Bundle Audit Committee 14 March 2019

9.30am, Boardroom, Carlton Court, St Asaph Business Park - for queries please telephone Dawn Sharp, Assistant Director and Deputy Board Secretary on 01745 586464 or email: dawn.sharp@wales.nhs.uk

1.8.1	10:30 - AC19/8c Booking of Medical Agency Staff - Sue Green, Executive Director of Workforce and OD
	AC19.8c FINAL REPORT Agency Medical Staffing.pdf
1.8.2	10:45 - AC19/8d Primary Care GP Leases - Assigning Leases to the Health Board - Clare Darlington, Assistant Area Director
	AC19.8d Final Internal Audit Report Primary Care GP Leases Assigning le....pdf
1.8.3	11:00 - AC19/8e Managing the Outpatients Backlog - Steve Vaughan, Director of Secondary Care
	AC19.8e Final Report Managing The Outpatients Backlog.pdf
1.8.4	11:15 - AC19/8f Implementing the Falls Policy, Deborah Carter, Deputy Director of Nursing
	AC19.8f Internal Audit Report Implementing the falls policy Final.pdf
1.8.5	11:30 - AC19/8g Concerns, Complaints and Redress - Part 6: Redress - Deborah Carter, Deputy Director of Nursing
	AC19.8g Final Internal Audit Report - Concerns - Redress.pdf
1.8.6	11:45 - AC19/8h Hospital Catering and Patient Nutrition Follow up review - Steven Grayston, Assistant Area Director of Therapies East
	AC19.8h Final internal Audit Report WAO catering nutrition hydration.pdf
1.9	12:00 - AC19/9 Clinical Audit Report - Adrian Thomas, Executive Director of Therapies and Health Sciences
	AC19.9a Coversheet Audit Committee March 2019 Clinical Audit Paper.docx
	AC19.9b Audit Committee March 2019 Clinical Audit Paper 7.3.19 v.02.docx
1.10	12:20 - AC19/10 Wales Audit Office Reports - Mike Usher, WAO
	AC19.10a WAO March 2019 AC coversheet - WAO.docx
	AC19.10b WAO Update_March 2019 (003).pdf
	AC19.10c WAO 2019 Audit Plan_final_1116A2019-20_BCU.pdf
	AC19.10d 1047A2019-20_BCUHB_Annual Audit Report 2018_English.pdf
	AC19.10e expenditure-on-agency-staff-by-nhs-wales-2019-eng-print-version.pdf
	AC19.10f preparations-in-wales-no-deal-brexit-english.pdf
1.11	12:55 - AC19/11 WAO Structured Assessment - Mike Usher, WAO
	AC19.11a Structured Assessment coversheet.docx
	AC19.11b Structured Assessment WAO report.pdf
	AC19.11c Structured Assessment Management Response updated.docx
1.12	13:05 - AC19/12 Audit Committee Workshop - 30.11.18 - Update report - Grace Lewis-Parry
	AC19.12 Audit Committee Workshop - 30.11.18 - progress update.docx
1.13	13:10 - AC19/13 Issues of Significance for reporting to Board
1.14	13:15 - AC19/14 Date of Next Meeting - 30th May 2019
	Please note that there will also be a workshop for Members of the Committee to review the suite of Committee Annual Reports on 14th May 2019.
1.15	13:16 - AC19/15 Exclusion of Press and Public
	Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

AUDIT COMMITTEE <mark>DRAFT</mark>
Minutes of the Meeting Held on 11.12.18
In the Boardroom, Carlton Court, St Asaph

Present:

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

In Attendance:

Tracey Cooper	Assistant Director of Nursing, Infection Prevention, Nursing and Midwifery Services (for Minute AC18/90)
Andrew Doughton	Performance Audit Lead, Wales Audit Office
Russ Favager	Executive Director of Finance
Dave Harries	Head of Internal Audit, NWSSP
Gill Harris	Executive Director of Nursing and Midwifery (for Minute AC18/80)
Amanda Hughes	Financial Audit Manager, Wales Audit Office
Grace Lewis-Parry	Board Secretary
Teresa Owen	Executive Director of Public Health (for Minute AC18/91)
Mark Polin	Chair of the Health Board (observing)
Huw Richards	Deputy Director, Specialist Services Unit, Audit & Assurance, Shared
Dawn Sharp	Services Partnership
Chris Stockport	Assistant Director, Deputy Board Secretary
	Executive Director of Primary and Community Services (for Minutes
Rod Taylor	AC18/82 and 18/83.)
Mike Usher	Director of Estates and Facilities (for Minute AC18/90)
	Engagement Director, Wales Audit Office

Agenda Item	Action
AC18/78 Opening Business and Apologies for Absence AC18/78.1 The Chair welcomed everyone to the meeting. There were no apologies.	
AC18/79 Declarations of Interest No declarations of interest were made at the meeting.	
AC18/80 Minutes, matters arising and review of summary action log In order to facilitate the attendance of a number of Executive Directors the Chairman varied the order of business and received an update at this point in the meeting from the Executive Director of Primary and Community Services on the WAO report on Primary Care Services (referenced later). The Executive Director of Nursing and Midwifery also joined the meeting at this point to provide an update on progress with overdue Internal and External Audit recommendations. Members of the Committee supported by the Chair of the Health Board who was observing the meeting expressed serious concerns about the lack of	

progress of a number of overdue recommendations and requested that the Executive Team address these as a priority.

RESOLVED: That

1) the Minutes of the last meeting of the Committee held on 11.9.18 be confirmed as a correct record;
2) the updates to the Summary Action Log recorded therein be noted, all actions having been closed;
3) the updates in respect of the Audit Tracker be noted and the Executive Team address the overdue recommendations as a priority.
4) the Minutes of the Joint Audit and Quality, Safety and Governance Committee held on 6.11.18 be received and it be noted that the Executive Director of Therapies and Health Sciences will prepare a report for the March Audit Committee on progress with the implementation of the actions in respect of Clinical Audit following re-examination by the Executive Team of the BCU elements of the clinical audit plan and process going forward, including future presentation, tracking and follow up of recommendations arising, with input from Internal Audit as appropriate.

AT

AC18/81 Issues discussed in previous In Committee session

The Committee formally received the report in public session of those issues discussed in the private session at the meeting held on 11.9.18 which related to:-

- Financial Conformance Report

- Post Payment Verification Progress Report

- Counter Fraud Progress Report

- Update on Internal and External Audit Recommendations

- Update on financial expenditure on major contracts associated with Tawel Fan

- Final Internal Audit Report – Staffing Costs – Review of Staff earning over £200k

RESOLVED: That the report be received.

AC18/82 Internal Audit Progress Report

NB. The GP out of hours report was discussed at the beginning of the meeting immediately following the discussion of the WAO report on Primary Care Services to facilitate the attendance of the Executive Director of Primary and Community Services.

The Head of Internal Audit presented the progress update. The report summarised assurance reviews finalised since the last Committee meeting in September and provided reasonable assurance on three reviews – namely Ysbyty Gwynedd Emergency Department capital scheme; the Sub-Regional Intensive Care Centre; and West Locality Compliance with the Budget Setting Methodology. The update also detailed two 'assurance not applicable' reviews relating to GP Out of Hours: Compliance with National Standards; and Benefits Realisation. Additionally the report provided an update on draft reports issued, current fieldwork, together with follow-up

status of recommendations reviewed. Members also received a detailed briefing on Capital Assurance which was provided by the Deputy Director, Specialist Services Unit, noting that a further audit was scheduled for Ysbyty Gwynedd in the new year and any issues would be highlighted for members. The Deputy Director agreed to provide an update paper on Ysbyty Glan Clwyd Open Book which he would share with Members. With regard to the GP out of hours review the Executive Director of Primary and Community Services responded, outlining the work that was being undertaken to address the three distinct cultures and linear management issues that were not working across the Health Board. Structural changes together with increased working with WAST and 111 were being progressed at pace. Despite this being a report where an assurance level was 'not applicable' under the current definitions, recommendations emanating from the review relating to Clinical Audit and Business Continuity (Ref 4.5 and 6.1) would now be tracked as part of the Audit Team Central tracking arrangements. The Executive Director agreed to confirm timelines for the management restructuring relating to OOH Services and business continuity arrangements. The Head of Internal Audit sought the Committee's agreement to defer the Staff Survey review which would be addressed as part of the Internal Audit 2019/20 planning discussions. The original scope was intended to review the survey action plan from 2016, however this had subsequently been superseded by the recently published 2018 staff survey results. Members agreed that reviewing an action plan that would be superseded added no value to the Health Board and it was too early to review progress against the 2018 findings and developed action plans. **RESOLVED:** **That the progress report be received and the Staff Survey review be deferred for this years' Internal Audit Programme.**	HR DH CS
AC18/83 Wales Audit Office Update Report The report provided the Committee with an update on current and planned WAO work and included presentation of the Structured Assessment; Primary Care Services; Management of Follow up Outpatients across Wales; and Radiology Services in Wales. As referenced earlier, discussion of the Primary Care Services report was taken at the beginning of the meeting to facilitate the attendance of the Executive Director of Primary and Community Services who responded to members' questions. All findings within the report had been accepted however he highlighted that some of the timelines were ambitious but needed to be. Many of the solutions had been discussed with colleagues over the last few months. The Executive Director stressed that it needed to be recognised that clusters were wider than GP clusters and needed to involve dental and community pharmacy colleagues. Members queried some of the data in the report and it was agreed that WAO would clarify this outside the meeting. Members noted the draft Structured Assessment which had been discussed at the Board workshop in November. Work was ongoing to prepare the Management response and this would be presented to the Board in January. For completeness the	 AD

final report together with the Management response would be presented to the March Audit Committee and open recommendations would be added to the audit tracker tool. With regard to the report on 'Managing follow up outpatients' Members felt that this could be a topic for a future deep dive. The Board Secretary agreed to consider this further to ensure effective co-ordination and avoid duplication given the number of deep dives being undertaken by other parts of the governance structure. Whilst this was a Wales wide review it was agreed that Recommendations 4, 6 and 7 were relevant to the Health Board and would be tracked as part of the Team Central tracking arrangements. Members formally received the Radiology report noting that the recommendations from it were for Welsh Government and as such these would not be monitored on Team Central. **RESOLVED: That the update be received and the relevant recommendations from each report be tracker via the Team Central tracker.**	 DS
AC18/84 Special Measures: Review of expectations allocated to the Audit Committee Following approval from the Special Measures Improvement Task and Finish (SMIF T&G) Group and Health Board Chairman, it had been agreed that special measures expectations were to be allocated to the relevant committee for review, to provide updates where necessary, and to provide an assurance report on progress to the SMIF T&F Group. The latest versions of the expectations allocated to the Audit Committee were presented for review. The Committee reviewed the log in detail and made the following comments:- - Line reference 4 – view that the action as specifically set out by Deloitte's had been achieved and as such could be closed and shaded as Green. In agreeing this course of action Members' acknowledged the ongoing work to revise the accountability framework and the requirement for this to be set alongside the governance structures which would be progressed via a forthcoming Board workshop. - Line reference 10 a – update noted. Agreement for the action to remain open, colour coded as Amber. - Line reference 10 b – update noted. Agreement for the action to remain open, colour coded as Amber. - Line reference 12 – Agreement for the action to remain open, colour coded as Amber pending the focus of the PMO moving to transformational activities as opposed to transactional. - Line reference 24 – Agreement for the action to remain open, colour coded as Amber noting that the issues were featured as part of the 2018 Structured Assessment. - **RESOLVED:** **That the Special Measures Improvement Framework Task and Finish Group be informed of feedback as outlined above.**	 DS

AC18/85 Charitable Funds Accounts 2017/18 Members noted the Charitable Funds Accounts for 2017/18 which were to be submitted to the December Charitable Funds Committee for approval together with the Annual Report and Letter of Representation. The Board (as Charitable Trustees) would then formally receive the accounts in January 2019. Wales Audit Office stated that due to the draft nature of the accounts were still technically draft, these should normally be presented in closed 'In Committee' session for future reference. **RESOLVED:** **That the accounts and approval route be noted.**	
AC18/86 Review of Corporate Risk Register The Committee reviewed the Corporate Risk Register and raised concerns that updates following review by other Board Committee meetings had not been shown in the version presented to the Audit Committee. The Board Secretary agreed to review the register with the Executive Team prior to its presentation to the Board in January and for future reports to provide a narrative update on what had changed since the last iteration. Members acknowledged the forthcoming Board Workshop on Risk Management which would discuss risk appetite of the Board, risk ratings and how risks were defined. **RESOLVED:** **That the Board Secretary review the register with the Executive Team prior to its presentation to the Board in January and for future reports to provide a narrative update on what had changed since the last iteration.**	GLP
AC18/87 Legislation Assurance Framework Progress Update The report provided an update on the Legislation Assurance Framework (LAF) and associated processes. Members welcomed the progress being made with positive engagement from key directorates since the last meeting. The work had been shared with the All Wales Board Secretaries Meeting in October and also Cardiff and Vale Internal Audit. Furthermore, following the Law Commission's Recommendations (The Form and Accessibility of the Law Applicable in Wales), the Welsh Government had committed to pursue a programme of (electronic) consolidation and codification of devolved legislation. BCUHB had supplied the list of compiled legislation to the Welsh Government. **RESOLVED: That** **(1) the contents of this report and the current position in respect of the LAF development be noted;** **(2) the further work required to liaise with Divisional Leads; Legislation allocation agreement and assurance criteria completion be noted; and** **(3) items of previous non-compliance now reporting substantial assurance be**	

removed from the next iteration of the report to be presented to the Committee in May 2019.	
AC18/88 Change to Provision of Voting – Welsh Health Specialised Services Committee, Emergency Ambulance Services Committee and NHS Wales Shared Services Partnership Committee Members gave consideration to a letter from the Cabinet Secretary for Health and Social Services which outlined revised criteria for the taking of all decisions by each of the aforementioned Committees. Officers at Welsh Government were in the process of revising the Model Standing Orders to take account of the Cabinet Secretary's decision. In the interim and in line with the Powers of Direction in Sections 12(3) and 19(1) of the National Health Service (Wales) Act 2006, the Board was required to adopt the amendment to the respective Standing Orders with immediate effect as if the revised Standing Orders had been issued. **RESOLVED:** **That the Board be asked to endorse with immediate effect the adoption of the changes to Standing Orders, issued by the Cabinet Secretary for Health and Social Services which outlined revised criteria for the taking of all decisions by WHSSC, EASC and NHS Shared Services Committee. All decisions to be subject to a 2/3 majority of voting Members present. Nominated deputies for LHB Chief Executives to formally contribute to the quorum and have delegated voting rights. Nominated deputies to be Executive Directors of the same organisation.**	DS
AC18/89 Audit Committee Workshop A workshop attended by all Audit Committee members had been held on 30th November 2018. The Workshop had covered financing, Local Counter Fraud, role, responsibilities and programme of work of both Internal and External Audit and Audit Committee effectiveness. Members welcomed the format and endorsed a number of suggestions put forward as part of the discussions which were to be considered by the Board Secretary who would report back to the March meeting of the Committee. Members felt that there would be holding such an event on an annual basis and it was suggested that consideration could also be given inviting the wider Board. **RESOLVED:** **That the Board Secretary consider the feedback and report back to the March Audit Committee meeting as appropriate.**	GLP (DS)
AC18/90 Audit Tracker – National Standards for Cleaning in NHS Wales *(NB this item was taken earlier in the meeting following the discussion of the Wales Audit Office report on Primary Care, to facilitate the attendance of the Director of Estates and Facilities and the Assistant Director of Nursing (Infection Prevention, Nursing, Midwifery and Patient Services).*	

The Committee received an update from the Director of Estates and Facilities and the Assistant Director of Nursing regarding the progress of the remaining actions emanating from the Internal Audit of the National Cleaning Standards for Wales. Audits had continued every other month throughout 2018, and a plan was in place for a phased return to monthly auditing using a risk-based approach in line with National Standards guidance. This was to be implemented from January 2019. Whilst this would not fully meet the audit frequencies in the National Standards in all locations, the risk-based approach would ensure focus on priority areas of higher risk, maximising available resources. The additional resources required to fully meet the audit frequency in the National Cleaning Standards were to be considered as part of the 2019/20 budget setting process. **RESOLVED: That** **(1) the status updates within the audit tracker, in response to recommendations from Internal Audit be noted;** **(2) the decision taken in January 2018 by the Safe Clean Care Programme Board relating to the reduction in audit frequency, and the plan and timescale for introduction of a monthly risk-based audit programme from January 2019 be noted; and** **(3) the additional resources required to fully meet the audit frequency in the National Standards be considered as part of the 2019-20 budget setting process, along with any other cost-pressure subsequently identified.**	
AC18/91 WAO Report on the Collaborative Arrangements for managing local Public Health resources: Programme Closure Report *The Executive Director of Public Health (BCU) joined the meeting via video conferencing for this item.* The Committee received the Public Health Wales Programme Closure report following the WAO Report on the Collaborative Arrangements for managing Public Health resources. The closure report provided an overview of how the programme had operated, the progress made against each of the actions in the management response and what changes had been made since the WAO reported in October 2017. The Committee noted with some concern the review of allocated funding across Wales which would have a £400,000 adverse impact on the North Wales population. The BCU Director of Public Health informed Members that despite discussions at Chief Executive level attempts to reverse this decision had been unsuccessful. **RESOLVED:** **That the closure report be noted.**	
AC18/92 Issues of Significance for reporting to Board. The Chair agreed to prepare his assurance report for the Board.	MH

AC18/93 Date of Next Meeting - 14th March 2018, Carlton Court, St Asaph.	
AC18/94 Exclusion of the Press and Public **RESOLVED: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.**	

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Actions from meeting held on 11.9.18				
Meinir Williams	AC18/59 – WAST IA report on Handover of Care	December	On agenda for March meeting. Briefing update also sent to Chair on 10.12.18.	Close
Dawn Sharp	AC18/65 – Board Assurance Map (BAM) – Document to be refined following outcome of discussions at September Board Workshop.	December	Annual Plan/IMTP timelines changed. BAM and BAF to be presented to May workshop once objectives in Plan agreed by Board.	May 2019 Audit Committee Workshop
Dawn Sharp	AC18/66 – Standards of Business Conduct Policy review	March	Review of Policy underway – to be updated to reflect electronic system modifications which it is hoped will be finished during April.	May 2019 Audit Committee
Adrian Thomas	AC18/81 – Minutes – Clinical Audit Plan –report to be prepared for March meeting on progress with the implementing of the actions in respect of clinical audit following re-examination by ET of the BCU elements of the plan and process going forward, including future presentation, tracking and follow up of recommendations arising, with input from IA as appropriate.	March	Report on agenda for March meeting.	Close
Huw Richards	AC18/82 – IA progress report – update briefing paper on YGC open book to be shared with Members.	January	Briefing note received 31.1.19 and circulated to members on 1.2.19	Close
Dave Harries	AC18/82 – IA report – GP out of hours – despite this being 'assurance not applicable report' recommendations relating to	February	Live on tracker.	Close

	Clinical Audit and Business Continuity – agreed to track these via team central.			
Chris Stockport	AC18/82 – IA report – GPOOH – CS to confirm timelines for the management restructuring relating to OOH Services and business continuity arrangements.	March	To be confirmed.	May 2019
Andrew Doughton	AC18/83 – WAO update – Primary Care Services – Members queried some of the data in the report and AD agreed to clarify outside the meeting.	February	Response from AD circulated to members on 19.12.19	Close
Dawn Sharp	AC18/83 – Relevant recommendations from WAO reports to be tracked via team central.	March	Live on team central tracker	Close
Dawn Sharp	AC18/84 – Special Measures – SMIF to be informed of Committee's feedback	December	Actioned. Feedback presented to SMIF	Close
Grace Lewis-Parry	AC18/86 – CRR – review register with ET prior to presentation to Board in January and future reports to provide narrative update on changes since last presentation	January	Actioned. Report presented to Board.	Close
Dawn Sharp	AC18/88 – SO changes re provision of voting WHSSC, EASC and SSP	January	Actioned. Recommendations made to Board.	Close
Dawn Sharp	AC18/89 – AC Workshop – GLP to consider feedback and report to March meeting	March	Actioned. Report on the agenda.	Close

Medwyn Hughes (Dawn Sharp)	AC18/92 – Chair's Assurance Report to be prepared	October	Complete	Close

NB See last page of document for list of changes made in March 2019

SECTION 2: SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS,

OTHER DIRECTORS AND OFFICERS

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

Delegated Matter	Table Reference No.
STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS	1
MEETINGS	2
FINANCIAL PLANNING/BUDGETARY RESPONSIBILITY	3
BANK/PGO ACCOUNTS (EXCLUDING CHARITABLE FUND ACCOUNTS)	4
EXTERNAL BORROWING	5
NON PAY EXPENDITURE	6
STORES AND RECEIPT OF GOODS	7
CAPITAL INVESTMENT MANAGEMENT	8
QUOTATIONS, TENDERING & CONTRACT PROCEDURES	9
FIXED ASSETS	10
PERSONNEL & PAY	11
ENGAGEMENT OF STAFF (NOT ON THE ESTABLISHMENT)	12
CHARITABLE FUNDS HELD ON LHB	13
PRIMARY CARE PATIENT SERVICES/HEALTHCARE AGREEMENTS	14
INCOME SYSTEMS, FEES & CHARGES	15
DISPOSAL AND CONDEMNATIONS	16
LOSSES, WRITE-OFFS & COMPENSATION AND EX-GRATIA PAYMENTS	17
REPORTING INCIDENTS TO THE POLICE	18
FINANCIAL PROCEDURES	19
AUDIT ARRANGEMENTS	20
LEGAL PROCEEDINGS	21
INSURANCE POLICIES AND RISK MANAGEMENT	22
CLINICAL AUDIT	23
PATIENTS' PROPERTY	24
PATIENTS & RELATIVES COMPLAINTS	25
SEAL	26
GIFTS & HOSPITALITY	27
DECLARATION OF INTERESTS	28
INFORMATICS AND THE DATA PROTECTION ACT	29
RECORDS	30
AUTHORISATION OF NEW DRUGS	31
AUTHORISATION OF RESEARCH PROJECTS	32
AUTHORISATION OF CLINICAL TRIALS	33
INFECTIOUS DISEASES & NOTIFIABLE OUTBREAKS	34

Delegated Matter	Table Reference No.
REVIEW OF FIRE PRECAUTIONS	35
HEALTH & SAFETY	36
MEDICINES INSPECTORATE REGULATIONS	37
ENVIRONMENTAL REGULATIONS	38
LEGAL & RISK PAYMENTS	39
INVESTIGATION OF FRAUD/CORRUPTION OR FINANCIAL IRREGULARITIES	40
COMMERCIAL SPONSORSHIP	41
COSTS/NOTIONAL RENT/THIRD PARTY DEVELOPER/IMPROVEMENT GRANTS	42
FREEDOM OF INFORMATION	43
COMPLIANCE LEAD ROLES: CALDICOTT GUARDIAN, DPO, SIRO	44
EMERGENCY PLANNING	45
NHS ACT 2006 (WALES) SECTION 33 AGREEMENTS	46
STATUTORY COMPLIANCE WITH RESPECTIVE LEGISLATION	47
APPOINTMENT OF MEDICAL & DENTAL CONSULTANT POSTS	48
INDIVIDUAL PATIENT FUNDING REQUESTS	49
CARBON REDUCTION COMMITMENT ORDER	50
HUMAN TISSUE ACT 2004	51
IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS 2017 [IR(ME)R]	52
NURSE STAFFING LEVELS (WALES) ACT 2016	53

Schedule 1

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SCHEME OF RESERVATION
AND DELEGATION OF POWERS

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Table A – Scheme of Delegation to Officers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. Standing Orders / Standing Financial Instructions		
a) Final authority in interpretation of Standing Orders	Chair	Chair
b) Notifying Directors, employees and agents of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Executive Director of Finance/Board Secretary	Directors
c) Responsibility for the security of the LHB's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial Instructions and financial procedures	Executive Director of Finance	Directors
d) Ensuring Standing Orders are compatible with Welsh Government requirements re building and engineering contracts	Chief Executive	Executive Director of Planning & Performance
2. Meetings		
a) Calling meetings of the LHB	Chair	Board Secretary
b) Chair all LHB Board meetings and associated responsibilities	Chair or Vice Chair in Chair's absence	Chair or Vice Chair in Chair's absence
3. Financial Planning/Budgetary Responsibility		
a) Setting:	Chief Executive	Executive Director of Planning & Performance

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Submit Three Year Plan and Annual Operating Plan to the LHB Board		
	Submit budgets to the LHB Board	Chief Executive	Executive Director of Finance
	Submit to Board financial estimates and forecasts	Chief Executive	Executive Director of Finance
b)	Implementing financial policies, plans and procedures, providing advice and co-ordinating any corrective action necessary	Executive Director of Finance	Finance Director (Operational)
c)	Issuing Budgets	Executive Director of Finance	Finance Director (Operational)
d)	Monitoring: Monitor performance against budget	Executive Director of Finance	Directors
	Submit monitoring returns	Chief Executive	Executive Director of Finance
	Effective budgetary control and a balanced budget	Executive Director of Finance	Directors
	Preparation of annual accounts and returns	Executive Director of Finance	Executive Director of Finance
	Identifying and implementing cost improvements and income generation initiatives	Executive Director of Finance	Directors
e)	Authorisation of Virement It is not possible for any officer other than the Executive Director of Finance to vire from non-recurring headings to recurring budgets or from capital to revenue/revenue to capital. Virement between different budget holders (Directors) requires the agreement of both parties and the Executive Director of Finance	Please refer to Table B – Delegated Limits	
f)	Maintaining an effective system of internal financial control	Chief Executive	Executive Director of Finance
g)	Delivery of financial training to budget holders (Directors)	Executive Director of Finance	Finance Director (Operational)
4.	**Bank/PGO Accounts (Excluding Charitable Fund Accounts)**		
a)	Operation: Managing banking arrangements and operation of bank accounts	Executive Director of Finance	Finance Director (Operational)

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Opening bank accounts	Executive Director of Finance	Finance Director (Operational)
	Authorisation of transfers between LHB bank accounts	Executive Director of Finance	Finance Director (Operational)
	Authorisation of: -PGO/GBS Schedules -BACS Schedules -Automated cheque schedules -Manual cheques	Executive Director of Finance	Finance Director (Operational)
b)	Investments: Investment of surplus funds in accordance with the LHB's investment policy	Executive Director of Finance	Finance Director (Operational)
5.	**External Borrowing**		
a)	Advise LHB Board of the requirements to meet payment of interest and originating capital debt	Executive Director of Finance	Finance Director (Operational)
b)	Application for loan(s) and overdrafts	Executive Director of Finance	Finance Director (Operational)
c)	Preparation of procedural instructions	Executive Director of Finance	Finance Director (Operational)
6.	**Non Pay Expenditure**		
For details of Delegated Limits please refer to Table B			
a)	Completion of an Operational Scheme of Delegation and Authorisation by each Budget Holder ensuring maintenance of a list of officers authorised to place requisitions/orders (including emergency verbal orders) and record receipts within the E-Financials Business Suite.	Executive Director of Finance	Directors
b)	Obtain the best value for money when requisitioning goods/services	Executive Director of Finance	Directors
c)	Ensuring expenditure is within budget	Chief Executive	Directors
d)	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive	Executive Director of Finance
e)	Orders exceeding 12 month period	Executive Director of Finance	Finance Director (Operational)

