes from the meeting (a draft approved by the Chair) to the public website as soon as possible – ideally within 3 working days.

7.9 Assessments were made regarding decisions deemed to be time critical, that could not be held over until such time that it is possible to allow members of the public to attend meetings. In addition, increased use of Chair's action (supported by enhanced processes as set out in the maintaining good governance papers) has been necessary to avoid delays to essential business. Although at the time of writing, the COVID-19 situation has greatly improved, due in no small part to the success of the vaccination programme, at the time of writing it was still unknown when face-to-face Board meetings will resume. It will be necessary to keep this under review.

7.10 The Health Board has overarching responsibility for risk management.

7.11 As Accountable Officer, I ensure that sufficient resources are invested in managing risk and I am supported in undertaking this role by the Medical Director.

7.12 At an operational level, risks are captured on the Datix risk management system and maintained on local and/ or corporate risk register level depending on the risk rating.

7.13 Local risk registers are monitored and mitigated in local and service risk registers and monitored at Executive Director Level where they are scored at 15 or more.

7.14 The corporate risk register is reviewed by each of the Board Committees individual to maintain oversight of their respective risks. The Audit Committee independently scrutinises the process to effectively maintain the risk register.

7.15 Where risk ratings are sufficiently high that they are likely to significantly impact the delivery of strategic objectives, they are added to the Board Assurance Framework, which is reviewed by the Board on a quarterly basis, and by Board Committee as a standing item.

7.16 The members of the Audit Committee play a key role in the internal control assurance processes by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the Health Board risk register, as well as corporate functions and service line risk registers, on a rolling basis.

7.17 The Board Committees all have responsibility for elements of the risk management system, with the Audit Committee providing assurance on overall effectiveness, taking into account the annual review carried out by the Internal Audit Function.

7.18 The Health Board Risk Management Strategy provides the framework for the continued development of the risk management process, building on the principles and plans linked to the Health Board's Assurance Framework, the Risk Register, the requirements of Healthcare Inspectorate Wales and national priorities.

7.19 Detailed narrative on deterrents to risks arising, and fraud deterrents is incorporated in section 15 (Counter Fraud and Anti-bribery arrangements) of this document.

8. Elements of the Assurance Framework

8.1 The key elements of the Board Assurance Framework include:

- Board agreed organisational objectives and identification of the principal risks that may threaten the achievement of these objectives;
- Identifying the design of key controls intended to manage these principal risks;
- Setting out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk;
- Identifying assurances and areas where there are gaps in controls and/or assurances;
- Putting in place plans to take corrective action where gaps have been identified in relation to principal risks;
- Maintaining dynamic risk management arrangements including a well-founded risk register.

8.2 Based on my assessment of the Board Assurance Framework and the Annual Governance Statement, (and taking into account the findings of the 2021/22 internal audit review risk management) I have identified three key priorities to be implemented in 2022/23 in order to enhance the internal control arrangements.

8.3 The implementation of these actions will further strengthen Board visibility of mitigating significant risks

8.4 These priorities are:

- Scrutiny and review of assurances about risk mitigations by the Board or relevant committees, where appropriate;
- Strengthen the process of achieving target risk ratings, as captured on the Board Assurance Framework;
- Align the Board and Committee cycle of business to significant BAF risks to ensure timely and effective review of risks.

8.5 The Board will oversee the implementation of these priorities, whilst receiving assurance from the work of relevant Board Committees.

9. Internal Audit

9.1 The Health Board has established processes for managing risks that impact on the quality and safety of information, staff and patients.

9.2 In 2021/22, Internal Audit carried out organisational reviews of the following areas with assurance ratings summarised below:

Review Title	Assurance Rating
Capital Funded Systems	Substantial
Statutory Compliance – Asbestos Management	Reasonable
Upholding Professional Standards in Wales	Reasonable
Maternity Cross - Border Arrangements	Reasonable
Procurement: Contract Management and Single Tender Waivers	Reasonable
Targeted intervention	Reasonable
Learning Lessons	Reasonable
Voluntary Early Release Scheme (VERS)	Reasonable
Financial Management, Reporting and Budgetary Control	Reasonable
Network and Information Systems (NIS) Directive	Reasonable
Cluster working – Governance	Reasonable
Recruitment – Employment of medical locum doctors	Reasonable
Waste Management	Reasonable
Impact Assessments	Reasonable
Risk Management	Reasonable
Establishment Control: Leaver Management	Limited
Standards of Business Conduct	Limited
Integrated Service Boards Governance	Limited
Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	Limited
Nursing Roster Management: Introduction of e-timesheets for Agency staff	Limited
Clinical Audit	Limited
On-Call arrangements	Limited
Business Continuity Plans	Limited
Security Invoice Review	Assurance Not Applicable
HASCAS & Ockenden external reports: Recommendation progress and reporting	Assurance Not Applicable
Secondary Care Division – Ysbyty Glan Clwyd	Assurance Not Applicable
Follow up - Progress against Healthcare Inspectorate Wales (HIW) recommendations: Mental Health and Learning Disabilities	Assurance Not Applicable
Temporary Hospitals: Follow up of KPMG recommendations	Assurance Not Applicable
HASCAS & Ockenden external reports: Recommendation progress and reporting – Workforce	Assurance Not Applicable
Decommission of Ysbyty Enfys Temporary Hospitals	Assurance Not Applicable

9.3 During the course of the year, action plans have been agreed with Internal Audit for all audits, with a particular focus on limited assurance audit outcomes.

9.4 As part of my review I also place reliance on the 2021/22 Head of Internal Audit's independent opinion of limited assurance, which substantiates this disclosure. The opinion is based on a review of the systems and processes underpinning the Assurance Framework and the internal audit risk–based plans reported during the 2018/19 period. The Health Board is implementing actions arising from internal audit reviews and providing assurances on progress to the Audit Committee.

9.5 For 2021/22, the Head of Internal Audit's Opinion reads as follows:

"The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Limited assurance		*More significant matters require management attention.* ***Moderate impact*** *on residual risk exposure until resolved.*

"This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there were eight audits in 2021/22)."

10. Quality Governance and Healthcare Inspectorate Wales

10.1 The Health Board has a quality governance framework which enables the monitoring of risks to quality of services, through the Quality Safety and Experience Committee. The Board Assurance Framework also provides a mechanism for monitoring, where these risks are significant to the delivery of the organisation's strategic objectives.

10.2 Systems and controls are in place to ensure the delivery of Quality Statements (when applicable), and the associated evidence also informs my assessment of the effectiveness of the risk management and internal control framework, in relation to risks to quality.

10.3 The performance management framework provides a structured approach to monitoring the delivery of the Health Board's contractual and national obligations, and associated mitigations of risks to safety.

10.4 Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales. HIW reviews and inspects NHS services in Wales, and regulates healthcare providers against a range of standards, policies and regulations to ensure they comply with regulations and meet the healthcare standards, highlighting areas of improvement. HIW also monitor the use of the Mental Health Act and review the Mental Health service to ensure that vulnerable people receive good quality of care in mental health services. HIW are also requested by HM Inspectorate of Prisons to provide a clinical review of a prisoner's healthcare if they die in custody.

10.5 There are systems and controls in place to ensure the Healthcare Inspectorate Wales (HIW) standards continue to be embedded within the Health Board. The Health Board has continued its positive working relationship with HIW through monthly engagement meetings with a designated relationship lead and through regular ongoing dialogue.