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
f)	Prompt payment of accounts	Executive Director of Finance	Executive Director of Finance
	DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
g)	Financial Limits	Please refer to Table B – Delegated Limits	
h)	Maintenance of sufficient records to explain the LHB's transactions and report on the LHB's financial position	Executive Director of Finance	Executive Director of Finance
i)	Approval of visits at a supplier's expense	Executive Director of Finance	Executive Directors
j)	Provision of electronic signatures within the E-Financials Business Suite in accordance with each Budget Holder's Operational Scheme of Delegation and Authorisation	Executive Director of Finance	Finance Director (Operational)
7.	**Stores and Receipt of Goods**		
a)	Responsibility for the systems of financial control over all stores including receipt of goods and returns	Executive Director of Finance	Directors
b)	Responsibility for the control of stores and receipt of goods, issues and returns: All stores (excluding pharmaceutical, fuel, oil and coal – see following)	Executive Director of Finance	Directors
	Pharmaceutical Stores	Executive Medical Director	Chief Pharmacist
	Fuel, oil and coal stocks	Executive Director of Planning & Performance	Director of Estates & Facilities
c)	Stocktaking arrangements	Executive Director of Finance	Directors
8.	**Capital Investment Management** For details of Delegated Limits for Delegated Matter 8d, please refer to Table B – Leases. In accordance with Welsh Government guidance:		
a)	Programme:		
	Preparation of Capital Investment Programme	Chief Executive	Executive Director of Planning & Performance
	Completion and signing off of a business case for approval	Chief Executive/Executive Director of Finance	Executive Director of Planning & Performance
	Appointment of Project Directors	Chief Executive	Executive Director of Planning & Performance

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
			with support from relevant Directors
	Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Executive Director of Planning & Performance	Executive Director of Finance/Executive Director of Planning & Performance with support from relevant Directors.
	Issuing of guidance on management of capital schemes	Executive Director of Planning & Performance	Executive Director of Finance/Executive Director of Planning & Performance
b)	Contracting – Selection of 3rd party developers, architects, quantity surveyors, consultant engineers and other professional advisors within EC regulations and LHB tender procedures	Chief Executive	Executive Director of Planning & Performance
c)	Private Finance – Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector	Chief Executive	Executive Director of Finance
d)	Leases – Granting and termination of leases	Chief Executive	Executive Director of Planning & Performance/Executive Director of Finance
e)	Financial control and audit- Arrangements are in place to review building and engineering contracts and property transactions comply with Welsh Government guidance.	Chief Executive	Executive Director of Finance with Executive Director of Planning & Performance responsible for the technical audit of the contracts.
9.	**Quotations, Tendering & Contract Procedures** For details of Delegated Limits, please refer to Table B – Quotations/Tenders.		
a)	Services:		
	Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Directors
	Nominate officers to oversee and manage the contract on behalf of the LHB	Chief Executive	Directors
b)	Quotations – Total value of the contract over its entire period:		
	Seeking quotations up to £5,000 in value	Executive Director of Finance (per SFI 11.7.1)	For details of delegated limits, please refer to Table B

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Obtaining minimum of 3 written quotations for goods/services of value between £5,000 and £25,000	Chief Executive (per SFI 11.1.2)	For details of delegated limits. Please refer to Table B
c)	Competitive Tenders – Total value of the contract over its entire period:		
	Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and the OJEU threshold (in compliance with EC Directives as appropriate)	Chief Executive	For details of delegated limits, please refer to Table B
	Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of the OJEU threshold (in compliance with EC Directives as appropriate)	Chief Executive	For details of delegated limits, please refer to Table B
	Receipt and custody of tenders prior to opening	Chief Executive	Executive Director of Finance
	Opening Tenders and Quotations	Chief Executive	Executive Director of Finance
	Decide if late tenders should be considered	Chief Executive	Executive Director of Finance
d)	Waiving the requirement to request quotes or tenders – subject to SFI Schedule 1 Para. 4.2 & 4.3 – Formally reported to the Audit Committee	Chief Executive	Chief Executive/nominated deputy (Board Secretary or Executive Director of Finance). Where the budget holder requesting the waiver is the Chief Executive/Board Secretary/Executive Director of Finance, they cannot approve their own waiver and must seek approval from one of the other two delegated officers.
10. Fixed Assets			
a)	Maintenance of asset register	Chief Executive	Executive Director of Finance supported by relevant Director
b)	Calculate and pay capital charges in accordance with Welsh Government requirements	Executive Director of Finance	Executive Director of Finance
c)	Responsibility for fixed assets – Land & Buildings	Chief Executive	Executive Director of Planning & Performance

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
d)	Responsibility for all other fixed assets (Plant, Machinery, Transport, IT assets including software, Furniture & Fittings)	Chief Executive	Directors
	DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
e)	Responsibility for security of LHB assets including notifying discrepancies to the Director of Finance and reporting losses in accordance with LHB procedures	Chief Executive	Directors
	11. Personnel & Pay		
a)	Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts in accordance with the "Policy for the Safe Recruitment and Selection Practices" together with accompanying guidance, particularly the need for pre-employment checks.	Chief Executive	Executive Director of Workforce & OD
b)	Approve the commencement of employment prior to all pre-employment checks being completed.	Executive Director of Workforce & OD	Executive Director of Workforce & OD
c)	Authority to fill funded post on the establishment with permanent staff.	Executive Director of Workforce & OD	Directors
d)	Authority to extend Locum appointments	Chief Executive	Interim Managing Directors, Mental Health Director and Area Directors for appointments over 12 months to 24 months. Executive Director of Nursing & Midwifery, Executive Director of Primary & Community Care, Executive Director of Therapies & Health Sciences and Executive Director of Workforce & OD/Director of MHLD for appointments over 24 months to 36 months only.
e)	The granting of additional increments to staff within budget in accordance with Terms & Conditions of Service	Executive Director of Workforce & OD	Directors with advice from Executive Director of Workforce & OD
f)	All requests for upgrading/ regrading/ major skill mix changes shall be dealt with in accordance with LHB Procedure	Executive Director of Workforce & OD	Directors with advice from Executive Director of Workforce & OD
g)	Authority to agree acting up salaries for staff other than Executive Directors (Approval of acting up salaries for interim Executive Directors to be	Chief Executive to agree acting up arrangements of Band 9 and above (Excluding Executive Directors)	Directors lead for acting up salaries up to Band 8d or equivalent.

	retained by Remuneration & Terms of Service Committee)		
h)	Establishments:		
	Additional staff to the agreed establishment with specifically allocated finance	Chief Executive	Directors with approval from Executive Director of Finance
	DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
	Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Executive Director of Finance
	Variation to the funded establishment	Chief Executive	Directors with approval from Executive Director of Finance
i)	Pay		
	Authority to complete standing data forms effecting pay, new starters, changes and leavers	Executive Director of Workforce & OD	Directors
	Authority to complete and authorise timesheets and payroll returns	Executive Director of Workforce & OD	Directors
	Authority to authorise overtime	Executive Director of Workforce & OD	Directors
	Authority to authorise travel & subsistence expenses	Executive Director of Workforce & OD	Directors
	Maintenance of a list of managers authorised to sign payroll and travel expense documentation.	Executive Director of Workforce & OD	Directors
j)	Leave		
	Approval of annual leave in accordance with LHB policy	Executive Director of Workforce & OD	Executive Director of Finance
	Carry over of annual leave in exceptional circumstances up to a maximum of 5 days	Executive Director of Workforce & OD	Directors
	Compassionate leave	Executive Director of Workforce & OD	Directors
	Special leave arrangements (to be applied in accordance with LHB Policy)	Executive Director of Workforce & OD	Directors
	Leave without pay	Executive Director of Workforce & OD	Directors
	Medical Staff Leave of Absence – paid and unpaid	Executive Director of Workforce & OD	Directors

Consultants Special Leave	Executive Medical Director	Directors
Time off in lieu	Executive Director of Workforce and OD	Directors
Maternity Leave – paid and unpaid	Executive Director of Workforce & OD	Directors
DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
k) Annualised hours/flexible working hours system- maintenance of adequate records	Executive Director of Workforce & OD	Directors
l) Sick Leave		
Extension of sick leave on half pay up to three months	Executive Director of Workforce & OD	Directors in conjunction with Executive Director of Workforce & OD
Return to work part-time on full pay to assist recovery	Executive Director of Workforce & OD	Directors in conjunction with Executive Director of Workforce & OD
Extension of sick leave on full pay	Executive Director of Workforce & OD	Directors in conjunction with Executive Director of Workforce & OD
m) Study Leave		
Study leave outside the UK (non-medical staff excluding clinical staff)	Executive Director of Workforce & OD	Directors
Medical staff study leave (UK)	Executive Medical Director/Executive Director of Workforce & OD/ Executive Director of Primary & Community Care	Directors
Consultant Medical Staff Leave (UK)	Executive Medical Director	Directors
All Medical and non-Medical Clinical Staff study leave outside the UK	Executive Medical Director/Executive Director of Nursing & Midwifery/Executive Director of Therapies & Health Science/Executive Director of Primary & Community Care	Directors
All other study leave (UK)	Executive Director of Workforce & OD	Directors
n) Removal Expenses		

	Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Executive Director of Workforce & OD	Directors in accordance with BCU HB policy/approval from the Executive Director of Workforce & OD
o)	Grievance Procedure	Executive Director of Workforce & OD	Directors
p)	Professional Misconduct/Competence- Medical and Dental Staff	Executive Medical Director/Executive Director of Workforce & OD	Assistant Medical Directors supported by Workforce & OD
	DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
q)	Suspension of Doctors employed directly by the LHB	Chief Executive	Executive Medical Director supported by Executive Director of Workforce & OD
r)	Removal of Practitioner from the Performers List	Chief Executive	Executive Medical Director supported by Executive Director of Workforce & OD and Executive Director of Primary & Community Care
s)	Requests for new posts to be authorised as car users	Executive Director of Finance	Directors
t)	Renewal of Fixed Term Contract	Executive Director of Workforce & OD	Directors
u)	Voluntary Early Release Scheme	Executive Director of Workforce & OD	Executive Director of Workforce & OD, with Executive Director of Finance for sign off of financial viability
v)	Settlement on termination of employment	Executive Director of Workforce & OD	Executive Director of Workforce & OD with approval from Welsh Government where the payment is Ex-gratia and exceeds the delegated limit of £50,000
w)	Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from Workforce & OD Department	Executive Director of Workforce & OD	Executive Director of Workforce & OD
x)	Disciplinary Procedure(excluding Executive Directors)	Executive Director of Workforce & OD	Directors
	12. Engagement of Staff Not On the Establishment		

		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	For details of Delegated Limits, please refer to Table B		
a)	Non clinical Consultancy Staff	Executive Director of Finance	Director accountable for relevant service
b)	Medical Locum staff	Executive Medical Director	Director accountable for relevant service.
c)	Booking of Agency Nursing Staff	Executive Director of Nursing & Midwifery	Director accountable for relevant service
d)	Booking of Bank Staff:		
	DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
	Nursing	Executive Director of Nursing & Midwifery	Director accountable for relevant service
	Other	Executive Director of Workforce & OD	Director accountable for relevant service
13.	**Charitable Funds Held on Trust**		
	For details of Delegated Limits, Please refer to Table B		
a)	Management: Funds held on Trust are managed appropriately	Executive Director of Finance	Directors
b)	Maintenance of authorised signatory list of Authorised Fund Holders	Executive Director of Finance	Executive Director of Finance
c)	Expenditure	Refer to Table B - Delegated Limits	
d)	Fundraising Appeals – Preparation/Monitoring/Reporting progress and performance	Executive Director of Finance	Executive Director of Finance
e)	Operation of Bank Accounts:		
	Managing banking arrangements and operation of bank accounts	Executive Director of Finance in conjunction with Corporate Trustees	Executive Director of Finance
	Opening bank accounts	Board	Executive Director of Finance
f)	Investments – Policy and Arrangements	Executive Director of Finance in conjunction with Corporate Trustees	Executive Director of Finance
g)	Authority to accept the discharge of a donor's estate	Executive Director of Finance	Executive Director of Finance

	14. Primary Care Patient Services/ Healthcare Agreements For details of Delegated Limits, please refer to Table B – Healthcare Agreements		
a)	Contract negotiation and provision of service agreements	Executive Director of Finance / Executive Director of Primary & Community Care	Executive Director of Planning & Performance
b)	Reporting actual and forecast contract income	Executive Director of Finance	Executive Director of Finance
	DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
c)	Pricing of all contracts and SLAs	Executive Director of Finance	Executive Director of Finance with relevant Director
d)	Signing agreements	Chief Executive	Chief Executive or Executive Director of Finance in Chief Executive's absence/Executive Director of Primary & Community Care for all primary care related agreements
	15. Income Systems, Fees and Charges		
a)	Private Patients, Overseas Visitors, Income Generation and other patient related services	Executive Director of Finance	Executive Director of Finance
b)	Pricing of NHS agreements	Executive Director of Finance	Assistant Directors of Finance
c)	Informing the Director of Finance of monies due to the LHB	Executive Director of Finance	Directors
d)	Recovery of debt	Executive Director of Finance	Executive Director of Finance
e)	Security of cash and other negotiable instruments	Executive Director of Finance	Executive Director of Finance and all Directors
f)	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due	Executive Director of Finance	Director of Finance (Operational)
g)	Non patient care income	Executive Director of Finance	Executive Director of Finance
	16. Disposal and Condemnations		

	Disposal of all property and land require formal approval by the Cabinet Secretary for Health, Well-Being & Sport		
a)	Issuing procedure for the disposal of assets obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	Executive Director of Finance	Executive Director of Finance/Executive Director of Planning & Performance
b)	Notification to Director of Finance prior to disposal	Executive Director of Finance	Directors
	DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
	17. Losses, Write-offs & Compensation		
a)	Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response plan and informing Counter Fraud Operational Services of frauds.	Chief Executive	Executive Director of Finance
b)	Losses of cash due to theft, fraud, overpayment of salaries, fees, allowances & other causes up to £50,000	Chief Executive	Executive Director of Finance
c)	Fruitless payments (including abandoned Capital Schemes) up to £250,000	Chief Executive	Executive Director of Finance
d)	Bad debts and claims abandoned: Private patients; overseas visitors & other cases up to £50,000	Chief Executive	Executive Director of Finance
e)	Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other up to £50,000	Chief Executive	Executive Director of Finance
f)	For personal and public liability claims, under the Legal & Risk scheme, authorisation from Legal & Risk is required before admissions may be made and monetary compensation offered. (Ex-gratia settlements offered by the LHB are by definition not payments based upon legal liability and are, therefore, not reimbursable under the WRP scheme)	Chief Executive	Executive Director of Nursing & Midwifery supported by the relevant Director after seeking appropriate legal advice, up to a max £150,000
g)	Compensation payments made under legal obligation:	Chief Executive	Chief Executive, Executive Director of Finance or

		Executive Director of Nursing & Midwifery
h) Extra contractual payments to contractors – Up to £50,000 as specified within the Losses and Special Payments Manual of Guidance	Chief Executive	Executive Director of Finance with reporting to the Audit Committee
17.1 Ex-Gratia Payments:		
a) Patients and staff for loss of personal effects up to £50,000	Chief Executive	Executive Director of Finance- Refer to Finance Policy on Losses and Special Payments
DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
b) For clinical negligence up to £250,000 (negotiated settlements)*. Report to Board > £50,000 (see also table B para.15)	Chief Executive	Executive Director of Finance/Executive Director of Nursing & Midwifery
c) For clinical negligence over £250,000 and up to £1,000,000* (negotiated settlements). Report to Board> £50,000 (see also table B para.15)	Chair	Chief Executive/ Executive Director of Finance/Executive Director of Nursing & Midwifery
d) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £250,000 (including plaintiff's costs) Report to Board > £50,000	Chief Executive	Chief Executive/ Executive Director of Finance/Executive Director of Workforce & OD/ Executive Director of Nursing & Midwifery
e) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £1,000,000 Report to Board > £50,000*	Board	Chief Executive/Executive Director of Finance/Executive Director of Nursing & Midwifery
f) Other, except cases for maladministration where there was no financial loss by claimant, up to £50,000	Chief Executive	Executive Director of Finance/Executive Director of Nursing & Midwifery
* For all clinical negligence and personal injury cases(including Court cases) the use of structured settlements should be considered involving costs to the NHS of £250,000 or more – All structured settlements require approval from the Welsh Government		
18. Reporting of Incidents to the Police		
a) Where a criminal offence is suspected		
Criminal offence of a sexual or violent nature	Chief Executive	Executive Director of Workforce & OD

	Arson or theft	Executive Director of Planning & Performance	Director of Estates & Facilities
	Other	Executive Director of Planning & Performance	Director of Estates & Facilities
19.	**Financial Procedures**		
a)	Maintenance & Update of LHB Financial Procedures	Executive Director of Finance	Executive Director of Finance
20.	**Audit Arrangements**		
	DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
a)	Review, appraise and support in accordance with Internal Audit standards for NHS Wales and best practice	Chair of the Audit Committee	Board Secretary/Head of Internal Audit
b)	Provide an independent and objective view on internal control and probity	Chief Executive	Head of Internal Audit/Wales Audit Office
c)	Ensure Cost-effective external audit	Chair of Audit Committee	Executive Director of Finance
d)	Ensure an adequate internal audit service	Chief Executive	Board Secretary
e)	Implement recommendations	Chief Executive	All relevant Directors
21.	**Legal Proceedings**		
a)	Engagement of LHB's Solicitors	Chief Executive	Board Secretary for all Board related matters/Executive Director of Workforce & OD for all employment related matters/Executive Director of Planning & Performance for all estate related matters/Executive Director of Primary & Community Care for all Primary Care related matters.
b)	Approve and sign all documents which will be necessary in legal proceedings	Chief Executive	Any Director of the Board or an officer formally nominated by the Chief Executive
c)	Sign on behalf of the LHB any agreement or document not requested to be executed as a deed	Chief Executive	Any Director of the Board or an officer formally nominated by the Chief Executive

22. Insurance Policies and Risk Management	Chief Executive	Executive Director of Finance/Board Secretary
23. Clinical Audit	Chief Executive	Executive Director of Therapies & Health Science
24. Patients' Property (in conjunction with financial advice)		
For details of Delegated Limits, please refer to Table B – Petty Cash/Patients Monies		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Executive Director of Nursing & Midwifery	Directors
b) Prepare detailed written instructions for the administration of patients' property	Executive Director of Nursing & Midwifery	Executive Director of Finance
c) Informing staff of their duties in respect of patients' property	Executive Director of Nursing & Midwifery	Directors
d) Issuing property valued >£5,000 only on production of a probate letter of administration	Executive Director of Finance	Executive Director of Finance
25. Patients & Relatives Complaints		
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Executive Director of Nursing & Midwifery
b) Responsibility for ensuring complaints are investigated thoroughly	Chief Executive	Executive Director of Nursing & Midwifery
c) Medical – Legal Complaints Co-ordination of their management	Chief Executive	Executive Director of Nursing & Midwifery
26. Seal		
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Board Secretary
b) Attestation of seal in accordance with Standing Orders	Chief Executive/Chair	Board Secretary
27. Gifts and Hospitality		
a) Keeping of gifts and hospitality register	Chief Executive	Board Secretary
28. Declaration of Interests		

a) Maintaining a register	Chief Executive	Board Secretary
29. Informatics and the Data Protection Act		
a) Review of LHB's compliance with the Data Protection Act	Chief Executive	Board Secretary
DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
b) Responsibility for Informatics policy and strategy	Executive Medical Director	Chief Information Officer
c) Responsibility for ensuring that adequate management (audit) trails exist in Informatics systems	Executive Medical Director	Chief Information Officer
30. Records		
a) Review LHB's compliance with the Retention of Records Act and guidance	Chief Executive	Board Secretary / Executive Medical Director
b) Approval for the destruction of records	Chief Executive	Board Secretary / Executive Medical Director
c) Ensuring the form and adequacy of the financial records of all departments	Executive Director of Finance	Executive Director of Finance
31. Authorisation of New Drugs	Chief Executive	Executive Medical Director on the advice of the appropriate professional bodies
32. Authorisation of Research Projects	Executive Medical Director	Director of Research & Development
33. Authorisation of Clinical Trials	Chief Executive	Executive Medical Director
34. Infectious Diseases & Notifiable Outbreaks	Chief Executive	Executive Director of Public Health
35. Review of Fire Precautions	Chief Executive	Executive Director of Planning & Performance
36. Health & Safety		
Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Executive Director of Workforce & OD
37. Medicines Inspectorate Regulations		

Review Regulations Compliance	Chief Executive	Executive Medical Director supported by Chief Pharmacist
DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
38. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Executive Director of Planning & Performance
39. Legal & Risk Payments	Chief Executive	Executive Director of Nursing & Midwifery/Executive Director of Finance
40. Investigation of Fraud/Corruption or Financial Irregularities	Executive Director of Finance	Lead Local Counter Fraud Specialist
41. Commercial Sponsorship		
Agreement to proposal in accordance with BCU HB procedures	Chief Executive	Executive Director of Finance
42. Cost/Notional Rent/Third Party Developer/Improvement Grants		
Approval of all schedules of payments	Chief Executive	Executive Director of Primary & Community Care
Submission to Welsh Government for all new GP premises or major extensions in accordance with BCU HB Primary Care Estates Strategy	Chief Executive	Executive Director of Primary & Community Care
43. Freedom of Information	Chief Executive	Board Secretary
44. Compliance Lead Roles:		
a) **Caldicott Guardian**	Executive Medical Director	Senior Associate Medical Director
b) **Data Protection Officer**	Chief Executive	Assistant Director of Information Governance and Assurance
c) **Senior Information Risk Owner**	Chief Executive	Board Secretary
45. Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)	Chief Executive	Executive Director of Planning & Performance

46. National Health Services (Wales) Act 2006 Section 33 Agreements: Arrangements between NHS Bodies and Local Authorities	Chief Executive	Executive Director of Finance
47. Statutory compliance with respective Legislation	Chief Executive	Board Secretary
DELEGATED MATTER	**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
48. National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 (Statutory Instrument 2005: 3039) Appointment of all Medical and Dental Consultant posts. Consultant posts within Public Health that are open to both medically qualified and those qualified in other disciplines other than medicine should follow this process, even though they fall outside of the requirements of the Statutory Instrument.	Chief Executive	Board level directors
49. All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR)	Chief Executive	WHSSC IPFR Panel £300,000 to £1,000,000; Chief Executive up to £299,999; Chair and Vice Chair of Health Board IPFR Panel together sign up to £125,000
* The IPFR Panel cannot make policy decisions for the health board. Any policy proposals arising from their considerations and decisions must be reported to the Health Board Quality, Safety & Experience Committee		
50. Carbon Reduction Commitment Order (Phase 2) Agency Registration	Chief Executive	Executive Director of Planning and Performance
51. Human Tissue Act 20014	Chief Executive	Executive Director of Therapies & Health Sciences
52. Ionising Radiation (Medical Exposure) Regulations 2017	Chief Executive	Executive Director of Therapies & Health Sciences
53. Nurse Staffing Levels Act (Wales) 2016	Chief Executive	Executive Director of Nursing & Midwifery

Table B – Scheme of Financial Delegation

Financial Limits are subject to funding available within relevant budget(s) and are inclusive of VAT irrespective of recovery arrangements.

All purchases must ensure compliance with Standing Financial Instruction Schedule 1 -
Procurement of Works, Goods and Services with regard to the required quotation or Tendering exercise.

Any expenditure approval must be within funding limits of approved budgets.
Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.
Executive Directors and Directors, Area Directors, and Hospital Care Directors to determine scheme of delegation within their structures.

	Budget changes	General expenditure	Healthcare agreements	Capital (Business Case and Contractual Commitment approvals)			Specialist				Charitable Funds		Procurement waivers	Staffing	
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establish't)	Agency and Waiting List Initiatives (all values)
WG (In advance of contract planning)	No requirement	£1m plus	£1m plus (Private sector)	£1m plus	£1m plus	£1m plus	No requirement	£1m plus	See Manual of Guidance for losses and SFIs, as special rules apply for certain losses and ex gratia payments.	No requirement	No requirement	No requirement	No requirement	No requirement	No requirement
Board following Chief Executive approval	£1m plus	£1m plus	Over £10m approved in advance, below £10m retrospectively reported. Over £1m for Private sector.	£1m plus	£1m plus	£1m plus	£0.5m plus or any which need signing under seal (Reservation of Power, Number 33)	£0.5m plus		£1m plus	No requirement	No requirement	No requirement	No requirement	No requirement
Audit Committee													Retrospective reporting		
Charitable Funds Committee (all Executives can authorise use of charitable funds up to £5k)											Over £5k (Up to £25k scrutinised by CF Advisory Group)	Over £5k (Up to £25k scrutinised by CF Advisory group)			
CEO through Executive Team	£0.5m to £1m	£0.5m to £1m	New or contract variation to £10.0m.	£0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£250k to £0.5m	£250k to £0.5m	£0.5m to £1.0m	£0.5m to £1.0m	Up to £5k	Up to £5k	As escalated by DoF	Can approve new posts across LHB	No requirement
Any 2 of CEO, Director of P&P and DoF (must include DoF)		Up to £0.5m	New or contract variation to £5.0m. (to £1m for Private sector).					Up to £250k		Up to £0.5m			As escalated by DoF		
Executive Director of Finance	Up to £0.5m	Up to £250k		Up to £0.5m	Up to £0.5m	Up to £0.5m	Up to £250k	Up to £100k	Up to £0.5m		Up to £5k	Up to £5k	As escalated by FD: OF	Can approve new posts within own structure.	Must approve in advance in own structure.

	Budget changes	General expenditure	Healthcare agreements	Capital (Business Case and Contractual Commitment approvals)			Specialist				Charitable Funds		Procurement waivers	Staffing	
							Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Area Directors, and Hospital Care Directors to determine scheme of delegation within their structures.								
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy support(individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establish'nt)	Agency and Waiting List Initiatives (all values)
Executive Directors, Board Secretary, Director of Mental Health and Learning Disabilities (unless noted below)		Up to £250k						Up to £100k					Waivers must be approved by FD: OF and Exec.Director of Finance or Chief Executive if escalated by FD: OF	Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Primary Cty Care		Up to £250k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Planning & Performance		Up to £250k		Up to £0.5m	Up to £0.5m		Up to £250k	Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Medical Director		Up to £250k				Up to £0.5m		Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of W&OD		Up to £250k						Up to £100k	Terminations up to £50k (over this to WG)					Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Nursing & Midwifery		Up to £250k						Up to £100k	Up to £150k					Can approve new posts within own structure.	Must approve in advance in own structure.

	Budget changes	General expenditure	Healthcare agreements	Capital			Specialist				Charitable Funds		Procurement waivers	Staffing	
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations only approved by Exec Director of W&OD; VERS require RATS Committee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)
Area Directors and Director of Mental Health & Learning Disabilities		Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med Mgt Group	Up to £5k			Can approve new posts within own team.	As escalated by Direct Reports*
Area Medical Director															Medical staff*
Area Nurse Directors															Nurse or other staff*
Secondary Care Medical Director		Up to £150k			Up to £150k			Up to £150k			Up to £5k				Medical staff*
Secondary Care Nurse Director		Up to £150k			Up to £150k			Up to £150k			Up to £5k				Nurse or other staff*
Interim Managing Directors		Up to £150k			Up to £150k			Up to £50k			Up to £5k			Can approve new posts within own team.	As escalated by Direct Reports*
Director of Estates & Facilities		Up to £150K		Up to £150K	Up to £150K			Up to £50K							
Hospital: Assistant Medical Director															Medical staff*
Hospital: Assistant Nurse Director															Nurse or other staff*
Procurement (NWSSP)													All signed off by Procurement		

Any expenditure approval must be within funding limits of approved budgets.
Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.
Executive Directors and Directors, Area Directors, and Hospital Care Directors to determine scheme of delegation within their structures.

	Budget changes	General expenditure	Healthcare agreements	Capital			Specialist				Charitable Funds		Procurement waivers	Staffing	
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations only approved by Exec Director of W&OD; VERS require RATS Committee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)
Deputy Director (Concerns)		Up to £75k							Up to £75k						
Deputy / Assistant Director Board Secretary		Up to £75k													
Assistant Director Primary Care		Up to £75k	Up to £75k		Up to £75k			Up to £75k			Up to £5k				
Assistant Director Community Hospital Services		Up to £75k	Up to £75k		Up to £75k			Up to £75k			Up to £5k				
Assistant Director Secondary Care		Up to £75k	Up to £75k		Up to £75k			Up to £75k			Up to £5k				
Head of Investigations and Redress									Up to £20k						
Claims Managers									Up to £5k						
Authorised fund holder (Charitable Funds)											Up to £5k				

Any expenditure approval must be within funding limits of approved budgets.
Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.
Executive Directors and Directors, Area Directors, and Hospital Care Directors to determine scheme of delegation within their structures.

	Budget changes	General expenditure	Healthcare agreements	Capital						Specialist				Charitable Funds			Procurement waivers	Staffing	
				Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Area Directors, and Hospital Care Directors to determine scheme of delegation within their structures.															
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy support(individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations only approved by Exec Director of W&OD; VERS require RATS Committee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)				
Medicines Management Group										All new drugs, unless cheaper than existing									

* Agency and Waiting List Initiatives must generally be approved in advance. However, in exceptional circumstances when staff are required out of hours, they can be approved retrospectively.

This scheme only relates to matters delegated by the Board to the Chief Executive and Directors, together with certain other specific matters referred to in Standing Financial Instructions. Each Director is responsible for delegation within their department. They should produce an Operational Scheme of Delegation and Authorisation for matters within their department, which should also set out how departmental budget and procedures for approval of expenditure are delegated.

Updated Master SoRD 2018 19 v0.05

Summary of SoRD Amendments made in March 2019

Page / Section	Nature of Amendment
Page 2 (index)	Table ref. 44 now includes reference to Date Protection Officer (DPO) and Senior Information Risk Owner (SIRO)
Page 2 (index)	Mental Health Act sections deleted (not part of Model Standing Orders)
Page 2 (index)	Added Human Tissue Act, IR(ME)R and Nurse Staffing Levels (Wales) Act at lines 51,52 and 53,
Various	All references to 'Chairman' throughout the document now read 'Chair'
Various	All references to 'Chief Operating Officer' (COO) deleted and replaced by Executive Director of Planning & Performance or Executive Director of Primary & Community Care, or other Executive as noted (see tracked changes)
Various	All references to Executive Director of Strategy deleted and replaced with Executive Director of Planning & Performance
2a	Deleted Executive Director of Finance from operational responsibility column
6b	Executive Director of Finance replaced by 'Directors' in the operational responsibility column

6i	Executive Director of Finance replaced by 'Executive Directors' in operational responsibility column
11d	Added Executive Director of Nursing & Midwifery and Executive Director of Primary & Community Care to operational responsibility column; replaced 'Hospital Directors' with 'Interim Managing Directors'. Reference to Secondary Care Director deleted.
11m	Study leave (medical staff UK) and all medical and non-medical clinical staff outside UK – Executive Director of Primary & Community Care added to 'delegated to' column
12 a and c	'Delegated to' column amended from COO to Executive Director of Finance and Executive Director of Nursing & Midwifery respectively
12d	'Nursing' – 'delegated to' column changed from COO to Executive Director of Nursing & Midwifery
12d	'Other' - 'delegated to' column changed from COO to Executive Director of Workforce & OD
18a	'Criminal offence of a sexual or violent nature' – operational responsibility column changed from COO to Executive Director of Workforce & OD
18a	'Arson or theft' – 'delegated to' column changed from Director of Estates & Facilities to Executive Director of

	Planning & Performance. 'Operational responsibility' column changed from Directors to Director of Estates and Facilities
18a	'Other' – 'delegated to' column changed from Director of Estates and Facilities to Executive Director of Planning & Performance. 'Operational responsibility' column changed from Directors to Director of Estates and Facilities
24 a b c	'Delegated to' column changed from COO to Executive Director of Nursing & Midwifery
27a	Operational responsibility column amended to read 'Board Secretary'
28a	Operational responsibility column amended to read 'Board Secretary'
29 (old)	Reference to Data Protection Act subject access fee deleted (no longer exists)
29 (new) b c	Operational responsibility column changed from Assistant Director of Informatics to Chief Information Officer
30 a b	Executive Medical Director added to Operational responsibility column
36	Operational responsibility column changed from COO to Executive Director of Workforce & OD
44	Delegated matter column title amended to 'Compliance Lead Roles' and DPO and SIRO added

44a	Operational responsibility column changed from Deputy Medical Director to Senior Associate Medical Director
44 b c	New delegated to and operational responsibility columns added and populated
46	Operational responsibility column changed from COO to Executive Director of Finance
48	Operational responsibility column now reads 'Board level Directors'
51 onwards	Mental health legislation fields deleted (not in Model Standing Orders). Human Tissue Act, IR(ME)R and Nurse Staffing Levels (Wales) Act added.
Table B	Job titles and financial limits amended as per tracked changes; Director of Estates & Facilities added. References to Secondary Care Director deleted. 'Hospital Directors' replaced by 'Interim Managing Directors'. 'Charitable Funds Committee' in first column amended to add '(all Executives can authorise use of charitable funds up to £5k)'.

Audit Committee **14.3.19**	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
	To improve health and provide excellent care

Title:	**Summary of In Committee business to be reported in public**
Author:	Dawn Sharp, Assistant Director and Deputy Board Secretary
Responsible Director:	Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Purpose of report:	Standing Order 6.5.3 requires the Committee to formally report any decisions taken in private session to the next meeting of the Committee in public session.
Approval / Scrutiny Route Prior to Presentation:	The issues listed below were considered by the Audit Committee at its private in committee meeting of 11.12.18.
Governance issues/risks:	Issues were considered as follows: • Financial Conformance Report • Counter Fraud Progress Report • Update on Internal and External Audit Actions
Financial Implications:	Not applicable
Recommendations:	The Committee are asked to note the report.

Health Board's Well-being Objects *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity			

7.To listen to people and learn from their experiences		

Special Measures Improvement Framework Theme/Expectation addressed by this paper
Governance and Leadership

Equality Impact Assessment
Not applicable

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

To improve health and provide excellent care

Title:	**WAST Internal Audit Handover of Care – Progress Update of BCU Management Response**
Author:	Meinir Williams
Responsible Director:	Meinir Williams
Public or In Committee	Public
Purpose of report:	This report is intended to update the UHBs Audit Committee on the progress made against the action plan developed in response to the Welsh Ambulance Services Trust (WAST) internal audit on Ambulance Handovers at Emergency Departments 2017/18.
Approval / Scrutiny Route Prior to Presentation:	No prior scrutiny
Governance issues/risks:	As detailed in the report
Financial Implications:	Not applicable
Recommendations:	The Committee are asked to note the update

Health Board's Well-being Objective*s* *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	WFGA Sustainable Development Principle *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper
Governance and Leadership
Equality Impact Assessment
Not applicable

Welsh Ambulance Services NHS Trust, Handover of Care at Emergency Departments Internal Audit 2017/18

Update Report to BCUHB Audit Committee on Management Response and Action Plan – March 2019

Situation

This report is intended to update the UHBs Audit Committee on the progress made against the action plan developed in response to the Welsh Ambulance Services Trust (WAST) internal audit on Ambulance Handovers at Emergency Departments 2017/18.

The UHB submitted a management response to the WAST audit in September 2018 in the form of an action plan, attached in appendix 1.

The action plan was updated in December 2018 and circulated to BCUHB Audit Committee members out of committee. The attached plan has been further updated to reflect the March 2019 position.

Background

In 2017/18, the UHB experienced large numbers of patients being delayed in ambulances outside of our Emergency Departments (EDs). This was further compounded by the length of the delays experienced by patients, often in excess of 7 hours.

The impact of this was twofold; demonstrable harm being caused to patients who were held in ambulances awaiting handover where pressure area care, hydration and nutritional needs were being compromised and clinical interventions being delayed, sometimes with catastrophic outcomes. In addition, the critical risk to our communities due to ambulance resources being delayed resulted in catastrophic harm to patients needing time critical, lifesaving emergency care .

The UHB reported 43 incidents in 2017/18 directly related to delays in ambulance handover, 5 of which were subject to Regulation 28.

Assessment

Prior to receiving the WAST Internal Audit, the UHB had already undertaken to address the risk posed by delayed ambulance handover, and collaboration with WAST local teams was well underway.

The audit and the subsequent report was timely in so far as it helped to consolidate what the UHB believed were the key themes and risks associated with delayed handover.

The action plan developed in response to the WAST Audit became the bedrock which informed the first cycle of the UHBs 90 day Unscheduled Care Improvement Plan.

Improvement in context

It is pleasing to report the impact of the work done to eradicate the trend of delayed ambulance handover. Though the UHB is not yet in a place where delays of >60minutes are considered a 'Never Event', the chart below describes the significant reduction which is being sustained month on month across the 3 EDs.

Chart 1.0 – Depicts the reduction in the number of patients delayed in an ambulance for 60 minutes or more between November to February 2017/18 compared to the same period 2018/19
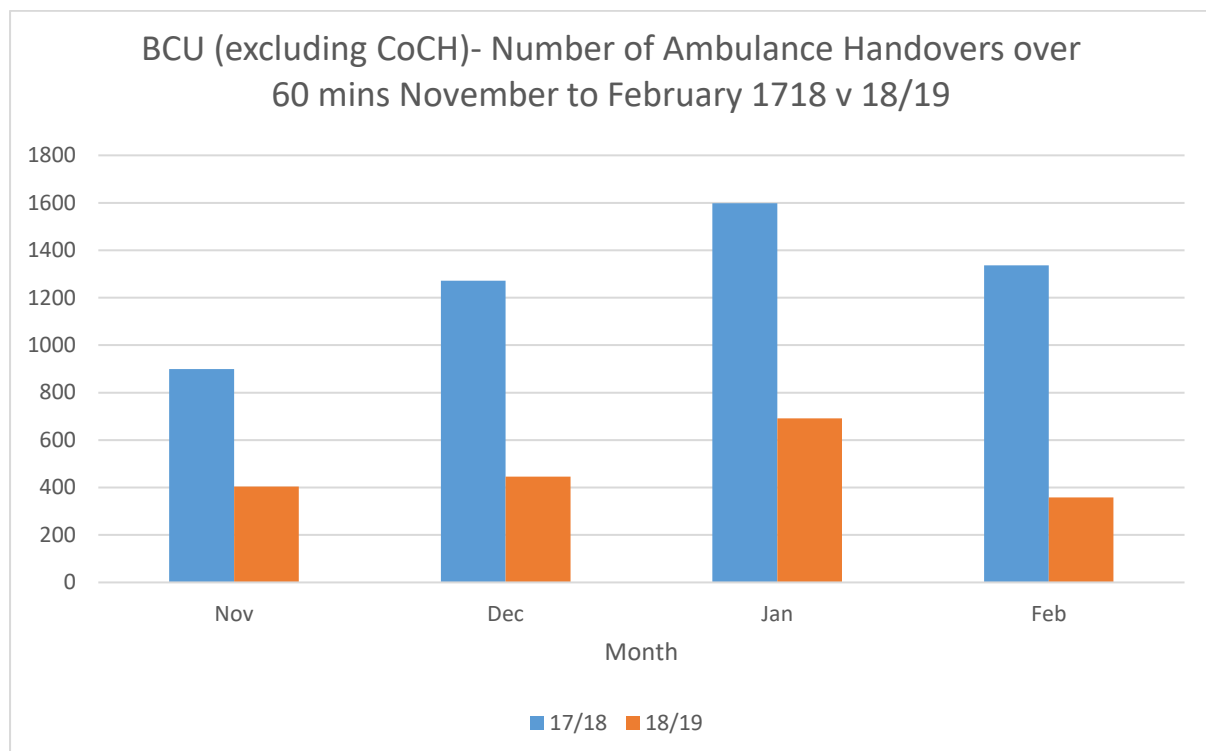
The consequence of the UHBs shift in ambulance handover has seen a marked reduction in the number and severity of incidents received for the same period in 18/19 (n.33) compared to 17/18 (n.43) with no Regulation 28 reports at time of writing, relating to harm resulting from ambulance delays in 18/19.

It must be noted that the significant improvement in handover has increased the risk in the EDs both at Ysbyty Glan Clwyd and Ysbyty Wrexham Maelor, as patients are often offloaded onto ED corridors. Work is picking up pace on actions to reduce the ED risk and ensure 'corridor nursing' does not become the new norm. Corridor nursing is a direct consequence of poor flow and bed capacity, and the 90 day plan focuses specific tasks designed to improve flow and facilitate timely discharge e.g. daily senior reviews/board rounds/ward rounds; develop a culture focused on best practice such as planned date of discharge and 'red to green'.

Wrexham Maelor remain the site with the greatest improvement gain despite the number of ambulance conveyances increasing over the period.

The UHB have been approached by the Emergency Ambulance Services Commissioner (EASC), and WAST teams with the request to work with them to understand the actions which have delivered the change, and ways in which this could be replicated across Wales.

Follow up
The UHB has received notification from WAST that a follow up audit is to be carried out within the next 3 months.

The UHB has approved the scope of the follow up audit, and meeting dates are currently being confirmed for the internal audit team to meet with key UHB staff.

During a recent meeting between BCUHB and WAST Executives, Independent Members and senior operational staff, the UHB were thanked for the proactive response to the WAST audit, and commended on the impact of the actions taken to secure and sustain the change in approach and attitude to handover delays.

Recommendations

It is the recommendations of this report that Audit Committee:
- receive the information on improvements made to date, and the work ongoing to move the UHB to a place where handover delays of >60minutes is considered a 'Never Event'
- recognise the 'best practice' status that the UHB has achieved in regards to practice in ambulance handover
- note the impact on ED risk and the practice of corridor nursing at YGC and YWM
- note the progress made against the Audit Action Plan and the impact for patients across North Wales
- receive the positive feedback from WAST Executive and Independent member

Finding 1 Patient care during handover delays	Risk
One of the key feedback improvement themes that has been identified by the WAST Quality, Safety and Patient Experience team is in regards to the provision of nutrition, hydration and continence when a patient experiences a significant delay and is held outside the ED. Although the majority of patients conveyed to ED are admitted within 60 minutes there are over 1,300 patients each month that wait in an ambulance for long periods. In order to address continence concerns WAST now participates with the All Wales Continence Bundle to ensure that pre-hospital patient care is included in their monitoring. The approach regarding the appropriate provision of continence, nutrition and hydration is currently informal and there are no standard operating procedures. Arrangements vary and it would assist ambulance crews if Health Boards had a clearer process in place, particularly at those hospitals that typically experience handover delays in excess of 60 minutes. During our site visits at EDs we observed instances where WAST staff were providing food and drink to patients from stock cupboards held at hospitals. In addition to nutrition, hydration and continence considerations, significant handover delays can lead to patients requiring pressure sore area care.	Safe and dignified care is not provided to patients during handover.

BCUHB Response to WAST Handover of Care at Emergency Departments Internal Audit Report 2017/18

Recommendation 1	Priority level - Low
We recommend that: ☐ Health Boards undertake a review of the arrangements in place for the provision of continence, nutrition and hydration at each hospital to	**HB Response** Though this is identified in the Audit report as low priority, from a HB and patient safety/experience perspective, this has been assigned as a high priority for the HB. Hydration, Nutrition and Continence Risk assessment charts and care plans are implemented for patients who are delayed in ambulanced outside of our three EDs. In addition, pressure area assessments are carried out for those patients falling within high risk criteria. More recently, sites have undertaken to review the outcomes of patients delayed within the ED for 12 hours or more so we are actively identifying incidents of harm as a direct result to flow and hospital delays. It is important to note that BCUHB recognises that any delay to the patient's care is detrimental to patient well being. We are focused on eradicating WAST delays at the front doors of our EDs, by doing so these actions will not be required.

Recommendation 1 - Update position 10/12/18: The risk assessments and practice noted above continue to be in place. In addition, teams carry out case reviews of patients delayed either in an ambulance or within our EDs which consider the consistency of application of the risk assessments, and the documented evidence to demonstrate that care plans to sufficiently address the nutrition, hydration and continence needs of delayed patients are in place.

Update position 03/19: As a result of the reduction in the number of patients delayed for >60mins, coupled with the shift in practice at each site where high dependency as well as acuity is considered as a priority for offloading, means that those patients who are delayed are ordinarily mobile and in the main self-caring.

Finding 2 Conveyance to ED	Risk
	Ambulance conveyance not being managed effectively by Health Boards and WAST resulting in patients being conveyed to ED inappropriately.
GP Referrals During this audit there was a particular point raised by all of the Health Boards and by WAST regarding the impact on conveyance and peaks in attendance to ED that result in handover delays. GP referrals are unscheduled and occur between GP hours, typically 10am to 6pm which can contribute to bottlenecks outside hospitals. Furthermore, we were informed that the time lost during hospital handover delays, coupled with the way the WAST clinical model is designed to prioritise calls in line with their red, amber, green rating, mean that ambulance crews are often unable convey GP referrals to hospital within the relevant department's opening hours. This is due to GP referrals typically being classified as green priority and results in the patient not receiving timely and appropriate care. It was generally recognised that improvements could be made by having scheduled conveyance for GP referrals where appropriate.	
	Priority level - High

Recommendation 2	
We recommend that: ☐ WAST and Health Boards undertake a project to investigate whether GP referrals could be scheduled, where the patient condition allows, so that the time of arrival at the ED is more likely to improve the patient experience by being aligned to the demand and capacity models of the hospital.	**HB Response** BCUHB are working in collaboration with the local WAST management team to identify ways to reduce the demand, not just on GP conveyances, but wider general HCP demand. Some initiatives in play are Advanced Paramedic Practitioners linked to GP practices and clusters who respond to patients requiring a home visit. This reduces the batching effect resulting in part from the way in which GP practices function (home visits ordinarily done after morning and afternoon surgery) The Integrated USC Coordination Service (hub) will provide opportunities to better meet the HCP demand by mobilising more appropriate professionals to manage patients closer to, or in their own homes. The HB will be in a better position by December of this year to provide performance data and patient outcomes which reflect whether the initiatives have been a success or not.

Recommendation 2 - Update position 10/12/18: The University Health Board's Single Integrated Clinical Assessment and Triage service (SICAT) went live on 12th November 2018. This service sits co-terminus within the WAST Control room. It is manned currently by an experienced GP working alongside an Advanced Paramedic Practitioner. The service focuses on HCP demand – though this is not exclusive, where calls of higher acuity are noted with potential to avoid ambulance deployment or patient conveyance. To date the service has managed almost 200 calls and of these calls has delivered an 80% stand down for WAST deployment; 65% avoidance of conveyance to ED – of these almost 50% have been returned to their GP for routine follow up, 20% have been given self-help advice. We have seen a 25% increase of ambulance conveyances to our Minor Injuries Units through the month of November and this has continued into December. The service has recruited an additional 4 GPs to work within the service, and is currently training Advanced Pharmacist who will

soon support both SICAT and GPOOH. The service will continue to grow as recruitment is advanced. This is a joint venture with WAST working through advanced risk sharing arrangements.

<mark>Update position 03/19:</mark> The Single Integrated Clinical Assessment and Triage service (SICAT) went live on 12th November 2018 for phase 1 of its implementation, responding to Healthcare Professional (HCP) calls and supporting the WAST stack. It's pleasing to report that recruitment into the service has been very successful, and from the end of February is functioning for 12 hours per day 7 days per week. Work is ongoing to establish the 4th GPOOH hub which will serve as the OOH coordination centre driving improvements in timely care and treatment across North Wales. Pharmacists are now in training to provide a pathway for urgent calls related to medication and minor illness, reducing demand on GP and ANP capacity, and moving ever closer to delivering the principles of prudent healthcare.

Finding 3 Pathways to bypass ED	**Risk**
As part of the audit we were provided with a schedule of pathways managed through the Clinical Pathways Approval & Appraisal Group (CPAG). We were also provided with a list of pathways by each of the six Health Boards. We were unable to reconcile these and were therefore unable to verify that: ☐ There is a clear and consistent process for WAST and Health Boards to formally approve each pathway; ☐ Where a pathway is approved, there is a clear flowchart that has been made available and understood by WAST staff, including the crews and staff within the Clinical Contact Centres; ☐ Each pathway is underpinned by detailed methodology to enable evaluation and monitoring of its success in reducing conveyance to ED; and	Pathways for emergency care that bypass the ED are not communicated, shared and understood

☐ There is a process in place to review and identify pathways that are effective and should be considered for implementation at other Health Boards. We were informed by the WAST Operations staff interviewed, that paramedics have not always been able to follow a pathway as the alternative location did not have capacity or resource to receive and treat the patient at the time. This is currently not well recorded and as such we could not audit this in any detail. We also noted during our visits that the WAST crews have a pathways folder in the ambulance that should enable them to identify and follow the appropriate pathway. Again, we were unable to reconcile that all of the pathways were in the folder and overall we could not be confident that all staff were fully aware of them.	
Recommendation 3	**Priority level - High**

We recommend that:	HB Response
☐ WAST and Health Boards undertake a review of the governance arrangements for the identification and approval of all pathways, together with a consistent process for recording, disseminating and measuring outcomes. ☐ WAST ensures that any blocks or breaks that prevent the use of a conveyance pathway to bypass ED are recorded and management action is taken to address any issues. ☐ WAST investigates the opportunity of developing an electronic pathways tool to assist paramedics in following pathways to bypass conveyance to ED.	The HB has a well established Pathways Development Group. The group comprises of WAST senior and operational staff, Primary Care, Community Services and Secondary Care. The group, led by the Area Nurse Director in the West, holds the responsibility of overseeing the development and implementation of pathways, coordinating the multi agency sign off of all new pathways (ensures good governance), and monitors the effectiveness of existing pathways. There are a number of pathways currently in differing stages of implementation or development. The HB focus is on areas such as Mental Health, falls, Catheters, Palliative Care and Care Homes. Direct access pathways for GP admissions are in existence but again in varying degrees across our three acute hospitals. YG is currently leading the way with GP referrals for acute medicine and ambulatory care, cardiology, surgery, trauma and orthopaedics, children and gynaecology who maintain robust direct access to assessment areas which are outside of the ED.

Recommendation 3 - Update position 10/12/18: The pathways group continues to meet and this is now further supported with live information from SICAT which is best placed to identify 'gaps' in pathways and/or service, and acknowledge where the agreed pathways are achieving the intentions. This evidence and knowledge will continue to gather pace and is a valuable information source to inform the UHBs USC improvement journey.

Update position 03/19: This work continues and is featured heavily in the second cycle of the UHBs 90 day USC Improvement plan.

Finding 4 HALO Role	Risk
Each of the Health Boards has meetings with WAST although their frequency varies. Managing delays in hospital handover is a daily activity that is monitored by the minute. There is constant communication and dialogue between WAST and the hospitals, aligned with escalation plans. We were informed by each Health Board that they have a good partnership working arrangement with WAST and meetings occur daily, weekly or fortnightly, typically; ☐ Daily 11am conference call between all Health Boards, WAST and the Welsh Government. ☐ Daily bed management / patient flow hospital meetings ('huddles'). ☐ Weekly or fortnightly meetings between ED staff and the WAST Area Operations Manager. Whilst the frequency and attendance at meetings (both formal and informal) varies, the purpose is the same with hospital staff aware that patient flow is key in preventing handover delay and bed management	Ineffective meetings between staff at WAST and Health Boards to manage emergency care flow. This could lead to poor decision-making negatively impacting WAST and Health Boards ability to reduce handover delays and patient health.
	Priority Level –Medium
	HB Response The HB values the role of the HALO and is currently working with WAST colleagues to agree ways in which this role can be re established across the three sites in North Wales. The HB understands that the role has been disestablished by WAST. Ensuring that the role adds value, reduces risk and maintains patient and public safety for both organisations is key to continue discussions with WAST Executive as to how the roles remain within WAST operational structures.

forms a fundamental role. We requested minutes of these meetings but were not provided with them and concluded that many of these meetings are indeed not minuted.

We were informed at some hospitals that attendance at site meetings by a WAST representative was often limited by the availability of the Clinical Team Leader (CTL). Other hospitals have a designated WAST Hospital Ambulance Liaison Officer (HALO) in place which results in better ongoing oversight of the handovers at the hospital. The feedback we received during our hospital visits was that most would value having a HALO as it provides more opportunity for WAST to liaise with the hospital staff to assist in managing hospital handovers.

We recommend that WAST undertakes a cost benefit analysis on the potential efficiency gains that may be available through the HALO role. This could be trialled initially at those hospitals with the lowest handover rates to measure the impact it has on improving handover performance.

BCUHB Response to WAST Handover of Care at Emergency Departments Internal Audit Report 2017/18

<mark>Recommendation 4 - Update position 10/12/18:</mark> We await an update from WAST as to their decision regarding re-establishing the HALO role across Wales. BCUHB can report however, that WAST in North Wales continue to support our EDs at peak times of pressure, and do consistently deploy senior ambulance staff to each of our EDs in support of flow and operational decision making. We are extremely grateful to WAST colleagues for maintaining this important partnership approach at times of pressure.