10.6 Due to the continuing COVID-19 pandemic, HIW continued to use a three-tiered model of assurance and inspection during the 2021/22 financial year, that reduces the reliance on onsite inspection activity as the primary method of gaining assurance:

- **Tier 1** - activity will be conducted entirely offsite and will be used for a number of purposes but, at this stage, primarily where issues cannot be resolved via their standard concerns process and where the risk of conducting an onsite inspection remains high;
- **Tier 2** will introduce a combination of offsite and limited onsite activity, whilst
- **Tier 3** will represent a more traditional onsite inspection.

10.7 As would be expected, the majority of inspections in the period April 2021 - March 2022 were carried out off-site by a process identified as a 'Tier 1 – Quality Check'. This process included the completion of a self-assessment form and a call with the local manager/lead of the area under inspection. The approach seeks assurance around four key areas of service. These are arrangements for dealing with COVID-19; environment; infection prevention and control (IPC); and governance.

Summary of Healthcare Inspectorate Wales Inspections April 2021-March 2022

10.8 Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover, April 2021

10.8.1 As part of their annual programme HIW undertook a remote review of the Welsh Ambulance Service NHS Trust (WAST). The focus of the review was to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and their overall experience. The Health Board contributed to this national review. As a result of their findings from this review HIW made a number of national recommendations around patient flow through ED, escalation and staff handover and improving patient experience. The Health Board has proactively developed a local action plan.

10.9 National Review of Mental Health Crisis Prevention in the Community, April 2021

10.9.1 HIW undertook a remote national review of Mental Health Crisis Prevention in the Community. The focus of this review was to identify how people at risk, or facing a mental health crisis are supported in the community, and how timely support can be accessed.

10.9.2 As part of this review, HIW engaged with professionals in the Mental Health Community Services and Primary Care along with a national public survey to capture the views of people. As a result of their findings, HIW made a number of recommendations around accessing services and receiving timely care. At the time of writing, an action plan was submitted to the Patient Safety & Quality Group in May 2022.

10.10 Mesen Fach Ward, Bryn y Neuadd Hospital, May 2021

10.10.1 HIW undertook a remote quality check of Mesen Fach ward, Bryn y Neuadd Hospital. Mesen Fach provides assessment and treatment, and therapeutic support services for up to nine patients with learning disabilities.

10.10.2 The quality check identified one recommendation for improvement around the discharge planning progress for patients admitted for lengths of stay. Overall HIW found evidence of a dedicated staff team that were committed to providing a high standard of care to patients. There was evidence of strong and supportive leadership and HIW found the service provided safe and effective care.

10.11 IR (ME) R Compliance Inspection of the Diagnostic Imaging Department – Wrexham Maelor Hospital, October 2021

10.11.1 HIW is responsible for monitoring service compliance with the Ionising Radiation (Medical Exposure) Regulations 2017. HIW completed an announced IR (ME) R inspection of the Diagnostic Imaging Department and identified areas of improvements in governance and leadership, delivering safe and effective care and workforce processes.

10.12 Hergest Unit, Ysbyty Gwynedd, September 2021

10.12.1 Healthcare Inspectorate Wales (HIW) completed two unannounced mental health inspections of Ysbyty Gwynedd, Hergest Unit within Betsi Cadwaladr University Health Board. The first starting the evening of 6 September 2021, the second starting the evening of 20 September 2021. During the inspection commencing 6 September, HIW identified a number of areas of concern particularly around Infection Prevention and Control, and Governance and Leadership. Due to concerns about patient safety, HIW issued an immediate assurance letter, where they wrote to the service immediately after the inspection with their findings requiring urgent remedial action. They then returned to undertake a further unannounced inspection on 20-22 September to ensure the Hergest Unit was providing safe and effective care. Overall, they found evidence that the Health Board had started to implement systems and processes to address areas identified in the immediate assurance issued. However, further improvements were identified in the inspection on the 20-22 September 2021.

10.12.2 The inspection found a dedicated staff team that were committed to providing a high standard of care to patients and treating patients with dignity and respect. From their findings improvements needed around infection prevention measures, governance and leadership, and patient safety of which an immediate assurance letter was issued. Staffing issues were also escalated during the inspection along with communication and engagement. Improvements were also required in the completion of patient care plans and staff rotas.

10.12.3 The published report has been presented at the Quality, Safety and Experience Committee where updates have been monitored in relation to action plans.

10.13 Tan Y Coed, Bryn Y Neuadd, 19 October 2021

10.13.1 HIW undertook an unannounced inspection of Tan y Coed on 19-20 October 2021. Tan y Coed provides a rehabilitation service for people with learning disabilities. HIW found evidence that overall the service provided a positive patient experience, with a good level of safe and effective care delivered to patients. HIW found evidence of a well-established management team, which was supported by a committed workforce and sound local governance arrangements. The inspection identified a small number of improvements to strengthen the service model and promote a quality patient experience.

10.14 National Review of Patient Flow, December 2021

10.14.1 As part of their annual review programme, HIW are undertaking a national review of Patient Flow. The focus of the review is to gain a greater understanding of the challenges that healthcare services face in relation to how patients flow through healthcare systems, and to test if arrangements for patient flow are robust. In order to assess the impact of patient flow challenges on quality and safety of care for patients awaiting assessment and treatment, HIW decided to focus our review on patients travelling through the stroke pathway. This will include the point of requesting an ambulance (or someone self-presenting at an Emergency Department), through to their discharge from hospital or transfer of care to other services. Following the submission of a self-assessment and an update on discharge processes (against national recommendations) HIW will undertake onsite visits, which will focus on case studies of people travelling through the stroke pathway. HIW have confirmed they will be visiting YGC on 9 – 11 August 2022.

10.14.2 Terms of Reference for the review are available on the HIW website.

10.15 Emergency Department, Ysbyty Gwynedd, February 2022

10.15.1 HIW undertook a two stage remote quality check of the ED department, which focused on infection prevention, environment, governance and staffing. The inspection found immediate assurance improvements were needed around timely access, discharge planning and record keeping and identified improvements needed for patient accessing facilities in the department and staff oversight of the waiting areas. An Immediate Assurance Improvement Plan was submitted and accepted by HIW; we are currently waiting for the final report to be published.

10.16 Foelas Ward, Bryn y Neuadd, February 2022

10.16.1 HIW undertook a remote quality check of Foelas Ward, which is an eight bedded learning disability ward. The focus of the quality check was on infection prevention, environment, governance and staffing and the Mental Health Act. The inspection found a dedicated staff team that were committed to providing a high standard of care to patients. There was evidence of strong and supportive leadership and HIW found the service provided safe and effective care. The quality check identified one recommendation for improvement around the risk assessments for mechanical restraint to be included in risk assessments. An Improvement Plan was submitted and accepted by HIW.

10.17 Vascular Services – Service requiring significant improvement status, March 2022

10.17.1 Further to the publication of the Royal College of Surgeons Clinical Record Review of Vascular Services, HIW issued Service requiring significant improvement status to the service, due to indications of significant risks to patients using the vascular service.

10.17.2 This process will enable HIW to gain assurance around specific issues outlined in the RCS report, including poor Multi-Disciplinary Team (MDT) working, poor documentation and record keeping, and the quality of clinical care, all of which may pose a risk to patient safety and outcomes. Furthermore, as a consequence of the findings of the RCS report, HIW has concerns over quality governance arrangements within vascular services.

10.17.3 The implementation of these remedial actions is being overseen by the QSE Committee, through Chair Assurance reports from the Vascular Steering Group as well as regular reports at Board meetings.

10.17.4 During the 2021/22 period an independent Vascular Panel was set up for the purposes of scrutinising the individual case reviews and determining which cases may need to enter the Putting Things Right process.