<mark>Update position 03/19:</mark> This remains an outstanding issue, however it must be noted that the partnership working with the local WAST teams has meant that when our EDs have been under extreme pressure with high WAST demand, WAST officers have been deployed into the EDs to support the decision making and turn-around of crews. This way of working has proved to be as effective as the previous HALO role.

Finding 5 Strategic forums	Risk
Whilst there is communication between WAST and Health Boards on operational matters, as highlighted in finding 4 above, there was little evidence of strategic direction and related forums. Such would assist in leading on and managing the issues of handover delays, conveyance, pathways, patient flow, HAS data quality and enable better uniformity and best practice sharing.	Opportunities to address All Wales issues and seek to develop consistent approaches may be missed.
Recommendation 5	**Priority level - Medium**
We recommend that WAST identifies all meetings that are held between WAST and Health Boards at hospital, Health Board and national level and determines the need for less or more and how they	**HB Response** The HB has a well structured formal meeting which includes WAST, NW Police and other partners. The Unscheduled Care Strategic group is Chaired by the

are recorded (agendas, minutes, action plans). In particular, how strategic decision making and sharing of best practice is performed in respect of handover of care at Emergency Departments.	Executive Director of Nursing and functions as the strategic owner of the HB and Partner Agencies USC Improvement Plan. In addition to the engagement and partnership working at a strategic level, local relationships and joins planning is done at groups such as the Pathways Development Group and site based planning cells.

Recommendation 5 - Update position 10/12/18: This arrangement continues and has been strengthened by the partnership working within the first 90 day planning cycle (the vehicle by which the HB is delivering its USC improvement actions)

Update position 03/19: This continues to be in place, and is the strategic partnership is further strengthened at tactical and operational level by the work undertaken by SICAT and local sites.

Finding 6 Patient flow initiatives	**Risk**

We reviewed Board meeting minutes for each Health Board and found that delayed handovers are included in performance reports. It was clear that all Health Board executives are aware of the problem of handover delays and set targets and actions to reduce them. As noted in Action 1 above, we have also reviewed the IMTP's for the six Health Boards and found that emergency care is included with reference to developing joined-up health and social care services. Whilst this is noted as a priority by all Health Boards, the AQI's over the past 12 months have shown little improvement in performance on handover delays. The only Health Boards that are near the 15-minute handover target of 100% are Cwm Taf University Health Board achieving almost 90% each month and Hywel Dda University Health Board achieving circa 80%. Cwm Taf University Health Board's performance may be attributed to its project to reduce delays and improve the flow of patients across hospital, GP and community services. The 'Focus on Flow' project won the NHS Wales Improving Patient Safety Award 2014. It should be acknowledged that all of the Wales NHS Health Boards have undertaken projects and initiatives to improve unscheduled care and address patient flow. Many of these are currently in operation. What is clear from the AQI's is that the initiatives applied by Cwm Taf University Health Board have been very effective in respect of the impact on WAST	Opportunities for sharing best practice that reduces handover delays may be missed resulting in lost hours.

and lost ambulance hours as a result of handover delays.	
Recommendation 6	**Priority level - Medium**
We recommend that WAST and Health Boards evaluate the key factors adopted by Cwm Taf University Health Board that resulted in their handover performance improving from circa 50% to 90% since 2013 and work together to drive similar improvement.	**HB Response** BCUHB staff has made several site visits to Cwm Taf to understand what learning we could implement locally to improve performance. Policies and practices such as Corridor Waiting and Reverse Boarding have been implemented across BCU. The impact of these new ways of working has not yielded a similar effect as seen at Cwm Taf. The HB has plans in place to review the changes recently implemented at Cardiff and Vale HB, who's performance standards within ED has seen a stepped and sustainable improvement within the last 3 months.

BCUHB Response to WAST Handover of Care at Emergency Departments Internal Audit Report 2017/18

Recommendation 6 - Update position 10/12/18: The work identified as key to the C&V UHB improvement reflected the shift of focus from the Board all the way down to the patient bedside. BCUHB Board have been visible and coherent in their message to staff that improvement in our USC performance is a priority. The launch of the 90 day plan was opened and closed by the Chairman and the CEO, both playing active roles throughout the day. This served to ensure that the Board message was clearly heard by HB staff and partners with almost 200 delegates attending the launch day. The 90 day plans are progressing and the HB is seeing differing degrees of improvement against its key performance indicators for USC. Additional external support is now in place working alongside the three Regional teams and supporting the operational teams to deliver sustainable change and improvement.

Of note is BCUHBs positioning with regard to the Safety Huddle and SICAT, both of which are leading the way in Wales, and have become reference points for other HBs to follow.

Update position 03/19: As a result of the UHB response to this audit, and the improvements seen in ambulance handover and partnership working, BCUHB have become the reference site across Wales. The UHB is soon to host visits from EASC, and members of the National Collaborative Group, and details of the UHBs best practice is being fed through the All Wales Chief operating Officers Group (COOs).

Finding 7 Delayed handover clinical triage	Risk
The Welsh Government health circular clearly states that *"WAST crews should not routinely be responsible for monitoring patients over prolonged periods outside A&E, and hospital clinicians should be responsible for overseeing the assessment of patients."* The University Hospital of Wales (UHW) was the only hospital of the 6 visited that did not undertake a face	Patients are not clinically assessed resulting in them coming to harm. There is also a missed opportunity for the ED clinician to undertake an assessment at an earlier stage that could have resulted in the patient being redirected, avoiding an unnecessary wait for the patient and lost hours to WAST.

to face assessment of the patient before admission to the hospital. In all other cases the clinician carried out an initial patient assessment in the back of the waiting ambulance as required. We were informed by staff at UHW that that the ambulance triage by ED clinicians is not one supported by the Royal College of Emergency Medicine and that whilst nurses do not enter the ambulance, the risk to patients is managed through the protocols and processes in place; a clinical assessment by the Majors Assessment Nurse (MAN) through communication with the paramedic. The current practice at the UHW is contrary to Point 3 of the Welsh Government guidance above. This is a conscious decision by the hospital, as outlined above, and results in greater responsibility on the paramedics to assess the patient condition and monitor that condition for over 30 minutes and sometimes several hours. There is also a missed opportunity for the ED clinician to undertake an assessment at an earlier stage that could have resulted in the patient being redirected, avoiding an unnecessary wait for the patient and lost hours to WAST.	

Recommendation 7	Priority level - High
We recommend that WAST seeks confirmation from Welsh Government regarding responsibility for undertaking a clinical assessment of patients prior to admittance to the ED.	**HB Response** BCUHB can confirm that each site is compliant with the Welsh Health Circular. Compliance is assessed through the daily conference calls, and non compliance escalated to the Executive.

Recommendation 7 - Update position 10/12/18: This continues to be the case within BCUHB

Update position 03/19: this continues to be the case.

Finding 8 HAS Data	Risk

Through discussion with paramedics and hospital clinicians (i.e. Nurse in Charge) we found some contradiction over the responsibility for completing the HAS handover entries. Some thought it was the responsibility of the other party, particularly when the entry had not been completed. Others felt it was the responsibility of both parties which had on occasions resulted in the paramedic finding the entry had already been made by the hospital. It was also found during observation at site visits that the point at which the paramedic updated the HAS varied. Some 'notified' as soon as they entered the ED and then notified the Nurse in Charge, others the other way around. Whilst this finding is mainly anecdotal it was apparent that the data is not as accurate as it would be if there was clear guidance and understanding on HAS roles and responsibilities and a consistent approach at all hospitals over exactly what point the paramedics or clinicians update the HAS. We analysed HAS data covering a sample of 7 days (Mon-Sun) over 7 weeks in September and October 2017. The analysis highlighted that the late reason is not completed over 25% of the time. If this data was complete and accurate it would provide both WAST and Health Boards with information to assist in reducing delays.	Incomplete and inaccurate data could undermine the quality of the management information reported. This could lead to poor decision-making negatively impacting WAST and Health Boards ability to reduce handover delays and patient health.
Recommendation 8	**Priority level - Medium**

We recommend that WAST and Health Boards: ☐ WAST and Health Boards ensure that the roles and responsibilities for recording data on the HAS are clearly understood. This should be supported by clear guidelines and protocols to ensure that the data can	**HB Response** Local protocols have not been developed, and the HB would welcome sharing of best practice across Wales. This action remains outstanding. **Plan:** protocols will be developed and implemented based on best practice. **Completed by:** 30th September 2018 **Responsible officer:** Associate Director of USC

Recommendation 8 - Update position 10/12/18: This action remains outstanding, however the HB have received confirmation from WAST that this is being developed pan Wales. We await the guidance from WAST.

Update position 03/19: This action is now completed and WAST protocols in practice. The UHB will continue to monitor compliance.

Audit Committee *14 March 2019*		**GIG CYMRU NHS WALES**	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
		To improve health and provide excellent care	

Report Title:	Special Measures: Review of expectations allocated to the Audit Committee
Report Author:	Liz Jones, Assistant Director
Responsible Director:	Grace Lewis-Parry
Public or In Committee	Public
Purpose of Report:	The Special Measures Improvement Framework Task & Finish (SMIF T&F) Group previously agreed that special measures expectations would be allocated to the most relevant committee for review, with a view to the committee providing updates where necessary and assurance on progress to the SMIF T&F Group.
	Work on the October 2018 – March 2019 section of the Framework has included a session held by the Executive Team in January 2019, dedicated to examining special measures progress in detail. As a result, it was deemed that several of the expectations had been satisfactorily addressed and could be closed for monitoring purposes. The SMIF T&F confirmed the decisions at its February 2019 meeting.
	All SMIF expectations allocated to the Audit Committee from the section of the Framework ending March 2019 are now deemed closed, however one Deloitte financial review and 2 Wales Audit Office Structured Assessment recommendations remain open, and it has been agreed previously that these would be incorporated into SMIF progress monitoring arrangements. The updated progress monitoring log extracts are presented for comment.
Approval / Scrutiny Route Prior to Presentation:	The special measures progress monitoring log is overseen by the SMIF T&F Group. The log was last reviewed by the Group on 25.2.19,
Governance issues / risks:	There is a risk that recommendations will not be fully met unless driven forward at sufficient pace.
Financial Implications:	No additional funding currently required in respect of this paper.
Recommendation:	The Committee is asked to: • review the updated information provided • include within its Chair's Assurance Report a summary of the Committee's discussion regarding the extracts, and a comment on the level of assurance on progress towards meeting the recommendations' requirements

	• share the Chair's Assurance Report with the Office of the Board Secretary, for submission of relevant information to the SMIF Task & Finish Group.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	WFGA Sustainable Development Principle *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life	√	3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		

Special Measures Improvement Framework Theme/Expectation addressed by this paper

http://www.wales.nhs.uk/sitesplus/861/page/81806
Audit Committee related expectations – leadership and governance.

Equality Impact Assessment

An Equality Impact Assessment is not considered necessary for a paper of this type.

EXTRACT FOR MARCH 2019 AUDIT COMMITTEE - Betsi Cadwaladr University Health Board: **Special Measures Monitoring Log** for the second Improvement Framework May 2018-Sept 2019 (incorporating Deloitte Financial Governance Review recommendations and WAO Structured 2017)

No Change since last update:
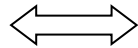
Improvement since last update:

Deterioration since last update:

*See previous monitoring log: This monitoring log builds upon actions and progress during phases 1-3 of the initial Special Measures Improvement Framework. The headings of the log have been adjusted to reflect a greater focus on measurable outcomes and to capture definitive evidence of success.

Line Ref	Theme	IM / Director (+Operational) & Committee Lead	Expectation	**Action:** What needs to be done and why are we doing it?	By When	Progress	**Outcomes** and impacts: what difference are the actions making?	RAG Status	Evidence (see iBabs and shared drive folder)
			Leadership and Governance						
			May 2018 to Sept 2018: (Carried over)						
10 a	Deloitte/Welsh Government Financial Review Dec 2017: Recommendation mapped across	Chairman / CEO Audit Committee	R12 The Executive team must proactively raise the status of accountability meetings and performance review across the HB and consider the various observations made throughout this report to enhance their effectiveness.	10a CEO to take steps to raise the status and ensure that observations in the Deloitte Report are given consideration.	~~Sept 2018~~ March 2019	Update 16.1.19: Revised interim arrangements for accountability review meetings have been agreed by executive directors, and finance and performance committee (December 18). The structure will be 'health economy' and the focus will be on our core delivery priorities for 2018/19 followed by our three-year plan. The intention is to 'learn by doing' and work closely with area teams to test out and develop consensus support for an approach going forward. For this reason, the current arrangements are described as interim, and will be reviewed during the summer of 2019. Update 25.2.19 – accountability meetings were held a week ago; CEO reflections on what went well will be provided	Secondary Care and Mental Health performance and accountability meetings have resulted in a step up in the level of contact between the divisions and members of the Executive Team to weekly meetings.	Amber	

Line Ref	Theme	IM / Director (+Operational) & Committee Lead	Expectation	Action: What needs to be done and why are we doing it?	By When	Progress	Outcomes and impacts: what difference are the actions making?	RAG Status	Evidence (see iBabs and shared drive folder)
						to the March F&P Committee; any necessary changes to the accountability arrangements will be considered and actioned as appropriate. The number of PADRs taking place has increased.		Amber	
10b	WAO Structured Assessment 2017 recommendation	Executive Director of Planning & Performance	R10f Strengthen accountability for progress against plans, including the annual operating plan and, when developed, the IMTP	10b Confirm the arrangements for monitoring progress against plans	~~Sept 2018~~ March 2019	See action 10a above. Update 16.1.19: The Health Board is working to strengthen accountability for delivery against plans, both in regards of progress against timescales and in terms of benefits realisation. A revised performance and accountability framework is being finalised following detailed discussion and input from the Executive Team and the full Board. The key principles in the revised performance and accountability framework will support the Health Board to deliver the strategy set out in the three year plan. It will ensure operational ownership of key priorities and clarity of expectation as to the level of performance expected. Revised arrangements will be put in place over the next 6 months and tested to ensure that they provide more robust and effective arrangements.

Update 25.2.19 – the CEO stated that more Board discussion needs to be had about the plan. Deliverables need to be summarised. The Health Board Chair states that the annual plan must not replicate last year's | | Amber ⬆ | |

Line Ref	Theme	IM / Director (+Operational) & Committee Lead	Expectation	Action: What needs to be done and why are we doing it?	By When	Progress	Outcomes and impacts: what difference are the actions making?	RAG Status	Evidence (see iBabs and shared drive folder)
						position. There should be no need for interpretation of the plan – a 'smart' statement is required. Indicators in the IQPR should reflect the plan.			
24	WAO Structured Assessment 2017 recommend-ation	Audit Committee Chair / Executive Director of Therapies & Health Science / Executive Director of Nursing & Midwifery Audit Committee	R9 Build on the Health Board's programme of clinical audit to ensure it a) aligns with quality strategy priorities and risks; b) sets out patient/quality outcomes or impact as a requirement of audit planning to help it understand the value that clinical audit is contributing and c) informs the Quality, Safety & Experience Committee with clear and focussed assurance reports.		~~May 2018~~ ~~March 2019~~ Sept 2019	Update 16.1.19: The Health Board has not significantly altered its clinical audit planning approach or strengthened its reporting to better provide targeted assurance into the Quality, Safety and Experience (QSE) Committee. There is a structured process for planning clinical audit which is based on analysis of clinical risk and aligned to organisation level Quality Improvement Strategy objectives. This will be overseen by the Quality Safety and Experience committee and will include a formal approach for determining the level of assurance arising from the clinical audit as well as an explicit expectation that audits identify improvement actions aligned to the priorities set out in the Health Board's quality improvement strategy. The terms of reference for the Quality & Safety Group (QSG) have been amended to include review of Corporate Clinical Audits. The programme is to be discussed at the February 2019 meeting.		Amber ⟷	May 2018 QSE paper

Line Ref	Theme	IM / Director (+Operational) & Committee Lead	Expectation	Action: What needs to be done and why are we doing it?	By When	Progress	Outcomes and impacts: what difference are the actions making?	RAG Status	Evidence (see iBabs and shared drive folder)
						The Breast Cancer Peer Review was presented to the January QSG. Issues of significance will be escalated to QSE when they are identified. Stroke and the National Emergency Laparotomy Audit have been presented to the Clinical Audit and Effectiveness sub Group and the Myocardial Infarction National Audit Project is scheduled to report in February 2019. Update 25.2.19 – Papers are scheduled to be submitted to the Audit Committee and QSE Committee to address this matter.			

V23.0 updated 18.1.19 Stored in:\Boards and Committees\governance \Special Measures\Improvement Framework inc PROGRESS ACTION MONITORING LOG\NEW ACTION PROGRESS MONITORING LOG JUNE 18- extract fo audit committee 2019

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Audit Committee 14.3.19	GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
	To improve health and provide excellent care

Report Title:	Internal Audit Plan 2019/20 and Internal Audit Charter
Report Author:	Dave Harries, Head of Internal Audit
Responsible Director:	Mrs Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Purpose of Report:	The draft audit plan has been developed in accordance with mandated Public Sector Internal Audit Standards – Standard 2010 - Planning to enable the Head of Internal Audit to provide internal audit services in a way which will facilitate:

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

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

The Charter is produced and updated regularly to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the Health Board's own Standing Orders and Standing Financial Instructions. |
| Approval / Scrutiny Route Prior to Presentation: | The draft plan and audit Charter has been considered and approved by the Board Secretary and following this was shared with the Executive Team for comment. |
| Governance issues / risks: | The plan has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

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

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

Financial Implications:	The outcome from reviews identified within the draft plan may identify issues/risks that have financial implications for the Health Board.
Recommendation:	The Audit Committee is asked to approve the draft plan for 2019/20 and internal audit Charter.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	WFGA Sustainable Development Principle *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	x
5.To improve the safety and quality of all services	x	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper
http://www.wales.nhs.uk/sitesplus/861/page/81806
The internal audit plan provides independent assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.

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

This plan does not, in our opinion, have an impact on equality nor human rights and is not discriminatory under equality or anti-discrimination legislation.

Betsi Cadwaladr University Local Health Board

Internal Audit Plan 2019/20

February 2019

**NHS Wales Shared Services Partnership
Audit and Assurance Services**

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2019/20 ('the Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

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

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

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

Accordingly this document sets out the risk based approach and the Plan for 2019/20. The Plan will be delivered in accordance with the Internal Audit Charter. All internal audit activity will be provided by Audit & Assurance Services, a division of NHS Wales Shared Services Partnership.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

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

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;

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

- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;

- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;

- quantification of the audit resources required to deliver the Internal Audit Plan;

- effective co-operation with external auditors and other review bodies functioning in the organisation; and

- the provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

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

- organisation's risk assessment and maturity;

- coverage of the audit domains;

- previous years' internal audit activities; and

- audit resources required to provide a balanced and comprehensive view.

Our planning also takes into account the NHS Wales Planning Framework 2019/22 and is also mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the 3 year plan and/or Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

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

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

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

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

Figure 1   Internal Audit assurance on the domains

Health Board's Strategic Goals

- Improve health and wellbeing for all and reduce health inequalities
- Work in partnership to design and deliver more care closer to home
- Improve the safety and outcomes of care to match the NHS' best
- Respect individuals and maintain dignity in care
- Listen to and learn from the experiences of individuals
- Support, train and develop our staff to excel
- Use resources wisely, transforming services through innovation and research

Assurance Domain

Annual Governance Statement

Corporate governance, risk and regulatory compliance

Strategic planning performance management and reporting

Financial governance and management

Quality and safety

Information governance and security

Operational service and functional management

Workforce management

Capital and estates management

Annual Internal Audit Opinion

Internal Audit Assurance

2.3 Link to the Health Board's systems of assurance

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

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

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit, working in partnership with the Performance Audit Lead [WAO], sought to meet with a number of Health Board Executives and Independent Members to discuss current areas of risk and related assurance needs. We have contacted/met with the following key individuals during the planning process:
- Director of Nursing & Midwifery;
- Director of Turnaround;
- Board Secretary and Deputy Board Secretary;
- Director of Finance and Finance Directors;
- Director of Planning and Performance;
- Director of Primary & Community Care;
- Director of Workforce & OD;
- Director of Public Health;
- Director of Mental Health & LDS; and
- Chair and Members of the Audit Committee.

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

3. Audit risk assessment

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

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2019/20

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

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

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

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

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

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

4.2 Keeping the plan under review

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

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. Hence, the plan will be kept under review and may be subject to change to ensure it remains fit for purpose. In particular the Plan will need to be periodically reviewed to ensure alignment with the developing systems of assurance.

Consistent with previous years and in accordance with best professional practice an unallocated contingency provision has been retained in the plan to enable internal audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee.   Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with the Wales Audit Office as the External Auditor and Healthcare Inspectorate Wales will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5.   Resource needs assessment

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

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

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

The top-slice funding passed to NWSSP, together with the recharge of £35,946.90 for capital audit assurance work, is sufficient to meet these audit resource needs. The recharge sum for 2019/20 reflects a reduction of £18,571 compared to 2018/19, consistent with the proposed, reduced programme of capital & estates assurance coverage to be delivered by the Specialist Services Unit. The resources highlighted exclude the contribution to the audit of national systems through the NWSSP plan.

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

6.   Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2019/20 and:
- Approve the Internal Audit Plan for 2019/20;
- Approve the Internal Audit Charter; and
- Note the associated internal audit resource requirements and key performance indicators.

Dave Harries CMIIA QiCA
Head of Internal Audit (Betsi Cadwaladr University Local Health Board)
Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2019/2020

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
Corporate governance, risk and regulatory compliance				
Annual Governance Statement	Mandatory	To provide an Opinion on key aspects of Board governance to underpin the completion of the Statement.	Board Secretary	Q1
Welsh Risk Pool Claims Management Standard	Mandatory	In accordance with the Welsh Risk Pool Standards, we will review a sample of completed files to ensure the required process has been complied with.	Director of Nursing & Midwifery	Q4
Health and Safety	CRR12	We will review progress taken by the Health Board for the management and scrutiny of health and safety arrangements.	Director of Workforce & Organisational Development	Q1-2
Welsh Language (Wales) Measure 2011		We will review the advertisement and employment of individuals to the following Welsh essential posts in accordance with the *Bilingual Skills Strategy*: • Receptionists • Switchboard; • Call centre / patient appointment booking centre; and • Ward clerks.	Director of Public Health	Q1
Health Board governance arrangements – Quality & Safety		We will review the flow of assurance from Areas/Hospitals/ Corporate functions to the Quality & Safety Group through to the Quality, Safety and Experience Committee.	Director of Nursing & Midwifery	Q2-3
Compliance with Standing Financial Instructions – Procuring goods and services: Estates - GRAMMS	CRR06	We will review compliance with Standing Financial Instructions and local operational procedures in procuring items through the system.	Director of Planning & Performance	Q1
Compliance with Standing Financial Instructions – Procuring goods and services: Therapies – Therapy Manager	CRR06	We will review compliance with Standing Financial Instructions and local operational procedures in procuring items through the system.	Director of Therapies & Health Science	Q1-2
Compliance with Standing Financial Instructions – Procuring goods and services: Pharmacy EDS	CRR06	We will review compliance with Standing Financial Instructions and local operational procedures in procuring items through the system.	Director of Therapies & Health Science	Q1-2
Compliance with Standing Financial Instructions – Procuring goods and services: Community Dental Services	CRR06	We will review compliance with Standing Financial Instructions and local operational procedures in procuring items through the system.	Director of Primary & Community Care	Q1-2

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
Strategic planning performance management and reporting				
Performance measure reporting to the Board – Accuracy of information	Audit Committee	In discussion with the Audit Committee, we will validate the reporting of a sample of performance measure(s) back to source data to confirm the integrity, accuracy and controls in place.	Director of Planning and Performance	Q2
Partnership governance - Section 33 Agreements		We will obtain details of current Section 33 Agreements and review to identify whether scrutiny, accountability and reporting arrangements are effective.	Director of Primary & Community Care	Q2-3
Financial Governance and management				
Delivery of savings against identified schemes	CRR06	We will review areas that have consistently not delivered against their savings plans to understand why this is the case; what support they have received; and how they plan to remedy the non-delivery of savings.	Director of Turnaround	Q2-3
Budget Setting	CRR06	We will review the process for budget setting and focus on engagement with budget holders and managers – we will liaise with the Wales Audit Office to eliminate the risk of duplication.	Director of Finance	Q1-2
Salary overpayments	CRR06	We will review the adequacy of arrangements to ensure identified overpayments are repaid to the Health Board in an acceptable and timely manner.	Director of Finance	Q2
Quality & safety				
Annual Quality Statement	Mandatory	The Board must assure itself that the information published is both accurate and representative. To provide an opinion on the process that has been adopted and the evidence recorded supports data sources.	Director of Nursing & Midwifery	Q1
HASCAS & Ockenden external reports – Recommendation progress and reporting	Special Measures & CRR13	We will review the reporting of progress against the agreed management actions for those recommendations formally accepted by the Health Board.	Director of Nursing & Midwifery	Q1
Quality Impact Assessment	External Report	We will review whether the Health Board has an adequate system in place for developing, monitoring and managing quality impact assessments.	Director of Nursing & Midwifery/ Medical Director/ Director of Therapies & Health Science	Q1-2
Safeguarding	CRR16	We will review progress since our last review and seek to work in partnership	Director of Nursing & Midwifery	Q2-3

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
		with Local Authority partners to ensure effective arrangements are in place.		
Decontamination	CRR02	Working with Infection Prevention and Control, we will establish adherence to Health Board procedure IPC17 – *Decontamination of Medical Devices Procedure*.	Director of Nursing & Midwifery	Q2-3
Deprivation of Liberty Safeguards (DoLS)	CRR16	We will review current Health Board process for compliance with relevant Statute.	Director of Nursing and Midwifery	Q1-2
Information Governance and Security				
Welsh Community Care Information System (WCCIS)	CRR10a	We will review the wider preparedness of the roll-out of the system in light of the pilots in the West Area and lessons learnt from these.	Director of Primary & Community Care/Medical Director	Q1-2
GDPR – Follow-up of the Information Commissioners Office (ICO) review	CRR10b	We will follow-up the implementation of the actions following the ICO review as well as progress against its action plan and obtaining evidence where actions are noted as delivered.	Board Secretary	Q2-3
Caldicott – Principles into Practice (CPiP) self-assessment		Following the reported 89% compliance against the 41 standards, we will review evidence to support this assessment.	Board Secretary	Q2-3
Cyber security	CRR10a	We will review the governance arrangements and reported action taken by the Health Board to minimise the risks through effective cyber security.	Medical Director	Q2
Operational service and functional management				
Managed General Practitioner Practices	CRR09	We will review the governance and management arrangements to ensure practices are held to account for performance.	Director of Primary & Community Care	Q2-3
Cluster governance arrangements	CRR09	We will review a sample of Clusters against the Welsh Government issued *Primary Care Cluster Governance – A Good Practice Guide.*	Director of Primary & Community Care	Q1-2
Continuing Health Care	CRR03	We will review the evidence underpinning the annual Welsh Government self-assessment; Use of the Broadcare system; as well as evaluating compliance with expected controls in reviewing and approving care packages.	Director of Primary & Community Care	Q2-3
Non-Emergency Patient Transport Service (NEPTS)	CRR11a	We will review the management arrangements and efficacy of the service against the developed business case.	Director of Nursing & Midwifery/ Director of Planning and Performance	Q1-2