10.18 Emergency Department, Ysbyty Glan Clwyd, March 2022

10.18.1 HIW undertook a two stage remote quality check of the ED department, in response to intelligence received from a significant incident reported to Welsh Government, and information provided by the Health Board. The quality check focused on patients receiving safe and effective care. Following the quality check HIW found immediate assurance improvements were required around timely access, discharge planning, record keeping, managing risk, and governance and leadership. An Immediate Assurance Improvement Plan has been submitted and accepted by HIW.

10.18.2 HIW subsequently carried out an unannounced on-site inspection between the 3rd and 5th of May 2022, resulting in the issue of a Service of Requiring significant improvement status due to limited evidence of improvement in relation to the Immediate Assurance issues identified during the March quality check. In addition, HIW identified additional areas of concern relating to patient safety. At the time of writing, the Health Board had completed an improvement plan which was considered by the Quality, Safety and Experience Committee on the 26th of May 2022.

11. Regulation 28 (Prevention of Future Deaths)

11.1 The Health Board responded to 3 Regulation 28 (PFD) Notices in the last full year (April 2021 to March 2022) addressing the following points:

- The implementation of the SNAP procedure – whereby N Acetylcysteine (NAC – the standard paracetamol antidote) may, from 31/01/2022, be safely given over a shorter period of time than previously;
- Confirmation that the process for escalation of abnormal Pathology results has been approved and implemented across the Health Board;
- Details on the new Incident Management Process;
- The implementation of an end of day safety huddle in community mental health teams to ensure safety plans are in place for vulnerable patients and handed over to out of hours teams.

11.2 The QSE Committee maintained oversight of the implementation of the associated action plans during the course of the 2021/22 period. In addition, a review of previously closed PFDs is currently underway in order to identify any gaps in implementation and effectiveness.

12. Data Security

12.1 The Executive Director of Finance is the Senior Information Risk Owner (SIRO) of the organisation, providing information risk management expertise at Board level. The SIRO oversees the consistent implementation of the information risk assessment process by Information Asset Owners, as described in the Information Risk Management framework and policy.

12.2 Lead responsibility for information governance in the Health Board rests with the Deputy Chief Executive Officer, with the Assistant Director of Information Governance and Assurance undertaking the designated role of the Health Board's Data Protection Officer in line with the Data Protection Act 2018.

12.3 The Medical Director is the Health Board's appointed Caldicott Guardian. Formal assurance to the Board on data quality is provided through an annual report to the Partnerships, People and Population Health Committee. Throughout the course of the 2021/22 period the assurance fed into the Digital and Information Governance (DIG) Committee, and onto the PPPH Committee from October 2021.

12.4 During the reporting period, the Committee received assurance on compliance with key performance indicators in relation to the quality and effectiveness of information and information systems against which the Health Board's performance will be regularly assessed.

12.5 The Health Board self-reported six data security breaches that triggered referral to the Information Commissioner's Office (ICO) and Welsh Government. Three of these self-reported incidents have been closed by the Information Commissioner's Office with no further action required by them due to the immediate actions and improvements put in place by the Health Board.

12.6 The remaining three were still open and awaiting a response from the ICO at year end. The ICO made one recommendation to check that policies and procedures are still fit for purpose and that all staff who handle personal data should receive regular data protection training which the Health Board has implemented. The Health Board did not incur any financial penalties during the year. Information relating to our information governance data breaches are included in section 21.4 of the Annual Governance Statement.

13. The NHS Pension Scheme Arrangements

13.1 As an employer with staff entitled to membership of the NHS Pension Scheme, the Health Board has control measures in place to ensure we comply with all employer obligations of the Scheme regulations. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

13.2 These systems and processes are subject to regular audit and review by Audit Wales as part of the annual audit of the financial statements, and internal audit of the payroll systems.

14. Climate Change Adaptation

14.1 During the 2021/22 period significant efforts were made to implement NHS Wales requirements in relation to sustainability.

14.2 The Board reviewed and agreed recommendations on 5th August 2021, regarding the Health Board's response to Welsh Governments NHS Wales Decarbonisation Plan, the details of which are summarised within this report.

14.3 The Partnerships, People and Population Health Committee, at a meeting on 9th December 2021, supported the recommendations to appoint the Carbon Trust to assist the Health Board with developing a five-year decarbonisation plan in response to Welsh Governments decarbonisation targets for 2030.

14.4 To reflect the prominence placed by the Welsh Government on climate change, decarbonisation and the sustainable recovery from the pandemic, the Health Board will establish a Decarbonisation Programme Board during the 2022/23 financial year, chaired by an Executive lead, with resources to address the targets set out in the plan and coordinate a wider and consistent integrated organisational response. The Decarbonisation Programme Board will feed into the Partnerships, People and Population Health Committee.

14.5 The Health Board is currently working with the Carbon Trust to gather carbon data and provide technical support required to produce a bespoke five-year decarbonisation plan that builds on work already undertaken.

14.6 The establishment of a programme board will lead this transformational initiative and seek to progress opportunities for financial benefits to sustain the programme and deliver other returns in terms through linking with other established programmes (e.g. agile working) to tackle the health emergency while reducing emissions to achieve the ambitious targets from the NHS Wales Decarbonisation Plan.

14.7 During the 2022/23 period, the Health Board will progress further engagement and implementation of the decarbonisation plan with oversight through the Partnerships, People and Population Health Committee. The plan is also incorporated within the Integrated Medium-term Plan for 2022-25.

15. Emergency Preparedness

15.1 Under the Health Board's Emergency Preparedness, Resilience and Response (EPRR) arrangements, there is a duty to respond effectively to major, critical and business continuity incidents whilst maintaining services to patients. Betsi Cadwaladr University Health Board is categorised within the Civil Contingencies Act (2004) as a 'Category 1 Responder' and therefore required to meet the full legislated duties under the Act.

15.2 In addition to these legal responsibilities, the Board must also meet the requirements set out within the NHS Wales Emergency Planning Core Guidance (April 2015). Furthermore, as best practice, the Health Board has adopted and conforms to the NHS England Core Standards for Emergency Preparedness and Resilience (EPRR). As a Category 1 Responder the organisation must plan and prepare for incidents and emergencies and adhere to the following duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place business continuity management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency.

15.3 The Health Board has arrangements in place to ensure that the organisation can respond to the demands of an incident and meet the designated responsibilities as a category one responder, by providing a coordinated response that links the operational management, shares the resources required and supports the needs of the whole of the health and care community in north Wales.

15.4 The Health Board has a Major Emergency Plan supported by site specific and community and primary care incident plans that describe the response of the organisation to an emergency defined as a major incident.

15.5 A governance structure provides oversight and coordination of the Health Board's emergency preparedness arrangements. This structure links into the North Wales Local Resilience Forum (LRF), which provides the coordinated planning and preparedness across all agencies involved in civil protection activities.

15.6 To support this, the Health Board commissioned an external specialist review of the organisational arrangements for emergency preparedness, and their effectiveness against the Core standards for EPRR, and a series of recommendations were made.

15.7 This included the formation of a refreshed Civil Contingencies Assurance Group (CCAG) to work strategically on behalf of the Executive Management Team to ensure that the Health Board's Emergency Management Plan and Business Continuity Plans are fit for purpose and fully comply with the Civil Contingencies Act 2004.

15.8 The CCAG will progress the implementation of the recommendations of the external review as well as the relevant aspects of the Business Continuity planning internal audit report (which was issued an audit opinion of 'limited assurance'), including embedding existing controls, such as the BCP policy and the associated work programme.

15.9 The PPPH Committee received an EPRR work programme on 20th May 2022, to enable the organisation to embed and demonstrate compliance of duties placed upon the Health Board through the Civil Contingencies Act (2004) and associated non legislative guidance. The work programme is reviewed at the CCAG to ensure the duties are being met.

15.10 There is a Civil Contingencies Risk Register in place, along with individual divisional risk registers which provide a means of reporting and escalating risks.

16. Equality, Diversity and Human Rights

16.1 Control measures are in place to ensure that the organisation is compliant with its obligations under equality, diversity and human rights legislation. These include provision of information to service users and staff on the Health Board website that meets the statutory publication duties.

16.2 The Health Board has put in place a range of systems, processes and governance arrangements to enable compliance with the Equality Act 2010, which are monitored by the Partnerships, People and Population Health Committee on a regular basis.

16.3 The Equality and Diversity Group maintains oversight of the delivery of the Health Board's Equality strategy and associated work plans, which incorporates mandatory compliance with the Workforce Race Equality standard.

16.4 Key work achieved during 2021/22 includes the establishment of a Task and Finish Group to oversee an implementation plan for the Socio-economic Duty, as well as associated Welsh Government guidance ready for 31st March 2022 go live date. Socio-economic Impact Assessments (SEIA) procedures have been established (including development of a policy and SEIA template).

16.5 A training plan to raise awareness and understanding of the responsibilities of senior leaders to deliver the Socio-economic Duty was developed, with a workshop delivered to the Board in April 2021.

16.6 A range of supporting documentation and guidance has been published, to ensure staff understand their responsibilities to the Equality Duty and Socio-economic Duty through specific guidance distributed through the BCUHB Equality Briefing and the equality intranet (BetsiNet) site. Next Steps for 2022/23: Work is ongoing to mainstream the Socio-economic Duty across the organisation, and the Socio-economic Duty Advisory Group will continue to oversee this and provide assurance.

16.7 The 2021/22 Annual Equality and Diversity report and Gender Pay Gap reports were reviewed and scrutinised by the People and Population Health Committee on 20th May 2022, and further updates will continue into the 2022/23 period.

17. Counter Fraud and Anti Bribery Arrangements

17.1 The Health Board has sound arrangements in place to ensure compliance with counter fraud and anti-bribery requirements, as set out in the Welsh Government Directions to NHS Bodies on Counter Fraud Measures issued on 1st December 2005 to NHS Bodies in Wales.

17.2 At an operational level, there are staff briefings and refresher fraud awareness sessions for staff.

17.3 The Health Board has had a counter fraud programme in place during 2021/22 and the Local Counter Fraud Specialist (LCFS) updates the Executive Director of Finance on a regular basis to monitor the delivery of the plan and discuss cases.

17.4 A fraud risk assessment is undertaken annually to assess and identify the Health Board's exposure to fraud risks. The outcome of the assessment is used to populate a fraud risk register which strengthens the Health Board's ability to evaluate, mitigate and monitor risks arising from fraud. Where appropriate these risks feed into the Health Board risk register.

17.5 The following arrangements are in place:

- Proactive and reactive measures are taken by the Local Counter Fraud Specialist to deter and identify, as well as to encourage staff to report,fraud; conflicts of interests are declared at all Board, Committee and sub-committee meetings;
- The Health Board's processes are aligned to maintain compliance with current conflicts of interests' guidance which has been refreshed to incorporate NHS England requirements with effect from June 2017;
- Operational arrangements are in place to enable timely notification of concerns pertaining to fraud to the LCFS or the Director of Finance, which are also reported to the Audit Committee;
- Internal Audit and the LCFS have liaised during the year in order to discuss high risk areas. In the event that management identify risks relating to fraud these are incorporated onto the risk register, with associated mitigations.

17.6 The Audit Committee receives regular progress reports and an annual report on the delivery of the LCFS work plan and investigative reports where appropriate. In addition, the Committee reviews anti-fraud and bribery Health Board policies and procedures.

17.7 The Health Board completes an annual self-assessment of its counter fraud arrangements against a number of Standards which are set by the counter fraud regulator, the NHS CFA. The Audit Committee takes assurance from this work, which ensures organisational objectives and investigative activities are appropriately investigated and concluded in a timely way to minimise potential future risks in the Health Board's systems of internal control.

18. Integrated Medium Term Plan

18.1 During the 2021/22 period Integrated Medium Term Plan (IMTP) planning arrangements were re-established across NHS Wales for 2022-25 following a pause due to the pandemic. Subsequently, the NHS Wales Planning Framework was received on 9th November 2021 modelled against Ministerial priorities outlined in July 2021:

- A Healthier Wales - as the overarching policy context
- Population health
- Covid - response
- NHS recovery
- Mental Health and emotional wellbeing
- Supporting the health and care workforce
- NHS Finance and managing within resources
- Working alongside Social Care

18.2 The planning framework emphasises the importance of the Primary Care Model for Wales which sets out how primary care will work within the whole system to deliver a place based approach (primary care is defined as primary and community health care services).

18.3 The Board and the Performance, Finance and Information Governance Committee scrutinised and reviewed the development of the IMTP between December 2021 and the approval of the document on 30th March 2022. The document demonstrates that the majority of our focus for 2022/23 is upon returning to full core business, including addressing the pandemic-related backlog of work, and consolidating developmental work that has already been begun but not yet finished, including work to deliver against the WG Targeted Intervention framework. A small number of new initiatives will be commenced, but only where they clearly contribute to delivering the two areas of focus above.

18.4 At the date of signing of the accounts and the Governance Statement, the Health Board had submitted a Board approved IMTP for 2022-2025 in accordance with the NHS Planning Framework and the status of this in terms of approval by Welsh Ministers.

Subsenquently, notification was received from Welsh Government on the 22nd of July 2022 that the IMTP was not approved, but was accepted as an annual plan. At the time of writing the Health Board was working towards the development of an IMTP for the 2023-2026 period.

As part of their feedback, Welsh Government acknowledged the significant improvements in the IMTP, noting particularly a strong engagement and focussed approach applied, which resulted in a coherent, board owned and board approved IMTP for the first time in a seven year period. This feedback will be used to further strengthen the process for the next IMTP submission

18.5 Our planning assumptions will continue to address Covid-19 programmes alongside re-establishing services. We will capture and utilise new ways of working and maintain good practice from lessons learnt throughout the first and second waves of the pandemic. The Test, Trace and Protect programme continues to play a pivotal role in protecting our population and we plan to continue this.

19 Targeted Intervention

19.1 In November 2020 Betsi Cadwaladr University Health Board transitioned from Special Measures to a reduced escalation of Targeted intervention by the Welsh Government. The scope of the Targeted Intervention framework extended to the following areas:

- Mental Health (adult and children);
- Strategy, planning and performance;
- Leadership (including governance, transformation, and culture);
- Engagement (patients, public, staff and partners).

19.2 Further to the internal control, quality and safety risks identified in the Royal College of Surgeons', as well as the Health Inspectorate, reviews of the vascular service, the Welsh Government announced the decision to widen the targeted intervention status at Betsi Cadwaladr University Health Board to incorporate Ysbyty Glan Clwyd.

19.3 The scope of the YGC Targeted intervention has been extended to include:

- Ysbyty Glan Clywd – governance, leadership, and oversight;
- Ysbyty Glan Clwyd – operational oversight and clinical safety governance including record keeping, incident management, team working, reporting concerns, and consent;
- Vascular Services;
- Emergency Department at Ysbyty Glan Clwyd;
- Clinical service standards.