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
Workforce management				
Roster management	CRR15	Using WP28 – Rostering Policy and associated guides, we will review the controls operating corporately to ensure the integrity of data coupled with seeking evidence of compliance with Policy.	Director of Workforce & Organisational Development	Q1-2
NHS Wales staff survey – delivering the findings	CRR14	We will review the progress made and seek evidence to support management action towards addressing the staff survey responses and identified action plans.	Director of Workforce & Organisational Development	Q3-4
Recruitment	CRR15	We will review the controls operating once an individual has been successful in obtaining a post and identify the steps and timelines taken from interview through to actual start date, including appropriate DBS checking – we will focus on a mix of internal and external appointments.	Director of Workforce & Organisational Development	Q2-3
Capital and Estates				
Environmental sustainability report	Mandatory	To provide an opinion that the Health Board has robust systems in place to record and report minimum sustainability requirements as required by Welsh Government.	Director of Planning & Performance	Q1
Carbon Reduction Commitment Order	Mandatory	To ensure the Health Board complies with the requirements of the Order and that the information held is accurate, complete and the purchase of Credits is based upon actual usage or informed estimates.	Director of Planning & Performance	Q1
Statutory Compliance: Fire Safety	CRR12	Working in partnership with the Corporate Fire Department, we will review documented compliance, for a sample of locations, relating to their respective local site fire management procedures, triangulating progress against action plans completed by the Corporate Fire Department audits.	Director of Planning & Performance	Q2
North Denbighshire Community Hospital		We will develop an integrated audit plan for the North Denbighshire Community Hospital development to consider the following: • Project Governance • Contract; • Management; • Design Development.	Director of Planning & Performance	Q2
Ablett Unit		At this early stage in the development of the project, the target programme provided at the SOC noted: •Outline Business Case (OBC) - January 2020.	Director of Planning & Performance	Q3

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
		•Full Business Case (FBC) – January 2021 •Complete - January 2023. Noting the complexity, anticipated value (£25.75m) and reputational risks associated with the scheme, it is proposed that an integrated audit plan will be developed for the project (for inclusion within the respective business case submissions), with audits proposed to commence during 2020/21.		
Ysbyty Wrexham Maelor Hospital – Redevelopment/backlog requirements		It has been indicated that strategically the Ysbyty Wrexham Maelor site presents the most immediate/ significant risks to the Health Board, consequently coverage may include: •Governance Strategy (Short/Medium Term) - Assurance that appropriate Governance structures have been determined, adequate resources have been identified and that key roles have been assigned to appropriate individuals; •Programme Management (Short/Medium Term) - A delivery programme should be established based on detailed activities to drive forward the programme through the project life cycle. The programme should be sufficiently detailed for the short term whilst also linking to the overall delivery target. •Risk Management - To obtain assurance that appropriate risk management arrangements are in place to manage risks associated with the site. •Backlog maintenance (focus on statutory compliance and patient and staff welfare/safety); Further developing the backlog maintenance audit undertaken in 2016/17, the review will seek assurance that the processes and procedures put in place by the the Health Board to support the management and control of the backlog maintenance programme (including statutory compliance) at the Ysbyty Wrexham Maelor site are robust, including: o Effective Management	Director of Planning & Performance	Q4

Planned output	CRR/ Mandatory	Outline Scope	Executive Lead	Outline timing
		o Identification; Categorisation and Prioritisation; o Delivery of the maintenance plan; o Monitoring and reporting.		
Substance Misuse Action funds		The following schemes have been progressed as a part of the 3-year Substance Misuse Action funds programme: • Holyhead (Craig Hyryd) - £1.337M (SOS June 19, complete May 2020); • Shotton £2.370M (funding approved – currently in design development); • Wrexham (the Elms) - £2.178M (complete May/June 19). Noting the varying stages of delivery, the audit will seek to provide assurance on the following: • Project Governance; • Project Management; • Appointments; • Delivery.	Director of Planning & Performance	Q2
Compliance with the Public Sector Internal Audit Standards				
Contingency		This element of the plan allows the flexibility to respond to management requests in order to meet specific Health Board needs throughout the course of the financial year.	Board Secretary	Q1-4
Audit Management and Reporting		An allocation of time is required for management:- • Planning liaison and management – Incorporating preparation and attendance at Audit Committee; completion of risk assessment and planning; liaison with WAO;HIW; PSOW; and organisation of the audit reviews; and • Reporting and meetings – Key reports will be provided to support this, including preparation of the annual plan and progress reports to the Audit Committee.	Board Secretary	Q1-4
Follow up of previous audit reports		We will conduct follow-up reviews throughout the year to provide the Audit Committee with assurance regarding management's implementation of agreed actions – reviews that received limited or no assurance.	Board Secretary	Q1-4

<u>Appendix B: Key performance indicators (KPI)</u>

The KPIs reported monthly for Internal Audit are:

KPI	SLA required	Target 2019/20
Audit plan 2019/20 agreed/in draft by 30 April	✓	100%
Audit opinion 2018/19 delivered by 31 May	✓	100%
Audits reported vs. total planned audits	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [20 days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Betsi Cadwaladr University Local Health Board

INTERNAL AUDIT CHARTER

February 2019

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1 Introduction

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

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

- Board means the Board of Betsi Cadwaladr University Local Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and

- Senior Management means the Chief Executive as being the designated Accountable Officer for Betsi Cadwaladr University Local Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

2 Purpose and responsibility

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

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

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

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;

- the appropriate assessment and management of risk, and the related system of assurance;

- the arrangements to monitor performance and secure value for money in the use of resources;

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

- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;

- compliance with applicable laws and regulations; and

- compliance with the behavioural and ethical standards set out for the organisation.

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

3 Independence and Objectivity

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

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

- approving the internal audit charter;

- approving the risk based internal audit plan;

- approving the internal audit budget and resource plan;

- receiving outcomes of all internal audit work together with the assurance rating; and

- reporting on internal audit activity's performance relative to its plan.

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

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

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

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

4   Authority and Accountability

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

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

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

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

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

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

5   Relationships

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

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

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

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

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

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

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

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

Figure 1   Audit reporting lines
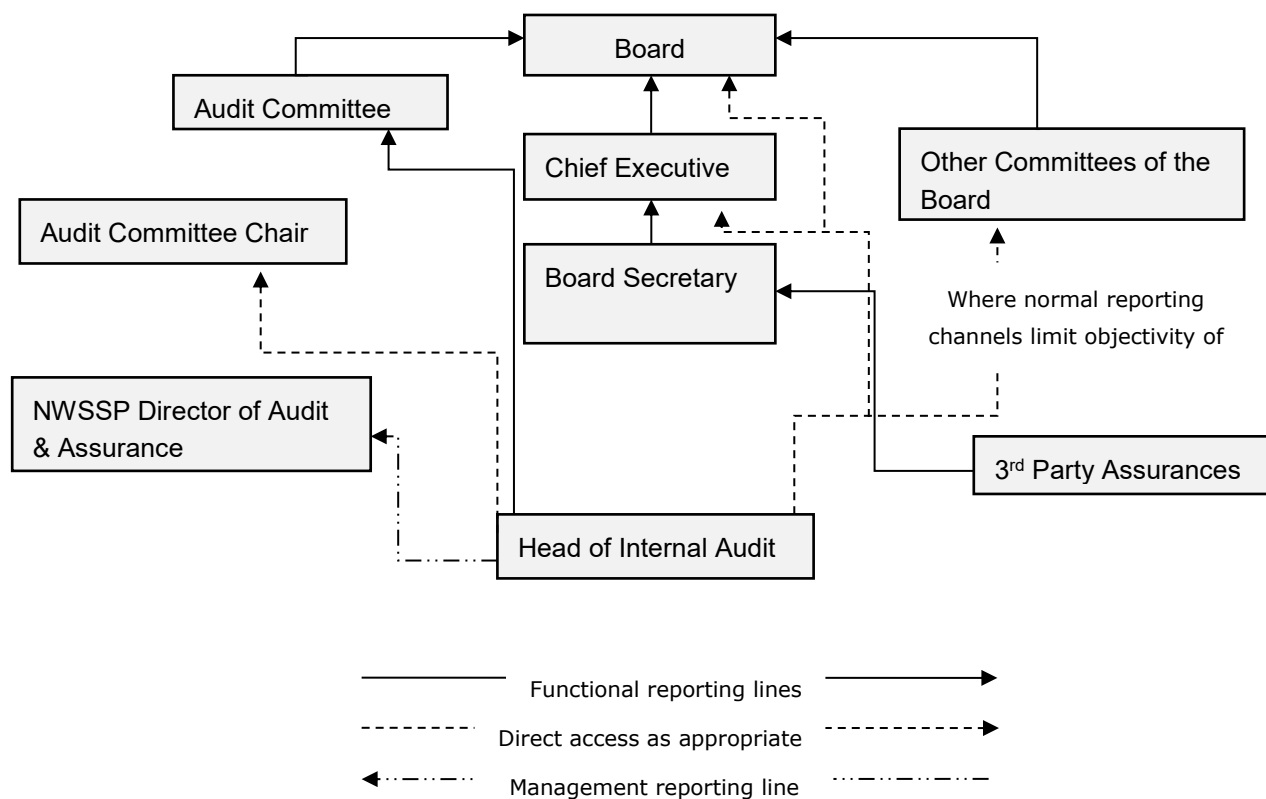
6   Standards, Ethics, and Performance

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

6.2   Internal Audit will operate in accordance with the Service Level Agreement (updated 2017) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators and we will agree with each Audit Committee which of these they want reported to them and how often.

7   Scope

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

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

- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;

- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;

- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;

- reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;

- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;

- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

- reviewing arrangements for demonstrating compliance with the Health and Care Standards.

- ensuring effective co-ordination, as appropriate, with external auditors; and

- reviewing the Annual Governance Statement prepared by senior management.

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

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

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

8   Approach

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

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

Figure 2 Audit planning hierarchy

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

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

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

▪ the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;

▪ audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisations objectives and risks;

▪ improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;

▪ an assessment of audit needs in terms of those audit resources which "are appropriate, sufficient and effectively deployed to achieve the approved plan";

▪ effective co-operation with external auditors and other review bodies functioning in the organisation; and

- the allocation of resources between assurance and consulting work.

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

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

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

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

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

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

Figure 3 Risk based audit approach

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┌─────────────────────────┐
│  Audit Risk Assessment  │
└─────────────────────────┘
    │
    │    ┌──────────────────────────────────────────┐
    ├────│  Strategic 3-year audit planning and     │
    │    │  production of annual internal audit plan│
    │    └──────────────────────────────────────────┘
    │
    │    ┌──────────────────────────────────────────┐
    ├────│  Agree scope and objectives for          │
    │    │  individual audit assignments            │
    │    └──────────────────────────────────────────┘
    │
    │    ┌──────────────────────────────────────────┐
    ├────│  Deliver audit fieldwork including       │
    │    │  review of control design and operation  │
    │    └──────────────────────────────────────────┘
    │
    │    ┌──────────────────────────────────────────┐
    └────│  Report audit findings with assurance    │
         │  opinion and areas for improvement       │
         └──────────────────────────────────────────┘
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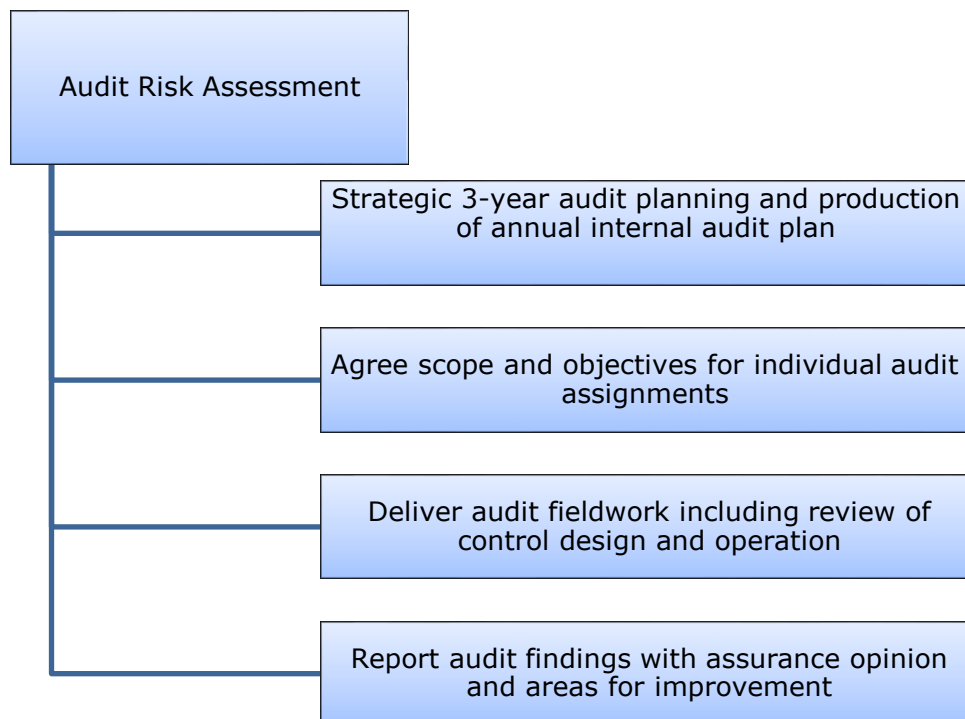
9   Reporting

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

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

- The Head of Internal Audit opinion will:

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

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

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

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

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

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

• For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and

• The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

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

• Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;

• Operational management will receive draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;

• The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B. The draft report will also indicate priority ratings for individual report findings and recommendations;

• Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 20 working days of issue, stating their agreement or otherwise to the content of the report, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;

Where the Executive lead advises Internal Audit that responding to the draft report within 20 days cannot be achieved due to the geographical nature of the Health Board, an alternative number of days will be agreed and formally reported to the Board Secretary and Audit Committee.

• The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the

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

- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;

- Final reports inclusive of management comments will be issued by Internal Audit to the relevant Executive Director within 10 working days of management responses being received; and

- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee. Where relevant, the Office of the Board Secretary will forward the final report to the Independent Member identified as Board Champion for the subject matter.

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

10   Access and Confidentiality

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

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

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

11   Irregularities, Fraud & Corruption

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

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

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

12 Quality Assurance

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

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

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

13 Resolving Concerns

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

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

14 Review of the Internal Audit Charter

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

Simon Cookson
Director of Audit & Assurance - NHS Wales Shared Services Partnership
February 2019

Appendix A: Audit Reporting Process

Audit fieldwork completed and debrief with management.	Following closure of audit fieldwork and management review audit findings are shared with operational management to check accuracy of understanding and help shape recommendations for improvement to address any control deficiencies identified.
A draft report is issued within 10 working days of fieldwork completion and the resolution of any queries.	Draft reports are issued with an assurance opinion and recommendations within 10 days of fieldwork completion to Operational Management Leads, and copied to the relevant Executive Leads.
Management responses are provided on behalf of the Executive Lead within 20 working days of receipt of the draft report, or longer if agreed at the audit brief stage.	A report clearance meeting may prove helpful in finalising the report between management and auditors. A response, including a fully populated action plan, with assigned management responsibility and timeframe is required within 20 working days of receipt of the Draft report or per agreed period in the brief.
Outstanding responses are chased for 5 further days.	Where management responses are still awaited after the 20 day deadline, a reminder will be sent. Continued non-compliance will be escalated to Executive management after 5 further days.
Report finalised by Internal Audit within 10 days of management response.	Internal Audit issues a Final report to Executive Director, within 10 working days of receipt of complete management response. All Final reports are copied to the Board Secretary, Executive Lead and Audit Committee.
Individual audit reports received by Audit Committee.	Final reports are received by the Audit Committee at next available meeting and discussed if applicable. For reports with "green/yellow" assurance ratings, Executive Summaries are received for noting. For those with "red/amber" ratings, the full reports are received for discussion. The Audit Committee identifies their priority areas for Internal Audit to follow up and will request that the relevant Committee or Sub-Committee assumes responsibility for monitoring progress where red/amber is given.

Appendix B: Audit Assurance Ratings

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

Audit Committee 14.3.19	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Report Title:	Internal Audit Progress Report - 1st December 2018 to 28th February 2019
Report Author:	Dave Harries, Head of Internal Audit
Responsible Director:	Mrs Grace Lewis-Parry, Board Secretary
Public or In Committee	*Public*
Purpose of Report:	The progress report is produced in accordance with the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management and the Board. The report summarises ten assurance reviews finalised since the last Committee meeting in December 2018, with the recorded assurance as follows: • Reasonable assurance (yellow) – three; • Limited assurance (amber) – six; and • Assurance not applicable (blue) – one. The report also details: • Reviews issued at draft reporting stage as well as work in progress; • Follow-up status of twenty-one recommendations reviewed in the period; and • Recommendation for deferment from the plan the reviews relating to Wellbeing of Future Generations (Wales) Act 2015; Roster management; and Sustainability plan.
Approval / Scrutiny Route Prior to Presentation:	The report has been discussed with and agreed by the Board Secretary and details the individual opinions issued by internal audit.
Governance issues / risks:	The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan.
Financial Implications:	The progress report may record issues/risks, identified as part of a specific review, which had financial implications for the Health Board.
Recommendation:	The Audit Committee is asked to: • Receive the progress report; and • Approve the deferment of the three reviews from the 2018/19 plan.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	WFGA Sustainable Development Principle *(Indicate how the paper/proposal has embedded and prioritised the sustainable*	√

		development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)	
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper
http://www.wales.nhs.uk/sitesplus/861/page/81806
The internal audit progress report provides independent assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.

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

This report does not, in our opinion, have an impact on equality nor human rights and is not discriminatory under equality or anti-discrimination legislation.

Board/Committee Coversheet v9.01 draft

Internal Audit Progress Report

1st December 2018 to 28th February 2019

**Audit Committee
2018/2019**

Betsi Cadwaladr University Local Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

Contents

Introduction

1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues and progress against the Internal Audit (IA) Plan for 2018/19 which have been finalised since the last Committee meeting. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Deputy Board Secretary.

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

Reports Issued

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

Table 1 – Summary of assurance reviews issued as final

Title	Assurance Level	High	Medium	Low	Key Messages
East area governance arrangements Review completed September 2018 with Executive approval November 2018 *Lack of evidence that performance management issues were being reported and scrutinised through the established governance structure.*	Reasonable	1	2	-	This review has identified a number of housekeeping issues which the Area need to consider. **Governance Structures** We reviewed the terms of reference (ToR) and a sample of minutes and agenda from a number of groups/committees. We noted that whilst the majority of the ToR followed the template suggested by the Office of the Board Secretary, some did not with one meeting group yet to prepare ToR. In addition we noted that, taking a literal view on membership and quorum, some meetings held by one committee were not quorate although identified as so. Whilst another meeting group were not quorate on two meetings during the period November 2017 to July 2018, this was however identified as such in the minutes of the meeting. The terms of reference for this group contains the following instruction to its membership "Given the strategic importance of this work by BCUHB, all members must make every effort to attend all meetings". From reviewing one group's minutes we noted that several of the listed membership did not attend any of the four meetings in our sample, this covered the period January to July 2018. Although an overarching Area East Cycle of business (COB) was provided for review, we established that the separate meeting groups had not produced their

Title	Assurance Level	High	Medium	Low	Key Messages
					own cycles of business, which we would consider to represent best practice and be in keeping with the requirements of the Office of the Board Secretary. It is understood that the Finance and Performance Committee are currently preparing a cycle of business for the current financial year.
					We found examples whereby records were detailed, noted areas of discussion, scrutiny/challenge and where further actions were required. However, in some instances we found that it was difficult to ascertain whether actions were reviewed in corresponding meetings and in some cases actions were not assigned dates by which they should be addressed, allied to the fact that they were not always numbered it meant the audit trail was not robust.
					Overall we identified an inconsistent approach in respect of the format, contents and coverage of agendas and minutes for meetings held.
					Quality and Safety Arrangements
					From our testing we note that there are several forums at which Quality and Safety issues are discussed. The Area East Nursing team in conjunction with the East Area Governance Lead, actively monitor and report on Quality and Safety Issues. There is a Quality and Safety Committee Meeting which is held monthly and there is a Quality and Safety Report that is produced and shared widely.
					However whilst the themes that are covered within the Harm Dashboard are widely discussed and reported on there is little mention of the Harm Dashboard itself. Whilst we are confident that it utilised as intended at ward level, from discussions it does not yet appear to have been embraced by all those who could make use of it from a governance perspective.
					Performance Reporting
					The Area holds monthly operational Finance and Performance (F&P) meetings underpinned by approved agendas and minutes. We noted the tabling of a range of update reports from across the Area from the minutes of the meetings that formed our sample. We were advised minutes are forwarded to the Area Management Group.

Title	Assurance Level	High	Medium	Low	Key Messages
					However on reviewing the minutes of the sample of F&P meetings we found that they do not provide explicit evidence to support the assertion that Performance is discussed in the manner specified within the Terms of Reference.
Freedom of Information (FOI) Act (2000) Review completed December 2018 with Executive approval December 2018 *Whilst evident that the Health Board has its Publication Scheme, the internet pages and associated information have not been maintained, recognising that the information is likely to be available through other searches or through formal requests to the Health Board, although the site is not the most intuitive and accessing the information can be challenging.*	Reasonable	-	2	-	**Policy & Procedure** Procedure IG03 for the Compliance with Freedom of Information Act 2000 and Environmental Information Regulations 2004 has been in place since the 14th June 2011, with the last update in April 2017 (Updated responsibilities' and roles) and is due for a scheduled review 14th June 2019. **All requests are recorded** All requests are recorded, tracked and reported via Datix - all documentation and correspondence is copied into each request file and time lines recorded. The Freedom of Information internet page provides guidance to the public via access to the Publication Scheme; details their general right of access; how they could request access to Health Records; access to the Health Boards Disclosure Log; and what to do if they wish to make a complaint. The Health Board internet pages are not the most intuitive and accessing this information can prove challenging. **Response times are met** We received a report containing all 199 requests made between 1st April and 30th June 2018 (quarter 1), sixty (30%) of which had exceeded four (4) weeks (20 working days) to close or respond – We note that management are aware of this as it was accurately highlighted in the *Key Performance Indicator Report for quarter 1 – 2018/19* that went to the Information Governance Group on the 23rd October 2018. Of those requests that had exceeded the four week response period, we reviewed thirty one requests which had been received from the following sources: • six from the media; • one from a pharmaceutical organisation; • sixteen general enquiries; and • eight from Assembly Members or Members of Parliament. Our review identified: Two were reporting as still in progress (as at 13th September Report) showing as overdue, however,

Title	Assurance Level	High	Medium	Low	Key Messages
					a reply had been recorded in Datix within the twenty working days for both these requests. Thus reducing the sample of overdue requests to twenty nine. • Eighteen Requests had all information delivered; • Ten Requests were completed with information partially delivered; and • One was recorded as Information Available Elsewhere. We did not find any evidence within Datix that a holding letter, apologising for the delay was sent to any of the requestors in the sample. There was no documentation held within Datix and we were unable to evidence any letters received or sent e.g. request, final letter, update, pricing. Of the delayed requests reviewed, one was due to Information Governance, with the remainder delayed by the relevant management or executive lead. Only 70% of the requests for the first quarter were responded to within the twenty working days target, however there is clear evidence that management have identified this as a key priority. **Delays in response times recorded, reported and quantified** The FOI performance is reported as part the departmental quarterly KPI reports which are presented at the Information Governance Group. Any issues of significance are reported to the Finance and Performance Committee and in future will be to the Information Governance and Informatics Committee. Performance is also reported via the Information Governance Annual Report. Information Governance provide weekly reports detailing the Freedom of Information and Environmental Information requests received as well as collating the Welsh Government Weekly return report [which is forwarded to all FOI Leads across Wales] detailing the number of specific requests from each Health Board/Trust; this weekly update report is provided to the Welsh Government each Thursday. **Publication Scheme** The Health Board has adopted the Model Publication Scheme (Latest Version 1.2 Published 23rd October

Title	Assurance Level	High	Medium	Low	Key Messages
					2015) produced by the Information Commissioners Office (ICO) which define seven broad classes of information, details of which are below, these are said to be available in both English and Welsh. We reviewed the available publication scheme online for completeness and seamless access to information and note whilst it is evident that the information is not accessible directly from the publication scheme internet pages, it is recognised that the majority of information is available to the public from the wider Health Board internet pages.
Risk Management Strategy Review completed November 2018 with Executive approval December 2018 *Progress was evident in achieving implementation of the risk management strategy and associated supporting documents/ governance structure; however there remains gaps across most areas to ensure it becomes fully embedded.*	Reasonable	1	-	-	This review has sought to evidence progress made across the three key headings. **Divisional Risk Management Procedure in place (RM04)** The Corporate Risk Management Department has developed a Risk Management Procedure template (RM04) to support the Division/Area/Function and this documents the formal escalation and de-escalation process for the respective area of the organisation. We met with all risk management leads (eighteen in total) to ascertain if the RM04 had been implemented within the respective Division/Area/Function. At the time of the review the Division/Area/Functions were at different stages of development. We found that eleven had an RM04 which had been ratified; six at draft stage with one yet to develop its procedure. **What training has been provided to support Areas/Divisions /Functions?** Risk Management Training is provided by the Corporate Risk Management Department, within the Office of the Board Secretary (OBS). Training dates have been evidenced for the Corporate Risk Management Team to deliver monthly Datix Risk Register Training within all three areas; similarly we noted monthly training sessions provided by the Datix manager for incident training. The Corporate Risk Management Team additionally provide ad hoc training when requested. Of note, capacity and engagement from some departments to support planned Risk Management training has been poor and requires improvement. Areas/Divisions/Functions have engaged with the training offered to various degrees. There was an

Title	Assurance Level	High	Medium	Low	Key Messages
					overall view that if the Corporate Risk Managers delivered more training in the relevant meetings within the localised governance structures, the training would be more pertinent to their Areas/Divisions/Functions. Likewise those who had received training within their existing meetings had found the training to be very beneficial. The Corporate Risk Management Department record all training that has been provided, however there did not seem to be a consistent approach to recording the attendance within the Areas/Divisions/Functions, where this is delivered by local risk officers as opposed to the corporate team. **Has Risk Management been embedded within the local governance structure?** When reviewing the governance structure there was a direct correlation between the development of the RM04 and the embedding of risk management within the structure. Areas/Divisions/Functions that had implemented the RM04 were able to evidence that risk management had been embedded within their governance structure. Where the RM04's were at a draft stage there was evidence of discussing risks, however the system was at a less advanced stage of implementation. **Summary** Across all areas/divisions/functions reviewed, we identified four which could not demonstrate full implementation (green) across any one of the three key headings. Area East; Medicines Management; and Radiology/North Wales Managed Clinical Services were noted as amber *(Progress has been made but further action required to complete)*. Nursing and Midwifery corporate function was noted as red *(No/limited evidence to demonstrate implementation)*.
Booking of medical agency staff Review completed August 2018 with Executive approval December 2018	Limited	2	-	-	**Agency Locum SLA/Procedures** We were provided with two contracts setting out the arrangements between the Health Board and Medacs Healthcare PLC. A letter from Medacs Healthcare PLC was also provided in respect of the original contract to confirm the contract start period was October 2015 however, due to a number of minor contract changes, this was not signed until July 2016 by Medacs Healthcare PLC Chief Executive

Title	Assurance Level	High	Medium	Low	Key Messages
We found inconsistent recording of information in MASDA and the SOP requirements were not always adhered to.					(27/7/16) and Executive Director of Finance (27/7/16) on behalf of the Health Board. A second copy contract showed sign off by Medacs Healthcare PLC Chief Executive Officer (2/8/18) and Executive Director of Finance (17/07/17) on behalf of the Health Board. We were provided with a copy of the Health Board Standard Operating Procedure (SOP) Medical Agency Locum Appointments (BCUHB) version 1.9 and version 2.0 and worked to this for ascertaining compliance. The review of the above documentation found: • The document relates to a three year period, expiry date 27th October 2018; we were advised that the contract will be rolled forward; • We were advised by Finance Director – Provider Services that suitability and quality of Agency staff provided by Medacs Healthcare PLC (Medacs) is included in the regular telephone call contract meetings. The review focused on three risk areas identified through discussion with management. **Womens** From the sample tested, in some instances, we found: • No specific examples whereby internal cover had been sought, no details why cross cover was not feasible detailed on Masda; • No long term plan or in some instances long term plan details are unclear, for example, "long term plan is to cover these in advance internally" or "Fill vacant posts". • No risk assessments to support necessity for Agency cover. • Risk assessment guidance is not set out in the Agency Locum SOP. • We noted from some of the vacancy information provided that there had been delays in posts being advertised. • Agency staff used to cover annual leave - We were advised that had agency cover not been used "clinical activity would need to be stood down". • We were provided with email details relating to the use of off-framework agency although approval had been recorded via the Masda system. **Ysbyty Glan Clwyd (YGC)**

Title	Assurance Level	High	Medium	Low	Key Messages
					Our sample covered the following specialities at YGC: • Cardiology; Haematology; Histopathology; ENT; Trauma and Orthopaedics; General Surgery; Accident and Emergency; Anaesthetics; Urology. From the sample tested, in some instances, we found: • No specific examples where internal cover had been sought; details had been entered on the MASDA system to state "cross cover is not an option due to the need to be specifically trained"/"other sites are having the same problem"/reference to support available at SHO level but unable to cover the on calls on the "2 x 12 hour rota". • Majority of non-medical staffing options to cover posts were recorded as either "Not Applicable" or "None"; Reference was made to nurse led clinics in place to support where feasible and further reference to training of specialist BMS staff however no further details were recorded. • Limited risk assessment, recruitment or longer term plan details to support information provided as a justification for booking Agency staff. • Longer term plan details recorded as awaiting start date for new doctor but no further information provided or correlation to a specific vacancy/recruitment action plans. • Limited information regarding the vacancy to be covered by agency staff requested/booked; No details of cross-cover or non-medical staffing options. • Booking requests were withdrawn or rejected, however no further details as to how post/duties were to be covered. In some instances booking requests had been initially raised to cover significant periods for example, 510 hours, 340 hours, 638 hours. **Mental Health & Learning Disabilities (MHLD)** From the sample tested, in some instances, we found: • No specific examples where internal cover had been sought due to the specialised care required and doctors working on other wards usually do not have the required experience.

Title	Assurance Level	High	Medium	Low	Key Messages
					• We were advised that a "bank system – junior doctors" may be used when appropriate but not for full-time vacancy post cover. Non-medical staff cannot be used for vacancy cover. The majority of non-medical staffing options to cover posts were recorded as either "Not Applicable" or "None"; Reference was made to nurse led clinics in place to support and further reference to training of specialist BMS staff. • No risk assessments were available or longer term plan details to support information provided as a justification for booking Agency staff. • Financial monitoring details provided with full year effect in respect of supply and costs. There was no management/monitoring information in respect of non-contract Agency staff.
Implementing the Falls Policy Review completed September 2018 with Executive approval October 2018 *The review identified the policy had been implemented across all areas visited; we identified issues of compliance with expected completion of documentation across the areas reviewed.*	Limited	3	1	1	**Progress since launching the Falls Policy** Our review of twelve wards (six acute; three mental health; three community) identified the following: • The falls pathway had been implemented within all the wards visited. However we noted that there did not seem to be a consistent approach to the arrangements of the pathway within the patient notes – this led to difficulty in locating the required entry within the patient file. • All general wards visited were monitoring their falls through the Harms Dashboard. • The mental health wards were using a monitoring system different to Harms, however the information being analysed on the wards was comparable [recording falls through a patient falls management and measles charts wall mounted board]. In accordance with Policy NU06 the Prevention and Management of Adult In-patient Falls, section 6.2, Training, notes the following: *All ward staff will receive mandatory falls training once every two years.* We noted that access to the training module was temporarily lost due to the migration to the Electronic Staff Record (ESR), consequently we cannot identify compliance that the training undertaken has met Policy requirements. **Completion of Patient falls Pathway testing** The testing was based on four wards within each area, two from acute one from community and one

Title	Assurance Level	High	Medium	Low	Key Messages
					from Mental Health. We were accompanied throughout the testing by clinical professionals as agreed and organised with the falls prevention project manager. Five patient notes were randomly chosen from each ward and within the notes the falls assessments were then scrutinised for completion. The review identified: • Signatures and Dates missing from sections of the patient falls assessment forms. • Patient Assessment forms are not being reviewed. • Variance section not completed if circumstances of the patient has changed. • Patient assessment forms found to have been photocopied. • Patient labels not attached to all of the sections. • Visual and hearing issues identified within adult nursing assessment documentation however not acknowledged within patient falls assessment forms. • Culpable medication identified within adult nursing assessment documentation however not acknowledged within patient falls assessment forms. • Adult nursing assessment documentation identified incontinence however not acknowledged within patient falls assessment forms. • Sections within the patient falls assessment forms for instance Medication, Visual and Hearing and mobility not fully complete.
Primary Care GP Leases: Assigning leases to the Health Board Review completed October 2018 with Executive approval January 2019 *There is no overarching procedure through which the Health Board structures its decision making*	Limited	3	-	-	**Process for agreeing Schedule of Dilapidation** There is no evident standard operating procedure in place which outlines the roles and responsibilities Area management, supported by Estates and Facilities, should follow due to changes in partnership or when a GP practice terminates their general medical service contract which also includes the appetite to transfer responsibility for existing property lease commitments. **Schedule of Dilapidation** At the point the Health Board receives a request to support the practice due to changes in partnership arrangements or receives a formal notice that the GP practice [single-handed or partner] decide to terminate their primary care contract with the Health Board, it may have implications for the associated lease taken out by the

Title	Assurance Level	High	Medium	Low	Key Messages
and identification of all costs prior to assuming lease ownership. We identified one lease which had not been formally approved by the Health Board at time of this review but has since been considered by the Board.					individual/practice and one which the Health Board may have to take over. The notice period for a practice to give the Health Board is dependent on the amount of GP's working within the practice [Single-handed GP required to give three months; Partner practice required to give six months]. There is no documented standard operating procedure for the management and agreement of the schedules of dilapidation when leases are to be signed to the Health Board. We sought to identify all transfer of leasehold responsibilities approved by the Finance and Performance Committee, on behalf of the Board, to verify approval and follow through the expected process. We identified through reviewing Committee meeting minutes for the period 24th January 2017 to 24th August 2018, six GP practices where the business cases were being considered and recommendations for approval by the Committee. We also met the Senior Property Manager who advised on a further four GP practices. Of the properties we identified, all were at different stages of completion with regards to the dilapidation schedule. Complications occur when the Health Board and GPs do not negotiate an agreed schedule of dilapidation. At the time of this review, two of the properties were at an impasse regarding the negotiations of the schedule of dilapidations. **Business cases for GP leases** From the ten GP leases we received six business cases. Having reviewed the business cases provided we could not find any evidence relating to the Schedule of Dilapidation and associated costs to the Health Board recorded. As a point of note time constraints relating to the notice period given to the Health Board from the GP's makes this difficult to include the associated costs. We note the Health Board has developed a Revenue Business Cases Guidance and Template (September 2017) and whilst some did follow in principle the methodology of the guidance, we noted variances against expected steps outlined in the template.

Title	Assurance Level	High	Medium	Low	Key Messages
					Welsh Government forms ADL 1, 2, 3 Welsh Health Circular (2015) 031 *Arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process)* issued 22nd June 2015 states detail the steps to follow in seeking Government approval. The ownership and responsibility for completing ADL 1 lies with the Senior Property Manager with ADL 2 and 3 the responsibility of Area Management. The review identified one ADL 1 having been completed (no Welsh Government approval required); no ADL 2 have been provided to us (as not required); and five ADL 3 forms have been sent. We received evidence of Welsh Government approval for four of the five. **Signing and Sealing Documents** Standing Order 8.0.1 states: *"The common seal of the Health board is primarily used to seal legal documents such as transfer of land, lease agreements and other important key documents. The seal may only be fixed to a document if the board or Committee of the Board has determined it shall be sealed, or if a transaction to which the document relates has been discussed previously by the board or the committee."* Working through the Office of the Board Secretary, we viewed the register of documents signed under seal on the 4th October 2018. We identified the following three having been signed under Seal on 13th September 2017(new lease); 13th November 2017 (assignment); and 29th January 2018 (signed as a deed of indemnity).
Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference Review completed October 2018 with Executive approval December 2018	Limited	3	3	-	*'Hospital catering and patient nutrition is a key element in ensuring that people make a full and healthy recovery while in hospital. Patients should be well fed and hydrated in hospital, this should not be optional or, left to chance depending upon which hospital or health board you are in.* *Without ensuring the availability of nutritious food and good hydration, there is a potential for patients to come to harm.'* (Source: Public Accounts Committee Report). This review has sought to evidence progress made across the five key areas considered in the report. Overall, we cannot evidence performance data or assurance being routinely scrutinised and reported

Title	Assurance Level	High	Medium	Low	Key Messages
The review identified a great deal of work was being undertaken operationally through INCHS, however this has not been subject to formal reporting or scrutiny through the Health Board Committee structure; There was poor self-assessment scores and no evidence how the wards were tasked with improving performance.	[yellow]				through the Committee structure to the Board. **Governance and reporting arrangements** There are a number of meetings established which can evidence discussing catering and nutrition, however there is no formal thread of assurance, through to the Health Board/Committee evidenced in the terms of reference (both approved and draft). <u>Policy</u> The review of the nursing policies and key documents intranet site records '*NU11 – Nutrition support clinical protocol for adults'* however on clicking the hyperlink, we were taken to the 'File not found' page. We identified draft policy 'NU17 – Nutrition and Hydration Policy [V0.1]' included on the agenda of the Quality and Safety Group meeting of the 14th March 2018 where the meeting noted receipt with the Minutes stating "...was not discussed." We discussed the status of the draft policy and were advised that this has not progressed. We also note in reviewing the nursing policies and guidance page that reference NU17 is already in use and relates to a different subject. <u>Improving Nutrition, Catering and Hydration Standards Group (INCHS)</u> The INCHS group is the vehicle established to drive forward all matters relating to catering, nutrition and hydration standards. We were provided with its Terms of Reference (TOR) referenced '*4.12.15 INCHS ToR updated January 2017'* and note that accountability "…….*will report through the east governance structures"* and reporting "….*Issues of significance and an update briefing will be provided to the East Area Quality & Safety Group and escalated to the Quality Assurance Executive where relevant*." We cannot see evidence of formal issues of significance or minutes reported through East Area and confirmed that this does not happen [we noted this was due to several changes in the Area Director of Clinical Services post]. **Training data – Food record chart** There is an all-Wales Food record chart training module where we were advised [and management believed] it was a mandatory training element for all nursing staff.

Title	Assurance Level	High	Medium	Low	Key Messages
					Management were subsequently advised it was not but are progressing this with Organisational Development for it to become mandatory as part of the refresh of required training.
					We obtained details from the Orientation and E-Learning department, Workforce and Organisational Development Directorate and noted poor completion rate for the period 1st August 2016 to 17th September 2018 where only sixty-eight individuals have completed the training and passed. The issue of training is identified across two recommendations made by the PAC in its report.
					Patient Feedback
					There are several ways in which the Health Board captures patient feedback.
					• Ward monthly audits
					Three specific questions are asked to a sample of patients as part of the ward Health & Care Standards Patient Experience Survey. There is a 95% target compliance score and from the findings, patients have regularly fed-back that there are opportunities for wards to improve the provision of nutritious food and snacks.
					We have been unable to ascertain that ward managers/matrons are actively using this data to improve services and are unclear how they are held to account for non-achievement of the target.
					• Community Health Council (CHC) Foodwatch/Carewatch
					We were provided with log where the Health Board has recorded twenty-seven CHC reports issued from April 2018, eighteen relating to Carewatch, which includes six questions under its *Eating and Drinking* section.
					One theme we noted at two wards visited concerned the availability of cold drinking water for patients as opposed to tap water.
					Ward quality and safety audit self-assessment
					Each ward should complete a self-assessment against a set of questions which is then input into the NHS Wales Health & Care Monitoring system which is signed off by the sister that all metrics are included. The Matron should then quality assure and locks the return. Data is then drawn down to the data warehouse to populate the dashboard.
					We note the Health Board is introducing ward

Title	Assurance Level	High	Medium	Low	Key Messages
					accreditation from October/November 2018 and we have been provided with the draft questions, where 25 key questions are noted on nutrition and hydration which significantly broadens those currently self-assessed by the wards. At the time of this review, the requirements for completing the ward quality and safety assessments remained live and for completion. Our review of ward quality and safety findings for nutrition and hydration identify (as at 2nd October 2018), overall poor self-assessment scores from across the Health Board for January to September 2018 (target compliance is 95%). **Financial and operational performance data in delivering the catering service** Estates and Facilities Performance Management System (EFPMS) EFPMS is a comprehensive collection of estates and facilities data set by Welsh Government to improve the management of NHS estate in Wales. The data is directly input by NHS Wales Health Boards and Trusts and is used to facilitate and monitor improvements in performance in the health estate in Wales. We obtained the current all-Wales EFPMS report relating to 2016/17 (2017/18 is set to be published in November 2018) and also obtained the Health Board's 2017/18 submission for comparative purpose. In 2016/17, the Health Board's cost per patient meal is 27p more expensive than average but it does produce one million more meals than the average for NHS Wales Health Boards. The Health Board significantly over-achieved its reported non-patient income compared to the all Wales average and also is one of only two Health Boards which has a positive contribution in delivering its non-patient catering service, thus generating income to offset its patient meal service. Finance reports We obtained the month 12 report for 2017/18 and month 5 report for 2018/19 and reviewed the income received and overall financial position. 2017/18 identified an overall overspend for patient and non-patient catering service of £255,463.

Title	Assurance Level	High	Medium	Low	Key Messages
					The review of month 5 2018/19 report noted the catering service is £50,876 overspent, with catering income overachieving by £85,397.83. Noting the financial pressures placed upon the service, we have been unable to ascertain whether the Health Board has formally considered and committed to subsidising the provision of non-patient catering services i.e. is it a welfare service for staff/visitors or an income generation activity.
Managing the outpatients backlog Review completed November 2018 with Executive approval January 2019 *The review has identified a number of issues surrounding data quality and the effective integration of systems to ensure the correct patients are on the outpatient follow-up list with those subject to formal discharge removed. However, we did escalate details to management of patients who appeared at risk and should have been followed up.*	Limited	4	1	-	We were provided with an overview of reporting processes to Welsh Government. We reviewed Outpatients Follow up appointments system data relating to Cardiology and Urology in respect of the 3 main Acute sites; Ysbyty Gwynedd (YG), Ysbyty Glan Clwyd (YGC) and Ysbyty Wrexham Maelor (WXM) for period ending 31st March and 31st August 2018 and agreed to totals reported for the same period to Welsh Government. **Procedures, roles and responsibilities** There is no overarching Health Board guidance or Speciality SOPs in place to clearly set out priorities, expectations, deadlines, accountability and reporting mechanisms. **Oversight governance and reporting arrangements** We attended and observed the Planned Care meeting to gain an overview of Planned Workstreams/transformation programmes to improve Outpatients appointments Backlog. The meeting was chaired by Welsh Government with Health Board management providing updates and agree outstanding actions/deadlines and timeframes. Performance Management reporting in respect of Outpatient Follow Up appointments is at a high level. There have been no reports (or oversight/scrutiny) in respect of the Outpatient Follow up Backlog by the Secondary Care Senior Management Team over a number of recent months. We were provided with details of the Outpatients/follow Up appointments raised on the Secondary Care Risk Register. **Outpatients follow up appointments waiting list testing** Our review included testing of computer generated random sample of Outpatients follow up appointments provided by Informatics in respect of

Title	Assurance Level	High	Medium	Low	Key Messages
					Urology and Cardiology specialties across the three district general hospitals. From the sample tested we found the following a number of specific issues across all including: • A follow up appointment showing on the waiting list over 200 weeks which we escalated; • Urgent overdue high risk patients with follow-up dates of 17th March 2017 and 14th August 2017 which we escalated; • Several patients with overdue follow-up appointments; • Several instances of the sample require removing from the Outpatients Waiting list with an additional up processes/systems to remove patient from waiting; • Systems do not appear integrated to remove patients from waiting lists when discharged or seen by other clinicians, in different clinics. We were advised that there is a large system backlog complicated by WPAS system data issues whereby Informatics staff informed management that patient data showing on the Outpatients waiting list maybe incorrect and that Senior Management (DGMs) and staff are currently reviewing each patient record to validate/remove from Outpatients Follow Up Waiting List.
The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Part 6: Redress Review completed December 2018 with Executive approval January 2019 *The Corporate Concerns Team and associated processes through to completion of*	Limited	1	-	1	Our sample comprised of ten random redress claims that were closed during quarter two (1st July 2018 through 30th September 2018) of the 2018/19 financial year. Of these ten redress claims, eight had been settled by means of financial compensation, one had been deemed not suitable for redress as the damages would likely exceed the £25,000 threshold outlined in the guidance notes. For the remaining claim, whilst a breach of duty had initially been accepted, expert evidence proved otherwise. The total monetary value of our sample was £62,250.00. **Process management and documentation** The Health Board has in place the PTR01a Concerns Procedure policy document which underpins the requirements set forth in Putting Things Right and The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 statutory instrument. Whilst concerns are managed and driven by Investigating Officers assigned from operational

Title	Assurance Level	High	Medium	Low	Key Messages
redress documentation were fully compliant with expected controls; Operational departments' compliance in responding to claimants was not routinely adhered to and breached Statutory timelines.					services, Clinical Governance teams, and/or the Corporate Concerns Team, working in compliance with policy requirements, redress cases are managed centrally by the Senior Concerns Manager – Redress. The Concerns Management Procedure policy document states the following; "An initial assessment of redress will have been made by the central concerns team. It is the duty of the Lead Investigator to review this and decide whether it is correct." However, we were advised that involvement is typically initiated following the drafting of the interim report, which is consistent with the process flow chart detailed in the policy document. **Redress claim documentation** For each of the ten redress claims in our sample we found no issues of significance with regards to the administration of redress claims documentation. The following findings were noted: • Qualifying liability in tort was noted in all interim reports reviewed. However we found one instance where a breach of duty was admitted in the interim report but was subsequently reversed following expert review. This was fully documented, and no payments were made. • No interim report was issued for one case in our sample. Rather, the final communication of decision including the investigation report per Regulation 33 had been issued in the first instance. • In each instance the documentation had been completed comprehensively and had been authorised by the Executive Director of Nursing and Midwifery. • In all instances where a financial offer of redress had been made, the offer was consistent with the advice of the Legal and Risk team. • There were two instances within our review sample where the initial financial offer had been rejected by the claimants. Amended offers had been made and subsequently accepted. In both instances, the process was transparent, fully documented and authorised. • Where relevant, waiver forms had been completed and signed by the claimant (or representative), and retained.

Title	Assurance Level	High	Medium	Low	Key Messages
					• Appendix T documentation had been completed appropriately. • All payment backing documentation and finance request forms had been retained, scrutinised, and authorised appropriately. • All physical files reviewed were well organised, and were consistent between cases. **Response timescale compliance** Whilst completion of the redress documentation was in full compliance with the requirements set out in the relevant statutory instrument and supporting policy documentation, we found several instances in our sample where the stipulated timelines for responding to claimants were not adhered to. The legislative and policy documentation states that an interim response under Regulation 26 must be issued within 30 working days of receipt of the concern, together with an interim report. We reviewed the dating of key documents for each claim in our sample against these requirements and found the following issues and limitations: • None of the Regulation 26 interim reports reviewed had been issued within thirty days of concern notification. • A holding letter explaining the process and reasons for delay had been issued for eight of the ten claims within our sample. However, none of these had been issued within thirty days of concern notification. • The initial holding letters within our sample had been issued between 37 and 98 days following notification (with our sample average being 59 days). • We found examples of subsequent holding letters having been sent keeping claimants apprised of how the investigations were progressing. However these were not subject to our review as neither the Regulations nor the policy documentation made provision for these. • Regulation 26 interim reports had been issued for seven of the ten claims in our review sample. Of these, only one interim report had been issued within six months of first notification. The remaining reports had been issued between 191 and 453 days following notification (with a sample average of 295 days).

Title	Assurance Level	High	Medium	Low	Key Messages
					• A report detailing the findings of the incident review and communicating the decision and offer to the claimant per Regulation 33 was available for nine of the ten cases reviewed. Of these, three had been issued within twelve months of the date of first notification in compliance with the statutory regulations. • Whilst one further offer was issued within one month of the required twelve month period (22 days over), the five remaining examples in our sample were significantly outside the timelines specified in the Regulations. • In these instances the offers were made 79, 118, 311, 429, and 673 days respectively over the initial twelve month period specified in the Regulation and policy documentation. The above findings demonstrate significant deviation from the response time requirements specified in the Regulatory and policy documents. We noted that the three Regulation 33 offers that had been made within twelve months in compliance with the policy requirements, were amongst the four cases that had been referred to the hub early (i.e. within five months of initial notification). **Datix administration** From our sample of ten cases, we found three instances where the primary complaints chain date recorded in Datix did not match the date of first notification. The dates varied by two, six, and fourteen days respectively. Whilst the above variances may not be considered material, it is imperative that the primary complaints date in Datix is accurate as all key reporting deadline dates are derived from this.
Follow up of the Informatics Service Clinical Coding Audit Report dated 18th April 2018 Review completed November 2018 with Executive approval December 2018	Assurance not applicable	-	-	-	The Health Board is mandated to clinically code all finished consultant episodes for all patients admitted through its system. Clinical coding requires accurate coding of patient diagnoses and procedures. The completeness and accuracy of this data is also measured by way of a data quality standard and is monitored against a Welsh Government performance measure for coding completeness. The measure requires all organisations to code 95% of all finished consultant episodes within one month of the episode and date. In September 2018 coding

Title	Assurance Level	High	Medium	Low	Key Messages
Progress has been made towards implementing all recommendations made, however some action is still required for all to become implemented in full.					completeness was reported as 95.6% demonstrating compliance with the performance measure. The Health Board had a significant backlog of finished consultant episodes (FCE) that required coding. In May 2017 this backlog amounted to a figure of 70,583. In September 2018 the backlog had been reduced to 2,874.
					Delivery Measure 44 of the NHS Wales Delivery Framework 2017-2018 requires an improvement in the *"Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme".* It was noted that a review of a sample FCE's reviewed by NHS Wales Informatics Service (NWIS) in April 2017 identified that 84.19% of those primary and secondary codes reviewed had been accurately coded. The September/October 2018 NHS Wales Informatics Service (NWIS) audit programme identified an accuracy scoring of 88.7% for the Health Board. The 2018 NWIS Coding Programme completed in September and October showed improvements across all aspects of coding accuracy measured across the three sites. Preliminary NWIS audit findings were provided by email from the NWIS National Audit Programme Clinical Coding Lead.
					Our review focused on the implementation of the recommendations issued by NWIS in April 2018.
					Fourteen recommendations were made in the report and we identified progress had been made across all, with four (28%) implemented and the remaining ten (72%) noting progress having been made but some additional management action required to fully implement.
					No recommendations were made as we expect the partially implemented ten recommendations to be the focus of management attention to fully implement.

Work in Progress Summary

4. The following reviews are currently in progress:

 Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Case management and disciplinary process	Draft discussion report has been issued and has been updated to reflect comments received – Report sent for Executive approval.	30th November & 21st December 2018; 6th February 2019
Mental Health and Learning Disabilities governance arrangements	Draft report issued and meeting held to agree the content.	15th January & 20th February 2019
Corporate Legislative Compliance: Nurse Staffing Levels (Wales) Act 2016	Draft report issued and discussion held with management to agree the content.	30th January 2019
Secondary Care Division governance arrangements	Draft report issued and comments received from management which are subject to consideration.	1st February 2019
Welsh Risk Pool – Claims Management Standard	Draft report issued and awaiting management response.	7th February 2019

Fieldwork

5. The following reviews are currently in progress:

- Three year Operational Plan 2018/2019 – Review has commenced.
- Business continuity arrangements – Review is almost complete.
- Sustainability plan – Brief awaiting Executive approval.
- Revenue business cases – Review has commenced.
- Procurement arrangements: Integrated Care Fund; Cluster funding; and Primary care funding – Review has commenced.
- Delivery of savings plans – Review has commenced.
- Delivering the mental health strategy – Review is almost complete.
- Quality improvement strategy – Review has been agreed and is about to commence.
- Management of patient safety incidents related to informatics processes – Draft brief agreed, awaiting approval.
- Patients Monies – Review has commenced.
- Capital Systems – Fieldwork is complete and a draft report is being prepared for issue.
- Ysbyty Gwynedd Emergency Department – Review is ongoing.
- Ysbyty Glan Clwyd, Open Book – Fieldwork has commenced.
- Ysbyty Glan Clwyd Pain/Gain Mechanism – Fieldwork Initiated.