At the time of writing, discussions were ongoing in relation to the content of the framework

19.4 The Health Board continued to implement improvement plans to progress through the Target Intervention status, since being removed from Special Measures in November 2020.

19.5 During 2021/22, the Board received assurance through the Targeted Intervention Steering Group (TISG), which maintained oversight of the delivery of the improvement plans.

19.6 The TISG maintained oversight of the progression of the implementation of stretch targets pertaining to the four Domains set out in the Improvement Framework issued by Welsh Government, as follows:

- Mental Health Service Management (adults and children);
- Strategy, Planning and Performance;
- Leadership (including Governance, Transformation, and Culture);
- Engagement.

The levels of organisational maturity achieved are measured according to the following scale:

0 - No Progress
1 - Basic Level
2 - Early Progress
3 - Results
4 - Maturity
5 - Exemplar

19.7 The Board reviewed TI self-assessment proposals, ahead of a series of moderation meetings held with each domain's Senior Responsible Officer and Link Independent Member, with the Good Governance Institute and Interim Director of Governance. A system moderation meeting, chaired by the Programme Senior Responsible Officer was then held.

Domain	Evidence Level	Outcomes Level	Recommended Self-Assessment
All Ages Mental Health	2	Not yet met at level 2	2
Strategy, Planning and Performance	2	Not yet met at level 2	2
Leadership	2	Not yet met at level 2	2
Engagement	2	Met at level 2	2 (high)

19.8 In November 2021 the Board set targets to achieve for this assessment as follows:

19.8.1 Mental Health: 2 (high) – the Board recognised that this was a stretch target, and whilst there is evidence of progress against the outcomes defined by WG in the TIIF the recommendation is to self-assess at a 2, the attached gap analysis shows some progress in the level 3.

19.8.2 Strategy Planning and Performance: 2 (high): The Health Board approved the IMTP for submission, but subsequently the IMTP was not approved by Welsh Government and so the recommendation is for a 2. The Gap analysis shows progress into level 3.

19.8.3 Leadership: 2 – recommendation achieved.

19.8.4 Engagement: 2 (high) – recommendation achieved.

19.9 During the 2021/22 period the Health Board continued to work closely with Welsh Government throughout the improvement journey. This work was subject to external scrutiny by Audit Wales. Further detail is available here: https://gov.wales/sites/default/files/publications/2021-03/targeted-intervention-framework-betsi-cadwaladr-university-health-board.pdf

20 Audit Wales Structured Assessment

20.1 During the 2021/22 period, staff of Audit Wales conducted Phase two of the Structured Assessment on behalf of the Auditor General for Wales, which considered how corporate governance and financial management arrangements have adapted over the last 12 months.

20.2 In particular, the report incorporated an overview of the Health Board's de-escalation to targeted intervention and the approach applied to achieve compliance.

20.3 In addition, the scope of the structured assessment also incorporated a review of the corporate arrangements for ensuring that resources within the Health Board are used efficiently, effectively, and economically.

20.4 Audit Wales assessed the Health Board's learning from the pandemic is shaping future arrangements for ensuring good governance and delivering value for money. Lastly, Audit Wales sought to gain an overview of the Board's scrutiny of the development and delivery of the Health Board's 2021/22 Annual Plan.

20.5 The output from this review was received by the Audit Committee in December 2021, and subsequently accepted by the Board in January 2022. Audit Wales' key messages following its Structured Assessment were:

"Overall, we found that in the context of dealing with significant service pressures the Health Board has continued to evolve its governance arrangements, service planning and financial monitoring. The initial response to the Welsh Government's Targeted Intervention framework has been positive and it will be important that this is used to demonstrate progress against a number of long-standing challenges. The immediate focus for the Board is to effectively manage the service pressures across all divisions and to ensure its wider strategic and recovery plans both align to those pressing recovery challenges and shape the organisation for the future."

20.6 The Auditor General for Wales' key messages as set out in the Annual Audit Report are detailed below. Further details of the full report can be accessed via the Audit Wales website at: https://www.audit.wales/publication/betsi-cadwaladr-university-health-board-structured-assessment-2021-phase-two

21. Significant Issues

21.1 Healthcare Inspectorate Wales

21.1.1 Vascular Services, Ysbyty Glan Clwyd – Service requiring significant improvement status
Issue Date: 1st March 2022

21.1.1.1 Further to the publication of the Royal College of Surgeons Clinical Record Review of Vascular Services, HIW issued Service Requiring significant improvement status to the service, due to indications of significant risks to patients using the vascular service.

21.1.1.2 Further detail on the findings of the RCS review are incorporated in section 10 of this document.

21.1.2 Emergency Department, Ysbyty Glan Clwyd – Service requiring significant improvement status
Issue Date: 16th May 2022

21.1.2.1 Due to the findings of a remote quality check and an onsite inspection at the Emergency Department, Ysbyty Glan Clwyd, HIW designated the Emergency Department at YGC as a Service requiring significant improvement status due to a failure to demonstrate improvements and implementation of actions within the Immediate Assurance Improvement Plan submitted in March 2022.

21.1.2.2 Further detail on the findings of the HIW review are incorporated in section 10 of this document.

21.2 Health and Safety Executive (HSE)

21.2.1 HSE Improvement Notice Management of Personal Protective Equipment

21.2.1.1 Letter of contravention Provision of Personal Protective Equipment Regulations 2002

21.2.1.2 Date Issued 23 February 2021.

21.2.1.3 The letter was received following an HSE investigation into an incident of potential exposure to Covid-19 in the workplace. The investigation identified inadequacies with ensuring that all staff required to wear half face respirators have attended a face fit session.

21.2.1.4 A comprehensive programme was implemented and compliance with the letter was ongoing at the time of this submission.

21.2.2 HSE Improvement Notice Management of in-patient falls

21.2.2.1 Date Issued 16 June 2021.

21.2.2.2 An HSE investigation was carried out following the reporting under RIDDOR of two separate patient incidents of falls leading to harm. The investigation identified failings in the completion of the falls assessments for both patients with no clear explanation of risk control measures to be followed or actions taken. A task and finish group was established to work through each element of the Improvement Notice and a response was submitted to the HSE.

21.2.2.3 Initial compliance date 16 September 2021

21.2.2.4 However, during the planned inspection -18th November 2021, the HSE identified the risk assessments were still not being completed correctly and a further Material Breach was issued.

21.2.3 HSE Improvement Notice of Contravention (Control of Hazardous substances)

21.2.3.1 Date Issued 19 August 2021.

21.2.3.2 A Notification of Contravention (NOC) letter was received following an HSE visit to the Rehabilitation Engineering Unit, part of the Posture and Mobility Service, at Bryn Y Neuadd Hospital. The letter identified two material breaches of the Control of Substances Hazardous to Health Regulations 2002 (COSHH). The Thorough Examination report for the LEV system in the unit was not suitable as it did not comply with the Approved Code of Practice.

21.2.3.3 Date of compliance: January 2022.

21.2.4 BCUHB planned inspection 16 – 18 November 2021

21.2.4.1 Prior to the COVID-19 pandemic the HSE announced their planned 'Inspections of Violence and Aggression and Musculoskeletal Disorders in Healthcare' programme. This is a national programme planned to examine management arrangements for violence and aggression (V&A) and musculoskeletal disorders (MSD's) at care providers in the public sector.

21.2.4.2 The Health Board were issued a Notification of Contravention letter after this inspection which gave eight areas of required improvements. This included two improvement notices, one for portering manual handling risk assessments and the other for patient handling risk assessments, four other material breaches and two advisory notices.