Follow Up

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

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

Table 3: Follow-up status of recommendations reviewed

Review Title	Recommendation Title	Follow-up status
Bleanau Ffestiniog Primary Care Resource Centre	Project Execution Plan	Closed - Verified
Bleanau Ffestiniog Primary Care Resource Centre	Phased Benefits Plan	Closed - Verified
Bleanau Ffestiniog Primary Care Resource Centre	Timely contracts	Closed - Verified
Bleanau Ffestiniog Primary Care Resource Centre	Costed AI's	Closed - Verified
Blaenau Ffestiniog Primary Care Resource Centre	Causality of AI Costs	Closed - Verified
Welsh Patient Administration System (WPAS)	Partnership Working- Formalising Contractual Arrangements	Closed - Verified
Welsh Patient Administration System (WPAS)	Governance Structure, Approvals, Reporting and Meetings	Closed - Verified
Welsh Patient Administration System (WPAS)	Dependencies	Closed - Verified
Welsh Patient Administration System (WPAS)	Budgetary Implications of WPAS	Closed - Verified
Welsh Patient Administration System (WPAS)	Quality Plan and Register	Closed - Verified
Welsh Patient Administration System (WPAS)	Service Continuity	Closed - Verified
Welsh Patient Administration System (WPAS)	Management of Project Risk	Closed – Verified; however the governance process followed requires improvement going forward to ensure actions are formally closed at the following meeting.

Review Title	Recommendation Title	Follow-up status
Carbon Reduction Commitment Order	Property Asset details	Closed - Verified
Access to Data - Business and Financial Systems and Workforce and Organisation Development	Policy and Procedure (Oracle R12)	Closed - Verified
Learning lessons – Welsh Government Reported Incidents	Closure on Datix	Closed - Verified
Learning lessons – Welsh Government Reported Incidents	Datix Administration	Closed - Verified
National Standards for Cleaning in NHS Wales	Governance Arrangements	Closed - Verified
Informatics: Service desk	Formalising Procedures	Closed - Verified
Informatics: Service desk	Maturity Level	Closed - Verified
Environmental Sustainability Report	Accuracy of reporting	Closed - Verified
Job Evaluation	Cancellation of Job Evaluation Panels	Closed - Verified

Third party assurance

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

Capital assurance

9. As outlined above, the draft report for the 2018/19 Capital Systems review is currently being prepared for issue. The focus of the current assignment has been on the capital prioritisation and approval arrangements operating within the Health Board.

10. Fieldwork is currently being concluded on the 2018/19 interim audit of the Ysbyty Gwynedd Emergency Department development.

11. The final audit briefs for the Open Book review and the examination of the Pain/Gain Mechanism at the Ysbyty Glan Clwyd redevelopment were issued on the 19th February 2019 (following agreement by management). Fieldwork is currently being initiated in respect of both reviews.

12. As previously reported, management had requested the deferment of the Primary Care review (i.e. systems in place to ensure benefits are realised and that appropriate lessons are identified and applied at any future procurement exercises), until Quarter 1, 2019/20. This will enable the consideration of the benefits realisation exercise scheduled for Canolfan Goffa Ffestiniog and reflect the end of defects period at Flint Health Centre within the proposed review.

Contingency/Organisational Support/Advice

13. Internal Audit is supporting the Health Board through providing advice and guidance on areas of control, new systems and processes, with increased time being used to support attendance and provide input at the three project meetings we are in attendance.

14. During the period, the following review/advice/guidance/support has been provided:

   - 'In attendance' at the Health Informatics Programme – WPAS Replacement Programme Board.

Delivering the Plan

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

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

17. The following reviews have been identified for deferment from the 2018/2019 original plan and have been agreed in principle with the Board Secretary prior to Audit Committee approval:

   - Wellbeing of Future Generations (Wales) Act 2015

     The Future Generations Commissioner for Wales has subsequently issued a self-reflection tool for completion by 14th December 2018 with further planned work in January 2019 by an independent team established by the Commissioner. A review of the self-reflection tool has confirmed that to proceed with the planned Internal Audit review would duplicate work and would not add value to the Health Board.

   - Roster Management

     Since the transfer of responsibilities to the Director of Workforce & OD, there is a great deal of work taking place across rota and roster management with two key Roster Improvement Plans developed with key milestone noted as 31st March 2019.

     In reviewing the *Paybill Review Progress Report* presented to the Finance & Performance Committee [17th January 2019 (Item FP19/13)], work is scheduled for completion by the 31st March 2019 and undertaking this review prior to then would not capture all steps and improvements being taken.

   - Sustainability Plan

     In scoping and developing the audit brief, the Executive lead has highlighted the timing of this review as we have noted that the plan is still being developed and the overarching strategy document remains draft.

     It is recommended that the three reviews are deferred for future planning and will feature when developing and considering the risk based plan for 2019/2020.

18. The following tables detail the planned performance indicators (Table 4) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 5) with the assurance provided.

19. Table 4 is reporting an amber status in the time taken to provide management response and has increased from 67% [2%] from the last Committee reporting period. We continue to experience delays in turnaround times of the management response and are referring more this year for the Board Secretary/Deputy Board Secretary's attention per the Charter.

Table 4 – Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement] with agreed extension by the Executive Lead at time of agreeing the audit brief	Amber	69%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v<20%	v<10%

Table 5 – Core Plan 2018-19

Planned output	Outline timing	Status	Assurance
Corporate governance, risk and regulatory compliance			
Annual Governance Statement	Q1	Complete – Head of internal audit annual report.	N/A
Welsh Risk Pool Claims Management Standard	Q4	Draft report issued.	
Risk Management Strategy	Q3	Final report issued.	Reasonable
~~Corporate Legislative Compliance: Wellbeing of Future Generations (Wales) Act 2015~~	Q4	Recommended for deferment.	The Future Generations Commissioner for Wales issued a self-reflection tool for completion by 14th December 2018 with further planned work in January 2019 by an independent team established by the Commissioner.
Corporate Legislative Compliance: Nurse Staffing Levels (Wales) Act 2016	Q2	Draft report issued.	
Approval of Plans by the Board	Q4		
Standards of Business Conduct	Q4		

Planned output	Outline timing	Status	Assurance
Mental Health and Learning Disabilities governance arrangements	Q3	Draft report issued.	
Secondary Care Division governance arrangements	Q3	Draft report issued.	
East Area governance arrangements	Q2-3	Final report issued.	Reasonable
Strategic planning, performance management and reporting			
Annual Report: Performance Analysis – Verification of reported data	Q1	Final report issued.	Reasonable
Three year Operational Plan - 2018/19	Q3-4	Work in progress.	
Business Continuity arrangements	Q4	Work in progress.	
~~Sustainability Plan~~	Q4	Recommended for deferment.	In scoping and developing this review, the plan is still being developed and the outline strategy is in draft format.
Revenue Business Cases	Q4	Work in progress.	
Financial governance and management			
West Locality Compliance with the Budget Setting Methodology	Q2-3	Final report issued.	Reasonable
Procurement arrangements: Integrated Care Fund; Cluster funding; and Primary care funding	Q3-4	Work in progress.	
Delivery of savings plans	Q3-4	Work in progress.	
Quality and Safety			
Annual Quality Statement	Q1	Final report issued.	Reasonable
Infection Prevention and Control – Safe, Clean Care	Q4	Work in progress.	
Quality Improvement Strategy	Q4	Work in progress.	
The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Part 6: Redress	Q3-4	Final report issued.	Limited
Delivering the Mental Health strategy	Q2-3	Work in progress.	
Managing the Outpatients Backlog	Q2-3	Final report issued.	Limited
Implementing the Falls policy	Q1-2	Final report issued.	Limited
Information governance and security			

Planned output	Outline timing	Status	Assurance
Management of patient safety incidents related to informatics processes	Q4	Brief issued.	
Freedom of Information (FoI) Act	Q2-3	Final report issued.	Reasonable
Clinical Coding (in partnership with Informatics)	Q2	Final report issued.	Not applicable
Operational service and functional management			
Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference?	Q2-3	Final report issued.	Limited
Patients Monies	Q4	Work in progress.	
GP Out of Hours (OOH) – Compliance with National Standards	Q1-2	Final report issued.	Not applicable
Workforce management			
Staffing costs – Review of staff earning more than £200,000	Q1	Final report issued.	Limited
~~Roster management~~	Q2-3	Recommended for deferment.	The Paybill Review Progress Report presented to the Finance & Performance Committee [17th January 2019 (Item FP19/13)] outlines continuing actions up to 31st March 2019 – Reviewing now would not capture all steps and improvements being taken.
Case management and disciplinary process	Q2-3	Draft report issued.	
~~NHS Wales staff survey – delivering the findings~~	~~Q3-4~~	Deferred.	Review has been superseded following publication of the 2018 survey findings and action plans were in the process of being developed.
Capital and estates management			
Environmental sustainability report	Q1	Final report issued.	Reasonable
Carbon Reduction Commitment Order	Q1	Final report issued.	Substantial
Primary Care GP Leases: Assigning leases to the Health Board	Q2-3	Final report issued.	Limited
SuRNICC	Q2	Final report issued.	Reasonable
Capital Systems	Q3	Work in progress.	
Ysbyty Gwynedd Emergency Department	Q4	Work in progress.	

Planned output	Outline timing	Status	Assurance
Ysbyty Glan Clwyd Follow Up	Q2-3	Complete	N/A
Ysbyty Glan Clwyd – Open Book	Q3-4	Work in progress.	
Ysbyty Glan Clwyd – Pain/Gain Mechanism	Q3-4	Work in progress.	
Compliance with the public sector internal audit standards – Contingency/assurance reviews			
Tendering for goods and services – Estates Department	Q3	Final report issued.	No assurance

Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Booking of medical agency staff

Final Report

BCU 2018/19

December 2018

NHS Wales Shared Services Partnership

Contents

Review reference:	BCU-1819-C38
Report status:	Final Report
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Draft report issued:	03/08/18
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	Head of Internal Audit
Executive sign off:	Executive Medical Director (17/12/18)
	Executive Director Workforce and Organisational Development (17/12/18)
	Finance Director Provider Services (6/12/18)
Distribution:	Director of Midwifery and Womens Services
	Finance Director- Commissioning and Strategy
	Assistant Director – Workforce
	Chief Finance Officer – MHLD
	Hospital Director - YGC
	Board Secretary
	Assistant Board Secretary
	Compliance and Assurance Manager
Committee:	Audit Committee

ACKNOWLEDGEMENT

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

Disclaimer notice - Please note:

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

1. Introduction and Background

This review was requested by the Finance Director on behalf of the Executive Director of Finance, and is additional to the detailed reviews within the financial governance and management domain within the 2018/19 internal audit plan. The relevant lead Executive Director for the assignment is the Executive Director of Finance.

The Health Board has developed and issued Standard Operating Procedure (SOP) *MD 01: Medical Agency Locum Appointments (BCUHB)* [Version 1.9] on the 18th April 2017 [with a noted review date of 18th July 2017] which records the process that must be followed in seeking to engage a locum, coupled with the workflow approval process through to engagement.

As the Health Board use a managed service, it is expected that the service provider is used for all engagements; under no circumstance should any department communicate directly with any agency except the managed service provider.

The *Finance Board Report – Month 10* [presented to the March 2018 Health Board meeting] records:

Secondary Care Division continues to overspend in month 10 and has a total overspend of £8.6m to date due to undelivered savings and other cost pressures within pay related expenditure. The use of medical and nurse agency remains a significant factor, some of which is being incurred to address costs associated with pressures within unscheduled care and deliver waiting time targets. Ysbyty Glan Clwyd remains a significant concern and the financial position deteriorated by £0.7m in January.

Mental Health and Learning Disabilities (MHLD) has a year to date overspend of £8.5m which is due to out of area placements, pressures with individual packages of care, agency costs and undelivered savings. Whilst the division still had an unacceptable overspent of £0.6m in month this is below the year to date overspend average run rate of £0.9m per month.

In reviewing the Performance Report, January 2018 [page 75: Exception report: Agency and Locum spend] the Women's Services expenditure appears to have remained constant and does not appear to have reduced.

2. Scope and Objectives

The objective of the review was to establish the controls operating are consistent with the SOP MD01 for the booking of medical agency staff.

The scope of the review was limited to Ysbyty Glan Clwyd (YGC); Women's Services and the Mental Health and Learning Disabilities (MHLD) Division.

3. Associated Risks

The potential risk considered at the outset of this review is a lack of internal control in respect of booking medical agency staff.
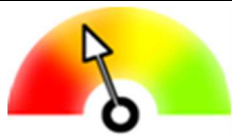
OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Booking of medical agency staff review is Limited assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	SLA/procedures		✓		
2	Womens		✓		
3	Ysbyty Glan Clwyd (YGC)		✓		
4	Mental Health & Learning Disabilities (MHLD)		✓		

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weakness in the system control/design for booking of medical agency staff.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weakness in the operation of the designed system/control for booking of medical agency staff.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Agency Locum SLA/Procedures

We were provided with two contracts setting out the arrangements between the Health Board and Medacs Healthcare PLC. A letter from Medacs Healthcare PLC was also provided in respect of the original contract to confirm the contract start period was October 2015 however, due to a number of minor contract changes, was not signed until July 2016 by Medacs Healthcare PLC Chief Executive (27/7/16) and Executive Director of Finance (27/7/16) on behalf of the Health Board. A second copy contract showed sign off by Medacs Healthcare PLC Chief Executive Officer (2/8/18) and Executive Director of Finance (17/07/17) on behalf of the Health Board.

We were also provided with management/monitoring graphical information by the Finance Director - Provider Services, as follows:

- Invoiced Hours and Invoiced expenditure;

- Hours filled; Hours by Reason; Hours by Grade; Directorate;

- Percentage over rate.

We were advised that the above key performance indicator reports are received monthly as a summary, for each site, with a weekly contract telephone call between Medacs and the Finance Director – Provider Services.

We were provided with a copy of the Health Board Standing Operating Procedure (SOP) Medical Agency Locum Appointments (BCUHB) version 1.9 and version 2.0. The SOP clearly defines roles and responsibilities and that the *"use of locum staff should not be regarded as a matter of routine. The Clinical Director / Directorate Manager / nominated clinical lead must ensure at all times that the use of locum staff is justified in terms of service provision, quality assurance and risk management… that Agency doctors are an expensive resource and paid at an enhanced rate"*.

Our review of the above documentation found:

- The document relates to a three year period, expiry date 27th October 2018; we were advised that the contract will be rolled forward;

- We were advised by Finance Director – Provider Services that suitability and quality of Agency staff provided by Medacs Healthcare PLC (Medacs) is included in the regular telephone call contract meetings;

- Section 4 of the SOP sets out a number of questions/justifications to be considered in determining locum requirements for each booking request. There is no specific guidance within the SOP in respect of completion of a risk assessment to support the agency booking request or that the supporting rationale/justification details should be uploaded into the MASDA system;

- Once the booking request has been submitted, from the SOP, it was not clear where responsibility lies to determine the urgency of the request. The SLA section 3B states that *"All engagements are filled quickly with a suitably qualified and experienced Work-seeker within set timeframes"*; we were not provided with monitoring information regarding Medacs response times. We were advised during several discussions with key leads that delays have been experienced in some instances in respect of the provision of Agency staff and that in some instances the number of Agency staff CVs may be limited;

- We found good practice with the Medacs financial monitoring information relating to agency staff hours, posts covered and grades.

We were not provided with details in respect of value for money in relation to expenditure, commission paid, total length of agency period/amount paid to individual agency staff and frequency/costs incurred when Medacs Services are not used (or the justification for this). No management/monitoring information was provided in respect of non-use of Medacs Agency staff.

Our detailed review did not consider the agency staff timesheets as the focus and scope agreed, was on the process followed in booking agency staff. The findings are detailed by the three areas our sample focused on.

Womens

We discussed the audit approach, sample coverage, Medacs contractual arrangements and working procedures with the Director of Midwifery and Women's Services and Chief Finance Officer prior to testing; Reference was made to the processes set out in Health Board Standing Operating Procedure in respect of Medical Agency Locum Appointments and the contract arrangements with Medacs. Our sample covered Agency staff booked to cover duties at the three main hospital sites.

From the sample tested, in some instances, we found:

- No specific examples whereby internal cover had been sought, no details why cross cover was not feasible detailed on Masda; The Senior Financial Advisor provided an email stating that internal cover is usually sought by telephone. However, the Director of Midwifery and Women's Services advised that internal cover / swaps are considered before agency in all circumstances as per SOP in Women's and manage the rates as per the NHS Internal cover arrangement rates; We have not corroborated this as part of our testing.

- No long term plan or in some instances long term plan details are unclear, for example, "long term plan is to cover these in advance internally" or "Fill vacant posts".

- No risk assessments to support necessity for Agency cover.

- Risk assessment guidance is not set out in the Agency Locum SOP. Our review of the risk assessments provided found several areas on the template which had either not been completed or had limited information detailed.

- We noted from some of the vacancy information provided that there had been delays in posts being advertised, e.g. Central vacancy effective date 11th September 2017; date of first advert 4th January 2018 and in two instances, two vacancies showing vacancy effective dates of 1st January 2018 with date of first advert 14th May 2018.

- Agency staff used to cover annual leave - We were advised that had agency cover not been used "clinical activity would need to be stood down"

- We were advised that discussions to take place to transfer to NHS Locum terms, do not usually take place for short term agency doctors.

- Justification reasons for cover were brief/generalised; for implications of the post not being covered, Masda states cover for vacancy however very brief note regarding recruitment/vacancy position/issues and no details stated of wider risk impact, operationally, financially.

- Overall rate payment analysis information is not explicit on booking request except if above capped rate and additional authorisation through Masda approvals hierarchy. The SOP states that Agency doctors are an expensive resource, paid at an enhanced rate and should not be regarded as a matter of routine. We were not provided with

monitoring information in terms of individual agency staff usage and costing implications over a longer period than the hours stated on the booking request.

- We were provided with email details relating to the use of off-framework agency although approval had been recorded via the Masda system.

We found examples of good practice; we were provided with details of reporting and oversight processes in place in respect of the Delivery Board; details of meetings where Medical Agency is discussed; examples of Monthly Directorate Finance and Performance Meetings/Bi Monthly Performance meetings; high value expenditure checks and copies of Medical Agency expenditure monthly reporting [with comparison to last year's expenditure] - we noted 2017-18, Medical Agency reduced by 64% compared to 2016/17.

We were also provided with vacancy details for each of the three hospital sites.

Ysbyty Glan Clwyd (YGC)

We discussed the audit approach, sample coverage, Medacs contractual arrangements and working procedures with the YGC Hospital Director and Chief Finance Officer prior to testing; Reference was made to the processes set out in Health Board Standing Operating Procedure in respect of Medical Agency Locum Appointments. Our sample covered the following specialities at YGC:

- Cardiology;
- Haemotology;
- Histopathology;
- ENT;
- Trauma and Orthopaedics;
- General Surgery;
- Accident and Emergency;
- Anaesthetics;
- Urology.

From the sample tested, in some instances, we found:

- No specific examples where internal cover had been sought; details had been entered on the MASDA system to state "cross cover is not an option due to the need to be specifically trained"/"other sites are having the same problem"/reference to support available at SHO level but unable to cover the on calls on the "2 x 12 hour rota".

- Majority of non-medical staffing options to cover posts were recorded as either "Not Applicable" or "None"; Reference was made to nurse led clinics in place to support where feasible and further reference to training of specialist BMS staff however no further details were recorded.

- Limited risk assessment, recruitment or longer term plan details to support information provided as a justification for booking Agency staff.

- Limited information recorded on the risk assessment - we were advised the template had been emailed by the Executive Medical Director with little guidance; staff were not aware of the Agency Locum SOP.

- Longer term plan details recorded as awaiting start date for new doctor but no further information provided or correlation to a specific vacancy/recruitment action plans.

- Limited information regarding the vacancy to be covered by agency staff requested/booked. High level explanation regarding the rationale/justification to request agency staff for example "failure to appoint locum would compromise on call days, night duties and ward cover". The narrative did not explicitly detail how this post would specifically impact on the ward/patient care or how long the vacancy has existed; No details of cross-cover or non-medical staffing options.

- Booking requests were withdrawn or rejected, however no further details as to how post/duties were to be covered. In some instances booking requests had been initially raised to cover significant periods for example, 510 hours, 340 hours, 638 hours. We noted as part of the justification for raising the request, implications of not having this post covered would impact on the safety of the ward and not being able to cover the on-call duties.

We found good practice with details/risks set out by the Haematology, Cancer Division Management Group, in respect of a paper "Senior Medical Cover - Haematology, YGC", (11th September 2017) stating issues concerning vacancies and the "fragile position due to the absence/vacancies of Consultant Medical Staff." Further details were provided regarding recruitment and cover options sought.

There was no management/monitoring information in respect of non-contract Agency staff.

Mental Health & Learning Disabilities (MHLD)

We discussed the audit approach, sample coverage, Medacs contractual arrangements and working procedures with the MHLD Business Support Manager and Chief Finance Officer prior to testing; Reference was made to the processes set out in Health Board Medical Agency Locum Appointments SOP.

From the sample tested, in some instances, we found:

- Vacancy/staffing establishment details were provided. The Business Support Manager advised of regular working liaison meetings, a co-ordinated approach with Workforce and Development and Clinical Directors that gaps are identified where substantive posts require agency cover. MHLD use agency doctors to cover substantive posts, not shifts. We were further advised of vacancies on the junior doctor rota due to lack of Deanery vacancies /ongoing LAS recruitment. We were advised there has been a period of three months to attract staff to MHLD posts.

- We were advised that there have been ongoing advertisements across MHLD with close monitoring during regular liaison meetings. In April 2018 one junior doctor was appointed from three vacancies and subsequently MHLD were able to reduce an initial request for agency cover by a third.

- No specific examples where internal cover had been sought due to the specialised care required and doctors working on other wards usually do not have the required experience.

- We were advised that a "bank system – junior doctors" may be used when appropriate but not for full-time vacancy post cover. Non-medical staff cannot be used for vacancy cover. The majority of non-medical staffing options to cover posts were recorded as either "Not Applicable" or "None"; Reference was made to nurse led clinics in place to support and further reference to training of specialist BMS staff.

- No risk assessments were available or longer term plan details to support information provided as a justification for booking Agency staff.
- Staffing establishment details provided with lists of advert deadlines.
- Financial monitoring details provided with full year effect in respect of supply and costs.
- Information relating to issues regarding Medacs were provided.

There was no management/monitoring information in respect of non-contract Agency staff.

7.   Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	2	-	-	2

Finding - ISS.1 - Agency staff engagements outside the managed service (Operating effectiveness)	Risk
There is limited evidence where engagements of Agency staff are made outside of the managed service.	Engagement of staff outside of the managed service are not scrutinised and may not deliver value for money.
Recommendation	**Priority level**
Controls and procedures for the engagement and monitoring of agency staff outside the managed service arrangements should be developed and properly embedded across the Health Board.	**High**
Management Response	**Responsible Officer/ Deadline**
As part of the Welsh Government implementation of Capped Rates for External Agency Locums, as per Welsh Health Circular WHC-17-042, an extensive communications plan was executed. During the implementation in October and November 2017, Clinical Directors, Clinical Leads, Rota Co-ordinators and other key stakeholders such as finance and WOD received individual letters and email communications with regards to the changes and actions required on a local basis both from Executive Medical Director and from the Head of Medical Workforce. A number of associated documents are detailed on the Executive Medical Director Intranet pages. This information will be circulated again to the Clinical Directors, Clinical Leads and Rota Co-ordinators.	**Head of Medical Workforce** **30 November 2018**

Finding - ISS.2- Processes for Booking Agency Staff (Operating effectiveness)	Risk
In reviewing the SOP, we noted no specific guidance in completing the risk assessment and once the booking request has been submitted, it was not clear where responsibility lies to determine the urgency of the request. The review across the three areas identified in this review identified: • No specific examples of where internal cover had been sought. • Majority of non-medical staffing options to cover posts were recorded as either "Not Applicable" or "None". • Risk assessment guidance is not set out in the Agency Locum SOP. • Limited/no narrative for the risk assessment, recruitment or longer term plan details to support information provided as a justification for booking Agency staff. • No long-term plan or in some instances the long term plan details are unclear, for example, "long term plan is to cover these in advance internally" or "Fill vacant posts". • Limited information regarding the vacancy to be covered by agency staff requested/booked. • Delays in posts being advertised. • No management/monitoring analysis information provided in respect of long term use of individual agency staff or Medacs services provided/agency staff booked.	Controls and processes are not operating as expected and guidance requires updating. Embedded controls in MASDA can be circumvented.
Recommendation	**Priority level**
The Medical Agency Locum Appointments (BCUHB) Agency Locum SOP (MD 01) is reviewed, updated and disseminated to all relevant officers across the Health Board to ensure internal controls in respect of booking Agency staff are adhered to in full.	**High**

MASDA fields are made mandatory and data is reviewed in full and gaps in rationale against the expected steps in the SOP identified and rectified prior to approving the booking.	
Management Response	**Responsible Officer/ Deadline**
The SOP will be reviewed and updated	**Head of Medical Workforce by 31 March 2019**
MASDA fields are made mandatory so that all information has to be identified before approving the booking or an alternative booking system will be introduced.	**Director of Finance, Provider Services 31 March 2019**

Appendix B - Assurance opinion and action plan risk rating
Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

	These are generally issues of good practice for management consideration.	

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

Betsi Cadwaladr University Health Board

Primary Care GP Leases: Assigning leases to the Health Board

Final Internal Audit Report

BCU 2018/19

January 2019

NHS Wales Shared Services Partnership

Limited Assurance

Contents   Page

Review reference:	BCU-1819-37
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Final report issued:	14th January 2019
Auditor/s:	Principal Auditor Head of Internal Audit
Executive sign off:	Director Primary & Community Care & Director of Planning & Performance
Distribution:	Assistant Area Director – Primary Care and Commissioning (East/Central/West) Director of Estates and Facilities Senior Property Manager Management Accountant Board Secretary & Deputy Board Secretary Finance Director Compliance and Assurance Manager
Committee:	Audit Committee

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1.   Introduction and Background

A lease is a legal document which regulates the occupation of a building between a landlord and tenant and details each side's responsibilities and liabilities. A lease will typically include the length of the agreement; monthly/yearly rental payment, as well as the obligations of the tenant while leasing the property.

Near the end of the lease term, unless the tenant has completed all the repair work required by the landlord under the lease, they should be issued with a Schedule of Dilapidations by the landlord. This outlines the details and work required to comply with the tenants obligations.

The Royal Institute of Chartered Surveyors (RICS) have published guidance for both tenant and landlord and noted the following *"Normally your surveyor and the tenant's surveyor will meet to narrow the differences to recommend a settlement figure to you and the tenant"[1]*.

Before the Health Board acquires the lease, the Health Board will need to consider and document for each transfer, through its *Interim Principles* [approved by the Finance & Performance Committee, 21st February 2017] the following:

- Strategic fit and long term requirement for health service provision of the premises;

- Functional suitability;

- Current internal and external condition of the premises;

- Alternative local premises;

- Sustainability of the GMS Practice; and

- Financial implications.

When the Health Board assumes liability for the leasehold with the landlord, it becomes accountable for all the dilapidation costs at the agreement's end. To this end, and in line with Interim Principles, the Health Board then should follow the same process for dilapidations with the outgoing GP leaseholder, who is accountable up to this point for all dilapidations.