21.2.4.3 Date of compliance: 17 of March 2022

21.2.5 Patient handling risk assessments.

21.2.5.1 The inspector has requested that a further visit is arranged to inspect risk assessments in two areas on one hospital site on the 18 May 2022.

21.2.5.2 Further to the above interventions the HSE confirmed a letter of contravention will be served on the Chief Executive week beginning 8 May 2022. The letter will confirm the areas where it is considered that the Health Board has breached health and safety legislation, pertaining to inadequate in-patient risk assessment (suicide risk), provision of a non anti -ligature bed and provision of the ligature. The HSE will soon be writing to the Health Board requesting their legal submission over potential further enforcement.

22.2.5.3 The Health Board is currently in the process of implementing the second improvement notice issued by the HSE as a result of the identification of weaknesses in health and safety operational infrastructure.

21.3 A comprehensive action plan is in place to not only address the gaps referenced by the HSE, but also to embed robust health and safety oversight and governance, feeding through to the Board.

21.4 Data Security Breaches

21.4.1 The Health Board self-reported six data security breaches that triggered referral to the Information Commissioner's Office and Welsh Government. These were in relation to:

Data Loss / availability	3
Inappropriate Access	1
Data Loss	1
PPI found in public place	1
Total	**6**

21.4.2 Three (3) of the above incidents have been closed by the Information Commissioner's Office (ICO) with no further action required by the ICO due to the immediate actions and improvements put in place by the Health Board. The remaining three are still open and awaiting a response from the ICO.

21.4.3 The ICO made one recommendation to check that policies and procedures are still fit for purpose and that all staff who handle personal data should receive regular data protection training which the Health Board has implemented. The Health Board did not incur any financial penalties during the year. During 2021/22 the Health Board has received 3 personal injury claims for harm and distress caused by a data breach and has settled 4 previous claims totalling £22,305.20 during the year.

21.5 Limited assurance opinion internal audit reviews

21.5.1 The limited assurance audit opinion reports for the 2021/22 financial year are summarised as significant issues:

Establishment Control: Leaver Management	Limited
Standards of Business Conduct	Limited
Integrated Service Boards Governance	Limited
Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	Limited
Nursing Roster Management: Introduction of e-timesheets for Agency staff	Limited
Clinical Audit	Limited
On-Call arrangements	Limited
Business Continuity Plans	Limited

21.6 Qualified 'true and fair' audit opinion on 2021/22 financial statements

21.6.1 The Health Board was issued a qualified 'true and fair' audit opinion on the 2021/22 financial statemes by Audit Wales, due to the lack of appropriate audit evidence that accruals and related expenditure has been accounted for in the correct accounting period.

21.6.2 This matter has also been included in the Report of the Auditor General to the Senedd

21.6.3 The internal control failure was highlighted when the auditors identified expenditure of £10.3m being allocated to the 2021/22 period (instead of the 2022/23 period), thus impacting on the disclosure in note 2.1, 'Revenue Resource Performance'.

(Note 2.1 reports an underspend of £0.3m which would be revised to £10.6m, had the accounts been adjusted.)

21.6.4 Expenditure was recorded against the Revenue Resource Limit when it met the definition of Capital Expenditure and should have been recorded against the Capital Resource Limit.

21.6.5 In addition, the audit identified a contract valued over £1m, which had been accrued into the 2021/22 period, without Board and Welsh government approval, as per the NHS (Wales) Act 2006 and Standing Orders.

21.6.6 In order to ensure these errors do not re-occur in future statutory accounts a range of significant actions will be undertaken to strengthen the financial control environment, for the purposes of embedding the 3 lines of defence assurance. At the time of writing a range of actions were in the process of being implemented, as part of a wider action plan that was under consultation and due for submission to Audit Committee and the Performance, Finance and Information Governance Committee independent oversight and monitoring respectively

21.7 These significant issues indicate a requirement for the Health Board to prioritise a review of the assurance arrangements for compliance, performance safety and risk management, through the implementation of an integrated assurance model.

22 Review of Effectivenes

22.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the Internal Auditors, and the Executive Directors within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

22.2 My review has also been informed by:

- Feedback from Welsh Government and the specific statements issued by the Minister for Health and Social Services;
- External inspections by Healthcare Inspectorate Wales;
- Delivery of audit plans and reports by Audit Wales and Internal Audit;
- Feedback from the Community Health Council;
- Feedback from NHS Wales
- Feedback from staff, patients, service users and members of the public;
- Assurance provided by the Audit Committee and other Committees of the Board;
- Audit Wales Structured Assessment.

22.3 I am partially satisfied with the effectiveness of the system of internal control, based on the significant issues referenced in section 21.

22.4 The Board and its Committees demonstrate a level of rigour and challenge underpinned by key elements that support effectiveness, such as Independent Member Committee Chairs' Assurance reporting to the full Board, the co-ordinating work of the Committee Business Management Group and the outputs of the Audit Committee.

22.5 However, as noted by Audit Wales and other sources of evidence, there is scope for further improvement to the system of internal control and governance arrangements.

As such, colleagues are working to continuously improve the effectiveness of the Health Board's systems of governance in a number of ways through, for example:

- A review of governance structures focusing on Committee reporting and Groups reporting through accountable Executives;
- A facilitated and structured Board Development Programme aligned to collective and individual needs;
- Implementation of external review recommendations;
- Ongoing review of Health Board wide policies and the agreement to purchase the associated Policy Datix Module to improve the robustness of the overall management of the system;
- Integrated performance reporting and a revised accountability framework;
- Continued efforts to meet the expectations of the Targeted Intervention Improvement Framework (this having replaced the Special Measures Improvement Framework following de-escalation as referred to earlier in this Statement);
- Recommendations from internal audit reports;
- Ongoing work to improve the management of concerns and complaints;

- A review of the Business Continuity Arrangements;
- Stakeholder engagement in the clinical strategy and plan development;
- Strengthening of the planning arrangements including an independent review of the function.

23 Conclusion

23.1 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Health Board which is supported by:

- The Audit Committee which considers the annual plans and reports of External and Internal Audit.
- The Quality Safety Experience Committee which maintains oversight of systems and processes in place for clinical governance and quality within the Health Board.
- The Performance, Finance and Information Governance Committee, which maintained oversight of financial, performance and information governance.
- The Executive Management Team which oversees the implementation of the strategic direction of the Health Board.

23.2 In addition, the Head of Internal Audit has a mechanism for identifying and recording in Internal Audit reports gaps in controls that need to be addressed. Action plans have been agreed with senior managers and further details are recorded in the Internal Audit progress reports presented to the Audit Committee at each meeting.

23.3 The Health Board is reliant upon information system controls operated by third parties over contracts negotiated by the Department of Health and under which the Health Board has no contractual or other influence over the managed service providers. For the ESR Payroll and HR system, the Department of Health has put in place arrangements under which the Health Board received formal assurances about the effectiveness of internal controls.

23.4 As indicated throughout this statement and the Annual Report the need to plan and respond to the COVID-19 pandemic has had a significant impact on the organisation, wider NHS and society as a whole. It has required a dynamic response which has presented a number of opportunities in addition to the risks. The need to respond and recover from the pandemic will be with the organisation and wider society throughout 2022/23 and beyond. I will ensure our Governance Framework considers and responds to this need.

23.5 Significant issues are outlined in section 21 of this report.

23.6 My review confirms that that the Betsi Cadwaladr University Health Board has a partially sound system of internal control that supports the achievement of its policies, aims and objectives, however there are processes requiring significant improvement in relation to patient safety and compliance assurance as set out in section 18 of this report. As noted within this report there have been three areas where there have been control failures, and we intend to conduct in-depth reviews of compliance within all relevant areas within the Health Board, to provide assurance that these were isolated incidents, and rectify any further gaps in control.

Signed:

Jo Whitehead
Chief Executive and Accountable Officer **Date: 24 August 2022**

Appendix 1 – Meetings of the Health Board and Committees held in public 2021/22

Meeting	Date								
Health Board	20/05/21	15/07/21	29/07/21	23/09/21	18/11/21	20/01/22	15/02/22	10/03/22	30/03/22
Quality, Safety & Experience (QSE) Committee	04/05/21	06/07/21	07/09/21	02/11/21	11/01/22	01/03/22	23/03/22		
Finance & Performance (F&P) Committee	29/04/21	24/06/21	26/08/21						
Digital & Information Governance Committee	18/06/21	10/09/21							
Performance, Finance and Information Governance (PFIG) Committee				28/10/21	23/12/21	24/02/22	24/03/22		
Strategy, Partnerships & Population Health (SPPH) Committee	15/04/21	17/06/21	12/08/21						
Partnerships, People and Population Health (PPPH) Committee				14/10/21	09/12/21	10/02/22			
Remuneration and Terms of Service Committee	07/06/21	22/07/21	21/10/21	18/01/22					
Mental Health Act Committee	25/06/21								
Mental Health and Capacity Compliance (MHCC) Committee		24/09/21	17/12/21						
Charitable Funds Committee	11/06/21	16/09/21	16/12/21	17/03/22					
Audit Committee	10/06/21	28/09/21	14/12/21	15/03/22					

Appendix 2 – Board and Committee Membership 2021/22

A number of changes to Board membership, including interim and acting up arrangements, have occurred during 2021/22 and are reflected in the table below.

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Mark Polin	Chairman		• Chair of the Board • Chair Remuneration and Terms of Service Committee • Chair Finance and Performance Committee	
Lucy Reid	Independent Member Vice Chair	Community Primary Care & Mental Health	• Board Member • Chair Quality, Safety and Experience Committee • Chair Mental Health Act Committee • Chair Mental Health and Capacity Compliance Committee • Member Remuneration and Terms of Service Committee	• Concerns
Lyn Meadows	Independent Member	Community	• Board Member • Acting Chair Strategy, Partnerships and Population Health Committee • Vice Chair Audit Committee to 14/12/21 • Vice Chair Quality, Safety and Experience Committee • Member Partnerships, People and Population Health Committee *to 09/12/21*	• Nutrition • Cleaning, Hygiene and Infection Management
Cllr Cheryl Carlisle	Independent Member	Community	• Board member • Member Quality, Safety and Experience Committee • Member Mental Health Act Committee • Member Mental Health and Capacity Compliance Committee • Member Charitable Funds Committee	• Carers • Children and Young People

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Cllr Medwyn Hughes	Independent Member	Local Authority	• Board Member • Chair Audit Committee • Vice Chair Remuneration and Terms of Service Committee • Member Digital & Information Governance Committee *to October 2021*	• Patient and Public Involvement • Welsh language
Prof Nichola Callow	Independent Member	University	• Board Member • Member Digital & Information Governance Committee • Member Strategy, Partnerships and Population Health Committee • Vice Chair Partnerships, People and Population Health Committee	
Jackie Hughes	Independent Member	Trade Union	• Board Member • Member Audit Committee • Member Remuneration and Terms of Service Committee • Member Quality, Safety and Experience Committee • Chair Charitable Funds Committee • Ex Officio Local Partnership Forum	• Violence and Aggression • Equality
John Cunliffe	Independent Member	Community	• Board Member • Chair Digital & Information Governance Committee • Chair Finance and Performance Committee • Chair Performance, Finance and Information Governance Committee • Member Strategy, Partnerships and Population Health Committee • Member Partnerships, People and Population Health Committee	

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Eifion Jones	Independent Member *to 31/08/21*	Community	• Board member • Vice Chair Finance and Performance Committee • Member Mental Health Act Committee • Member Audit Committee	
Linda Tomos	Independent Member	Community	• Board member • Member Finance and Performance Committee • Member Performance, Finance and Information Governance Committee • Member Strategy, Partnerships and Population Health Committee • Chair Partnerships, People and Population Health Committee • Member Charitable Funds Committee	
Jo Whitehead	Chief Executive		• Board Member • In attendance Remuneration and Terms of Service Committee • In attendance Audit Committee (at least annually) • Joint Chair / Member, Local Partnership Forum	
Gill Harris	Executive Director Nursing and Midwifery / Deputy Chief Executive		• Board Member • Lead Director / In attendance Quality, Safety and Experience Committee • Member Local Partnership Forum • In attendance Mental Health Act Committee • In attendance Finance and Performance Committee • In attendance Performance, Finance and Information Governance Committee • In attendance Partnerships, People and Population Health Committee • In attendance Audit Committee	

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Sue Hill	Executive Director of Finance		• Board Member • In attendance Audit Committee • Lead Director / Member, Charitable Funds Committee • Lead Director / In attendance, Finance and Performance Committee • Lead Director Performance, Finance and Information Governance Committee • Member Local Partnership Forum • In attendance Digital and Information Governance Committee *to October 2021*	
Teresa Owen	Executive Director of Public Health		• Board Member • In attendance Quality, Safety and Experience Committee • In attendance Strategy, Partnerships and Population Health Committee • In attendance Partnerships, People and Population Health Committee • Lead Director / In attendance Mental Health Act Committee • Lead Director / In attendance Mental Health and Capacity Compliance Committee	

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Sue Green	Executive Director of Workforce & Organisational Development (OD)		• Board Member • Lead Director/In attendance, Remuneration and Terms of Service Committee • In attendance Finance and Performance Committee • In attendance Performance, Finance and Information Governance Committee • In attendance Strategy, Partnerships and Population Health Committee to October 2021 • In attendance Partnerships, People and Population Health Committee • Lead Director / Member, Local Partnership Forum • In attendance, Quality, Safety and Experience Committee	
Mark Wilkinson	Executive Director Planning and Performance *to 24/08/21*		• Board Member • Lead Director / In attendance, Strategy, Partnerships and Population Health Committee • Member Charitable Funds Committee • In attendance Finance and Performance Committee • Lead Director / In attendance Stakeholder Reference Group	

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Prof Arpan Guha	Acting Executive Medical Director *to 11/07/21*		• Board member • In attendance Quality, Safety and Experience Committee • In attendance Digital and Information Governance Committee • In attendance Finance and Performance Committee • Member Charitable Funds Committee • In attendance Remuneration & Terms of Service Committee • In attendance Strategy, Partnerships and Population Health Committee	
Nick Lyons	Executive Medical Director *wef 12/07/21*		• Board member • In attendance Quality, Safety and Experience Committee • In attendance Digital and Information Governance Committee • In attendance Finance and Performance Committee • Member Charitable Funds Committee • In attendance Remuneration & Terms of Service Committee • In attendance Strategy, Partnerships and Population Health Committee	
Dr Chris Stockport	Executive Director Primary and Community Services		• Board member • In attendance, Quality, Safety and Experience Committee • Lead Director / In attendance Strategy, Partnerships and Population Health Committee • Lead Director / In attendance Partnerships, People and Population Health Committee • Lead Director / In attendance Digital and Information Governance Committee	

Name	Position	Area of expertise / representation role	Board Committee membership	Champion roles
Adrian Thomas	Executive Director Therapies & Health Sciences		• Board member • Lead Director / In attendance Healthcare Professionals Forum • In attendance Quality, Safety and Experience Committee	
Louise Brereton	Board Secretary		• Board Member • In attendance at Audit Committee	
Associate Board Members				
Morwena Edwards	Associate Member	Director of Social Services, Gwynedd	• Associate Board Member	
Ffrancon Williams	Associate Member	Chair Stakeholder Reference Group	• Associate Board Member	
Claire Budden	Associate Member		• Associate Board Member	
Gareth Evans	Associate Member	Chair Healthcare Professionals Forum	• Associate Board Member • In attendance Quality, Safety & Experience Committee	

Appendix 3 BCUHB Health Board member attendance at Board Meetings held in public 2021/22

Y = Present A = Apologies P = Part attendance

		20/05/21	15/07/21	29/07/21 AGM	23/09/21	18/11/21	20/01/22	15/02/22	10/03/22	30/03/22
Mark Polin Chairman	Member	Y	Y	Y	Y	Y	A	Y	Y	Y
Prof Nichola Callow Independent Member	Member	P	Y	Y	A	Y	Y	A	Y	A
Cllr Cheryl Carlisle Independent Member	Member	Y	Y	Y	Y	Y	Y	A	Y	P
John Cunliffe Independent Member	Member	Y	Y	Y	Y	Y	Y	Y	Y	A
John Gallanders Independent Member	Member					Y	Y	Y	Y	Y
Cllr Medwyn Hughes Independent Member	Member	Y	Y	Y	Y	A	Y	Y	Y	Y
Jackie Hughes Independent Member	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y
Eifion Jones Independent Member	Member	Y	Y	Y						
Lyn Meadows Independent Member	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y

		20/05/21	15/07/21	29/07/21 AGM	23/09/21	18/11/21	20/01/22	15/02/22	10/03/22	30/03/22
Richard Micklewright Independent Member	Member					Y	Y	Y	Y	Y
Lucy Reid Independent Member / Vice Chair	Member	Y	P	Y	Y	P	Y	Y	Y	Y
Linda Tomos Independent Member	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y
Jo Whitehead Chief Executive	Member	Y	P	Y	Y	P	Y	Y	Y	Y
Gill Harris Executive Director Nursing and Midwifery / Deputy Chief Executive	Member	Y	Y	Y	Y	Y	Y	A	A	Y
Teresa Owen Executive Director Public Health	Member	P	Y	Y	Y	Y	Y	Y	P	Y
Prof Arpan Guha Acting Executive Medical Director *to 11.07.21*	Member	Y	Y	A						
Nick Lyons Executive Medical Director *wef August 2021*	Member				Y	Y	Y	Y	Y	Y
Sue Hill Executive Director of Finance	Member	Y	Y	Y	A	Y	Y	A	Y	Y
Sue Green Executive Director of Workforce & OD	Member	Y	A	Y	Y	Y	Y	A	Y	A

		20/05/21	15/07/21	29/07/21 AGM	23/09/21	18/11/21	20/01/22	15/02/22	10/03/22	30/03/22
Adrian Thomas Executive Director Therapies and Health Sciences	Member	Y	Y	Y	Y	Y	A	A	A	A
Gareth Evans Executive Director Therapies and Health Sciences *wef* 02/03/22	Member								Y	Y
Chair of Healthcare Professionals Forum *to 01/03/22*	Associate Member	Y	Y	A	A	Y	Y			
Dr Chris Stockport Executive Director of Primary and Community Services	Member	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mark Wilkinson Executive Director Planning and Performance *to 24/08/21*	Member	Y	Y	A						
Louise Brereton Board Secretary	In Attendance	Y	Y	Y	Y	Y	Y	Y	Y	A
Morwena Edwards representing Directors Social Services	Associate Member	Y	A	Y	Y	P	Y	A	Y	Y
Clare Budden Chair of Stakeholder Reference Group	Associate Member			Y	A	Y	Y	Y	Y	P

Appendix 4 Welsh Health Circulars 2021/22

WHC No.	Date Received	Description	Executive Lead for Action	Date sent onwards for action
005 (2021)	08/04/21	The National Health Service (Cross-Border Healthcare) (Wales) (Amendment) Directions 2021 and the National Health Service (Reimbursement of the Cost of EEA Treatment) (Wales) (Amendment) Directions 2021	Executive Director of Finance	21/04/21
008 (2021)	27/05/21	Revised National Steroid Treatment Card	Executive Medical Director	27/05/21
010 (2021)	17/09/21	Amendments to Model Standing Orders, Reservation and Delegation of Powers and Model Standing Financial Instructions – NHS Wales	Board Secretary	21/09/21
011 (2021)	23/04/21	2021/22 LHB, SHA & Trust Monthly Financial Monitoring Return Guidance.	Executive Director of Finance	23/04/21
012 (2021)	06/05/21	Implementing the Agreed Approach to Preventing Violence and Aggression towards NHS Staff In Wales	Executive Director of Workforce & OD	06/05/21
015 (2021)	28/05/21	NHS Pay Bonus for Primary Care	Executive Director of Workforce & OD & Executive Director of Primary and Community Services	01/06/21
019 (2021)	04/08/21	The National Influenza Vaccination Programme 2021/22	Executive Director of Public Health	04/08/21
021 (2021)	31/08/21	Introduction of Shingrix® for immunocompromised individuals (from September 2021)	Executive Director of Public Health	31/08/21
022 (2021)	16/09/21	Quality and Safety Framework.	Executive Director of Nursing and Midwifery	17/09/21
023 (2021)	23/09/21	Care Decisions for the Last Days of Life: Assurance and Implementation	Executive Director of Nursing and Midwifery	23/09/21

WHC No.	Date Received	Description	Executive Lead for Action	Date sent onwards for action
025 (2021)	30/09/21	All Wales Carpal Tunnel Syndrome management pathway	Executive Director of Primary and Community Services	13/10/21
026 (2021)	11/10/21	Overseas Visitors' eligibility to receive Free Primary Care	Executive Director of Primary and Community Services	11/10/21
027 (2021)	28/09/21	NHS Wales Blood Health Plan	Executive Director of Therapies and Health Sciences	28/09/21
028 (2021)	28/09/21	AMR HCAI Improvement Goals 2021/22	Executive Director of Nursing and Midwifery	28/09/21
030 (2021)	13/10/21	Referral guidelines for Urological conditions: Erectile Dysfunction, Male Lower Urinary Tract Symptoms (LUTS), Recurrent Urinary Tract Infections (UTI), Scrotal Swellings, and Urinary Incontinence in women	Executive Director of Primary and Community Services	13/10/21
031 (2021)	11/11/21	NHS Wales Planning Framework 2022-2025	Executive Director of Primary and Community Services	11/11/21
032 (2021)	17/11/21	Role and Provision of Dental Public Health in Wales	Executive Director of Primary and Community Services & Executive Director of Public Health	17/11/21
033 (2021)	20/12/21	Role and Provision of Oral Surgery in Wales	Executive Director of Primary and Community Services	23/12/21
034 (2021)	22/12/21	Health Board Revenue Allocation 2022/23	Executive Director of Finance	23/12/21
005 (2022)	24/03/22	Data requirements for Value Based Health Care	Executive Director of Finance	25/03/21
007 (2022)	01/03/22	Recording of Dementia Codes	Executive Director of Nursing and Midwifery	01/03/22
010 (2022)	30/03/22	Reimbursable vaccines and eligible cohorts - for the 2022/23 NHS Wales Seasonal Influenza (flu) programme	Executive Director of Public Health & Executive Medical Director	30/03/22
011 (2022)	25/03/22	Patient Testing Framework – Updated guidance	Executive Director of Public Health	25/03/22