In reviewing reports presented to the Finance & Performance Committee (F&P) since February 2017 to date, the Health Board has considered four '*Request to Transfer the Lease for GP Premises'* in the following areas:

- Central – Two approved by Committee [21st February 2017 & 21st November 2017].

- East – One approved by Committee [19th December 2017] and one deferred [21st January 2018].

2.   Scope and Objectives

The overall objective of the review was to determine if the Health Board is

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[1] Source: A clear, impartial guide to Dilapidations For use in England and Wales. RICS November 2013/DML/18832/ CONSUMERGUIDES

actively agreeing with outgoing General Practice (GP) leaseholders a schedule of dilapidation at transfer for all inward GP lease transfers agreed by the Health Board for the period April 2017 through to August 2018.

We have reviewed the process followed by the Health Board in agreeing a Schedule of Dilapidation for GP leases assigned to the Health Board.

We have reviewed the business cases established for the transfer of lease and reviewed the costs associated to the Health Board and how the issue of dilapidation is recorded and how the final negotiated settlement is reported.

In accordance with Welsh Health Circular (2015) 031 *Arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process)*, we will seek evidence that the relevant submission to Welsh Government on Acquire or Dispose of a Lease in Property (ADL) Forms ADL1; ADL2; or ADL3 have been made.

Signing and Sealing Documents - In accordance with Standing Order 8.0.1 "The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements…….." we have reviewed evidence to ensure all lease agreements have been appropriately signed.

3.   Associated Risks

The risks considered at the outset of the review were as follows:

- No contractual agreement to ensure that the Health Board is able to acquire the property back from the GP practice at the end of the lease.
- Unable to recover all the costs of the scheme of dilapidation if the process is not fit for purpose.
- Financial consequences to the Health Board.
- Reputational risk to the Health Board as disputes could culminate in court proceedings.

OPINION AND KEY FINDINGS

4.   Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Primary Care GP Leases: Assigning leases to the Health Board review is limited assurance.

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

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

5.   Assurance Summary

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

Assurance Summary					
1	Process for agreeing Schedule of Dilapidation		✓		

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weakness in the system control/design for Primary Care GP Leases: Assigning leases to the Health Board.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for Primary Care GP Leases: Assigning leases to the Health Board.

6.   Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This review has sought to evidence progress made across the four key areas considered in the report. It is based upon the information/documents provided by management and responses during discussions. We have relied solely on the documents, information and explanations provided and except where otherwise stated, we have not undertaken any work to verify the accuracy of data.

Process for agreeing Schedule of Dilapidation

There is no evident standard operating procedure in place which outlines the roles and responsibilities Area management, supported by Estates and Facilities, should follow when a GP practice terminates their general medical service contract which also includes the appetite to transfer responsibility for existing property lease commitments.

Table 1 details the findings relating to the review.

Schedule of Dilapidation

At the point the Health Board receives a request to support the practice due to changes in partnership arrangements or receives a formal notice that the GP practice [single-handed or partner] decide to terminate their primary care contract with the Health Board, it may have implications for the associated lease taken out by the individual/practice and one which the Health Board may have to take over.

The notice period for a practice to give the Health Board is dependent on the amount of GP's working within the practice [Single-handed GP required to give three months; Partner practice required to give six months].

Where the Health Board, through the Area management teams are unable to identify alternative property from which to deliver general medical services, the Health Board will, subject to Board and Welsh Government approval, assume responsibility for the lease.

As part of the process, albeit undocumented, the Health Board Estates and Facilities Directorate support the Area Teams by engaging an independent Chartered Surveyor to undertake a review of the property and identify a schedule of dilapidation, thus identifying all the necessary repair work required under the lease to make good the property upto a lease compliant order.

The Senior Property Manager formally writes to the GP practice with the report and the amount required to make good the property prior to the Health Board assuming responsibility for the lease and the liability for dilapidation at the end of the lease.

The GP practice is advised to obtain an independent schedule of dilapidation and at this point, negotiations between both parties seek an amicable agreement on the dilapidation amount for which the outgoing GP/Practice need to fund.

There is no documented standard operating procedure for the management and agreement of the schedules of dilapidation when leases are to be signed to the Health Board.

We sought to identify all transfer of leasehold responsibilities approved by the Finance and Performance Committee, on behalf of the Board, to verify approval and follow through the expected process.

We identified through reviewing Committee meeting minutes for the period 24th January 2017 to 24th August 2018, six GP practices where the business cases were being considered and recommendations for approval by the Committee.

- 21st February 2017 - Meddygfa Gwydir GP practice (Area - Central);

- 21st November 2017 - Rysseldene GP practice (Area – Central);
- 19th December 2017 - Ruabon GP practice (Area – East);
- 25th January 2018 - Hillcrest GP practice (Area – East);
- 28th June 2018 – Gyffin Surgery (Area – Central); and
- 24th August 2018 - Rhoslan Surgery (Area – Central).

We also met the Senior Property Manager who advised on a further four GP practices below

- Conwy Llys Meddyg (Area – Central) – Outside review period but lease signed under Seal 13th September 2017;
- Pen Y Maes (Area – East) – Deed of Indemnity signed under Seal 29th January 2018;
- Seabank Prestatyn (Area – Central) – Paper presented to the Health Board 21st January 2016;
- Connahs Quay Health Centre (Area – East) – A paper was presented to the Executive Management Group (EMG) on 4th October 2017 [Agenda Item EMG 17/133] with a Minute that "..*Discussions took place with regards to the different options for what the space should be utilised for but it was felt that further work is required on the paper and impact analysis on the different options and [CEO] requested that this work is carried out and the paper brought back to EMG."*

  We can find no evidence that the paper was brought back to the Executive Management Group or a paper was subsequently presented to the Finance & Performance Committee.

Of the properties we identified, all were at different stages of completion with regards to the dilapidation schedule.

Complications occur when the Health Board and GPs do not negotiate an agreed schedule of dilapidation.

At the time of this review, two of the properties were at an impasse regarding the negotiations of the schedule of dilapidations.

Business cases for GP leases

From the ten GP leases within the table 1 below we received six business cases for:

- Sea Bank;
- Rysseldene;
- Gyffin;
- Meddygfa llanrwst
- Llys Meddyg; and
- Rhoslan

Having reviewed the business cases provided we could not find any evidence relating to the Schedule of Dilapidation and associated costs to the Health Board recorded. As a point of note time constraints relating to the notice period given to the Health Board from the GP's makes this difficult to include the associated costs.

We note the Health Board has developed a Revenue Business Cases Guidance and Template (September 2017) and whilst some did follow in principle the methodology of the guidance, we noted variances against expected steps outlined in the template.

<u>Welsh Government forms ADL 1, 2, 3</u>

Welsh Health Circular (2015) 031 *Arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process)* issued 22nd June 2015 states;

The Minister has agreed that where Health Boards require consent to enter a lease or dispose of (including surrenders/assignments) of a lease in property, a similar process to that which applies to contracts is to be introduced. The general consent will be based on the following arrangements:

- *For leases with a cumulative rental value of up to £500,000 each Local Health Board and Trust will be required to submit a return to the Minister on a 6 monthly basis summarising relevant transactions on form ADL 1 (first return will be required on 30th January 2016 and 6 monthly thereafter);*

- *For leases with a cumulative rental value of between £500,000 to £1million (for each Local Health Board) and any contract in excess of £500,000 (for Trusts) a contract summary form should be provided as per form ADL 2 for Ministerial review before the lease is agreed. Whilst it is not necessary to obtain specific Welsh Ministers consent to enter the lease agreement, adequate information should be provided to enable the Minister to review the particulars. A briefing note will need to be prepared for the Minister at least two weeks before the lease being agreed (or as soon as possible after heads of terms reported)so that particulars can be noted; and*

- *For leases with a cumulative rental value exceeding £1 million, each LHB will require specific consent from the Minister. An application for consent is to be submitted as soon as possible after agreement of heads of terms as per form ADL 3. For Trusts notification will be required as per the process set out in (2) above.*

The ownership and responsibility for completing ADL 1 lies with the Senior Property Manager with ADL 2 and 3 the responsibility of Area Management.

The review identified one ADL 1 having been completed (no welsh government approval required) ; no ADL 2 have been provided to us (as not required); and five ADL 3 forms have been sent. We received evidence of Welsh Government approval for:

- Meddygfa Gwydir;
- Rysseldene;

- Rhoslan;and
- Connahs Quay.

We did not view evidence of Welsh Government approval for:

- Ruabon.

Signing and Sealing Documents

Standing Order 8.0.1 states:

> *"The common seal of the Health board is primarily used to seal legal documents such as transfer of land, lease agreements and other important key documents. The seal may only be fixed to a document if the board or Committee of the Board has determined it shall be sealed, or if a transaction to which the document relates has been discussed previously by the board or the committee."*

Working through the Office of the Board Secretary, we viewed the register of documents signed under seal on the 4th October 2018.

We identified the following have been signed under Seal:

- Llys Meddyg - 13th September 2017(new lease).
- Rysseldene - 13th November 2017 (assignment).
- Pen Y Maes - 29th January 2018 (signed as a deed of indemnity).

Table 1: Review of information underpinning transfer of lease to the Health Board

GP Premises	Area	Schedule of Dilapidation Completed	Business Case: Are cost detailed for transfer Schedule of dilapidation detailed	Welsh Government Approval ADL 1,2,3	Lease signed under Signed under Seal by the Board	Other Evidence
Pen Y Maes	East	Copy of Schedule sent as evidence - £21,501 per the Health Board Surveyor comments 7th December 2017.	Business case 24th May 2016 Development of Managed practice.	No ADL Required. No change to the lease arrangements.	29th January 2018 - Dead of Indemnity.	
Hillcrest Wrexham	East	Copy of Schedule - Costs of £110,688	Business case to Committee 25th January 2018 – Schedule of	No evidence viewed, as not completed until lease finalised.	In Progress	Considered by F&P Committee - 25th January 2018 Agenda item FP18/16.

GP Premises	Area	Schedule of Dilapidation Completed	Business Case: Are cost detailed for transfer Schedule of dilapidation detailed	Welsh Government Approval ADL 1,2,3	Lease signed under Signed under Seal by the Board	Other Evidence
		(maximum) identified.	dilapidations costs included within the report. Lease value £267,000.			We have been unable to see this formally presented for consideration to the Board. We have not seen this included in the Chairs Assurance report. We were advised that a dilapidations claim had been submitted in the normal manner and that the former GP tenant had responded by stating he would attend to the listed items himself (i.e. as opposed to agreeing a financial settlement). Despite prompts via Solicitors nothing has apparently transpired to-date. We have not corroborated this assertion.
Ruabon	East	Waiting for the GP Tenants to confirm that the landlord has agreed the lease transfer to the Health Board.	Business case to F&P Committee 19th December 2017 – no Schedule costs included.	ADL 3 submitted.	In Progress	Considered by F&P Committee - 19th December 2017 Agenda item FP17/235. We have been unable to see this formally presented. for consideration to the Board. We

GP Premises	Area	Schedule of Dilapidation Completed	Business Case: Are cost detailed for transfer Schedule of dilapidation detailed	Welsh Government Approval ADL 1,2,3	Lease signed under Signed under Seal by the Board	Other Evidence
			Lease value £1,668,125.			have not seen this included in the Chairs Assurance report.
Connahs Quay Health Centre	East	Copy of Schedule - Costs of £12,382 (maximum) identified.	Business case submitted to Executive Management Group 4th October 2017 not viewed as presented to the F&P Committee.	ADL 3 submitted.	In Progress	Request to take the Assignment of the Lease submitted to Executive Management Group 4th October 2017 but we have seen no further evidence of the F&P Committee receiving the transfer of lease business case for approval. WG approval
Conwy Llys Meddyg	Central	Schedule of Condition completed 14th July 2017 – No value recorded.	Submitted to 5th December 2016 – Schedule of condition no costs detailed for inclusion. Lease value – 160,000.	ADL 1 form completed.	13th September 2017.	EMG meeting 3rd August 2016 received an options appraisal with a note that it was to be presented to the Board In Committee September meeting – We have not been able to corroborate this.
Seabank Prestatyn	Central	Copy of Schedule - Costs of £18,418 (maximum) identified.	21st January 2016 - North Denbighshire Primary care services – Schedule of costs not included in business case.	Not completed until lease finalised	In Progress	We were advised a claim for dilapidations had been submitted in the normal manner but that the tenant had consistently failed to respond We have not

GP Premises	Area	Schedule of Dilapidation Completed	Business Case: Are cost detailed for transfer Schedule of dilapidation detailed	Welsh Government Approval ADL 1,2,3	Lease signed under Signed under Seal by the Board	Other Evidence
			Lease value – no cost specified.			corroborated this assertion.
Rysseldene	Central	No Dilapidation - new build.	Business case 16th June 2017 - Schedule of condition no costs detailed for inclusion. Lease value £1,830,000.	ADL 3 form completed.	13th November 2017.	Considered by F&P Committee 21st November 2017 Agenda item FP17/200 The F&P Chairs Assurance report to the Board meeting 14th December 2017 records *"The Committee agreed to seek Welsh Government consent to take assignment of a surgery lease due to be managed by BCU."* Assigned and completed new build no dilapidations. WG approval
Gyffin Surgery	Central	No Dilapidation schedule available as recent lease discussion.	Paper dated 28th June 2018 – no details of Schedule costs included. Lease value £157,000.	No evidence viewed, as not completed until lease finalised.	In progress	Executive Team received a report in April 2018 detailing the options appraisal. F&P Committee meeting 28th June 2018 considers Request to Assign the Lease for GP Premise Agenda item FP17/122 We have been unable to see this formally presented for consideration to the Board. We

GP Premises	Area	Schedule of Dilapidation Completed	Business Case: Are cost detailed for transfer Schedule of dilapidation detailed	Welsh Government Approval ADL 1,2,3	Lease signed under Signed under Seal by the Board	Other Evidence
						have not seen this included in the Chairs Assurance report. We were advised that a decision not to seek a claim for dilapidations in this instance was that the assigned lease was fairly recent (2017) and limited by a Schedule of Condition.
Meddygfa Gwydir	Central	Copy of Schedule - Costs of £43,802 (maximum) identified.	Paper dated 21st February 2017 – no details of Schedule costs included. Lease value £1,431,000.	ADL 3 form completed.	In Progress	F&P Committee 21st February 2017 Agenda item FP17/33. Health Board Meeting 16th March 2017 Agenda Item 17/53.1. WG approval
Rhoslan	Central	No Dilapidation new build	Paper dated 23rd August 2018 – no details of Schedule costs included. Lease value £2,000,000 (approx.)	ADL 3 form completed.	In Progress	F&P Committee 23rd August 2018 Agenda item FP18/166 Board Meeting 6th September 2018 Agenda Item 18/202 WG approval

7.   Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - ISS.1 – Standard Operating Procedure - Agreeing Schedule of Dilapidation (Operating effectiveness)	Risk
There is no documented standard operating procedure for the management and agreement of the schedules of dilapidation when leases are to be signed to the Health Board. Our review identified a number of Schedules where the former lease holders have not engaged with the Health Board to agree responsibility for costs.	The Health Board is liable for costs which pre-date assignment of the lease.
Recommendation	**Priority level**
Area management, with input from Estates and Finance, develop a procedure to document the process to be followed on receipt of contract termination through to the Health Board assuming responsibility for the lease.	High
Management Response	**Responsible Officer/ Deadline**
A detailed 'Checklist' is designed to be used initially during any transition to managed practice status, but also as an ongoing resource for the development of a managed practice. This provides actions to follow for Communications, IT, Workforce, Finance & Estates (F&E), Operational Delivery. The F&E list does include requirement to confirm with outgoing partners any costs associated with dilapidation that have to be paid to the landlord. A SOP for agreeing the schedule of dilapidation will be developed and embedded into this checklist for further detail.	Primary Care Project Manager Senior Property Manager Deadline: 31st March 2019

Finding - ISS.2 -Reviewing of the business cases for GP leases (Operating effectiveness)	Risk
The review of business cases submitted to the Finance & Performance Committee and Executive Management Group differed in terms of presentation and content. Whilst noting timing, dilapidation costs were not included in the business case to ensure the Health Board were cognisant of all potential financial risks when agreeing to take responsibility for the lease.	Health Board does not receive all required information on which to make an informed decision.
Recommendation	**Priority level**
All business cases submitted follow the *Revenue Business Cases Guidance and Template (September 2017)* as greed by the Executive Management Group.	High
Management Response	**Responsible Officer/ Deadline**
The Business Case guidance has been used as a reference for reassignment of GP Practice leases for those approvals required after September 2017. The guidance was not available for lease transfers required before that date.

The Guidance and template will be used for all such recommendations going forward as required. | Assistant Area Directors – Primary Care and Commissioning (East/Central/West)

Deadline: Immediate as required |

Finding - ISS.3 -Reviewing and approving business cases (Operating effectiveness)	Risk
Whilst it is evident that the route for approving lease transfers, subject to Board approval, is via the Finance & Performance Committee, we were unable to verify that all leases had been subject to consideration by the Board via presentation of the business case/the Chairs Assurance Report – We confirmed with the Office of the Board Secretary that all leases of property transfers should be ratified by the Board.

We have been unable to identify formal approval by the Board or Finance & Performance Committee concerning the transfer of the Connah's Quay lease to the Health Board, despite the ADL 3 Form evidenced as being submitted. | Health Board governance has not been adhered to. |
| **Recommendation** | **Priority level** |
| In accordance with Standing Order 8.0.1 and Schedule 1 – Scheme of Reservation and Delegation of Powers [Table B – Scheme of Financial Delegation] *"£0.5m plus or any which need signing under seal (Reservation of Power, Number 33)"* all leases should be considered and approved by the Board.

Management provide evidence that the business case for the Connahs Quay practice has been considered and approved by the Finance & Performance Committee/Board. | High |
| **Management Response** | **Responsible Officer/ Deadline** |

Contact has been made with the Director of Estates who has said the paper needs CEO sign off. A request has been made for the paper to go again to F&P asap. Date is awaited but this is urgently required.	Assistant Area Director – Primary Care and Commissioning East Deadline: January 2019

Appendix B - Assurance opinion and action plan risk rating
Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Managing the Outpatients Backlog

Final Internal Audit Report

BCU 2018/19

January 2019

NHS Wales Shared Services Partnership

Limited
assurance

Contents

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	Head of Internal Audit
Executive sign off:	Executive Director of Nursing & Midwifery
Distribution:	Interim Director of Secondary Care
	Secondary Care Medical Director
Committee:	Audit Committee

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

Disclaimer notice - Please note:

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

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1.   Introduction and Background

Outpatient services are complex, providing a wide range of services and cover a number of departments. A follow-up appointment is an attendance to an outpatient department following an initial appointment with a consultant or clinician. It is usually the step in the patient's pathway where diagnostic tests are reviewed and the decision to treat or request additional testing is made. More than 3.1 million outpatient appointments were provided by NHS Wales during 2016.

Since 2013, the Chief Medical Officer and Welsh Government officials have liaised with Health Boards to ascertain the number of patients overdue a follow-up/backlog appointment and actions taken to manage and address the outpatient backlog. Due to the lack of historical consistent and reliable information regarding overdue follow-up appointments across Wales, the Welsh Government introduced, in 2015, an all-Wales 'Outpatient Follow-up Delay Reporting Data Collection' requirement.

The Welsh Government, January 2015, instructed Health Boards to submit a monthly return providing details in respect of the number of patients waiting (delayed) for an outpatient follow-up appointment, and by what percentage they are delayed based on their target date. For example, a patient with a planned appointment date that is due in four weeks would be 100 per cent delayed if they were seen after eight weeks.

The Health Minister announced in February 2016 that outpatient care will be delivered in a radically different way in the future as part of the prudent healthcare action plan. The plan, Securing Health and Wellbeing for Future Generations, outlines work all health boards and NHS trusts will undertake to transform outpatient services and reduce over-testing and over-medication in the Welsh NHS, redefining the outdated outpatient model.

To improve Outpatient service delivery, the Health Board has set up a Transformation Group with five specialties identified and a number of workstreams to improve on the consistency of services, management and practices by site, specialty and individuals which may impact upon service delivery and levels of Follow Up backlog.

2.   Scope and Objectives

The overall objective of this review was to establish the robustness of processes in place to ensure all backlog outpatients are being effectively managed within the agreed process.

The following areas were included in our review:

- There are formally agreed processes in place to manage the follow up outpatients backlog;

- Roles and responsibilities are clearly defined;

- Robust systems and arrangements are in place to capture, record, validate and report outpatient backlog data;

- The outpatient backlog position is reported to the appropriate oversight committee/group; and
- Evidence that actions are taken to manage and address the outpatient backlog.

3.   Associated Risks

The risks considered at the outset of the review were as follows:

- Patient Harm;
- Inaccurate, incomplete outpatient backlog data is reported;
- Inefficient systems and processes;
- Ineffective use of outpatient departments and clinics;
- Unused capacity, inefficient, ineffective use of resources;
- Delays in Patient Care;
- Lack of scrutiny and poor decision making.

OPINION AND KEY FINDINGS

4.   Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Managing the Outpatients Backlog review is limited assurance.

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

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

5.   Assurance Summary

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

Assurance Summary						
1	Procedures, roles and responsibilities			✓	
2	Oversight governance and reporting arrangements		✓		
3	Outpatients follow up appointments waiting list testing	✓			
4	Actions taken address outpatient backlog			✓	

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

Design of Systems/Controls

The findings from the review have highlighted 2 issues that are classified as weakness in the system control/design for Managing the Outpatients Backlog.

Operation of System/Controls

The findings from the review have highlighted 3 issues that are classified as weakness in the operation of the designed system/control for Managing the Outpatients Backlog.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information received, responses made during discussions with key officers and additional documents provided to internal audit.

We have relied solely on the documents, information and explanations provided and except where otherwise stated, we have not undertaken work to verify the authenticity of the information provided.

We were provided with an overview of reporting processes to Welsh Government. We reviewed Outpatients Follow up appointments system data relating to Cardiology and Urology in respect of the 3 main Acute sites; Ysbyty Gwynedd (YG), Ysbyty Glan Clwyd (YGC) and Ysbyty Wrexham Maelor (WXM) for period ending 31/03/18 and 31/08/18 and agreed to totals reported for the same period to Welsh Government.

Procedures, roles and responsibilities

We were provided with a set of structured overview guidance notes "Local Processes for Managing Backlog Review October 2018" inclusive of a Standard Operating Procedure (SOP) by the Cardiology Speciality Lead at Ysbyty Gwynedd

(YG). We were also provided with system screen shots, performance data, job descriptions, details of waiting list validation processes (with some sample documentation); WHC guidance "Consolidated Rules for Managing Cardiac Referral to Treatment Waiting Times" (April 2018); WHC guidance "National Planned Care Programme Follow up Priorities, September 2017 (Review date March 2018) clearly stating Priority Four (page 4) "Urology Actions for Health Boards".

We were also provided with well-structured Transformation Programme documentation, overview presentation, guidance and programme details by the YGC Hospital Director and Outpatients Programme Manager, Service Transformation.

We liaised with colleagues across Informatics, Hospital Management and Site Speciality Leads. We were unable to ascertain the overall Operational Lead. We were advised that the YGC Hospital Director role relates to Transformation Programme responsibilities, not operational responsibilities.

However there is no overarching Health Board guidance or Speciality SOPs in place to clearly set out priorities, expectations, deadlines, accountability and reporting mechanisms and formally assign roles and responsibilities.

Oversight governance and reporting arrangements

We attended and observed the Planned Care meeting (18th September 2018) to gain an overview of Planned Workstreams/transformation programmes to improve Outpatients appointments Backlog. The meeting was chaired by Welsh Government with Health Board management providing updates, discuss issues and agree outstanding actions/deadlines and timeframes.

We were provided with a copy of the Follow up Clinical Safety & Improvement Agenda dated 6th March however the year was omitted; Agenda item 4 states Follow Up Waiting List Validation - No further details were available. We were also provided with a copy of Central Area WPAS Follow up Waiting List (Two Ticks) incident report presented to Executive Management Group (5th September 2018) with options for actions to be considered/decided.

We received no reporting/oversight information to the Health Board in respect of the Outpatients Follow up Backlog. Performance Management reporting in respect of Outpatient Follow Up appointments is at a high level.

There have been no reports (or oversight/scrutiny) in respect of the Outpatient Follow up Backlog by the Secondary Care Senior Management Team over a number of recent months.   We were provided with details of the Outpatients/follow Up appointments raised on the Secondary Care Risk Register.

From an operational oversight level, we found good practice of our review of several Planning Cell meeting action point notes provided by YGC Outpatients Planning Cell meetings.

We discussed Outpatients Planning Cell meetings with YG and WXM leads however we were advised that the discussion/action points are not recorded. We were also provided with WXM Cardiology Business Meeting details (3rd August 2018) where performance and the Backlog was discussed; Actions were

identified however there was no action log/tracker and we are unclear of the accountability and reporting mechanisms for this meeting.

We were advised by the YG Cardiology site Lead that the backlog review position is reported to the site Finance and Performance meeting on a monthly basis - We were not provided with evidence oversight/reporting information, meeting documentation and can therefore not verify this assertion.

Outpatients follow up appointments waiting list testing

Our review included testing of computer generated random sample of Outpatients follow up appointments provided by Informatics in respect of Urology and Cardiology specialties across the YG, YGC and WXM.

The objective of our testing was to ascertain the robustness of systems and arrangements in place to capture, record, validate and report outpatient backlog data. From the sample tested we found the following:

WXM Cardiology

We identified an issue with follow up appointments showing on the waiting list over 200 weeks. We escalated this issue during testing to the Directorate General Manager (DGM) who took immediate action to obtain details from Informatics for the Cardiology Site Lead to investigate/validate overdue patient appointments. Confirmation of the outcome of above was requested by Internal Audit and the Secondary Care Medical Director;

We found other instances impacting on patients follow-up which we notified management of:

- Appointment target date of 3rd September 2016 with no clear outcome to indicate if follow up appointment is required;

- Appointment target date of 6th December 2017 with a Consultant letter to their GP on the 9th December 2016 for current medication with 12 month follow up – Advised by Site Lead as valid on waiting list;

- Patient seen by Consultant on 28th November 2017 with letter to GP on patient file dated 20th December 2017 – We were advised the timeframe for letters sent to GPs should be two weeks;

- Discrepancy regarding dates on letter to GP/system following hospital treatment. Hospital treatment superseded clinic appointment however the patient remains on follow up appointment waiting list from the original clinic appointment;

- Patient was seen and discharged by Lead Nurse however the systems were not linked and waiting list details not updated to remove patient from follow up waiting list - Patient incorrectly showing as overdue for follow up appointment.

WXM Urology

We identified a patient with follow up appointment target dates of 17th July 2017; 23rd September 2017; 30th January 2018, correctly showing on the waiting list

was raised with the Site Lead with confirmation of the outcome requested by Internal Audit and the Secondary Care Medical Director;

The Site Lead confirmed that five instances of the sample tested, required removing from the Outpatients Waiting list with an additional 2 instances requiring further investigation but likely to also be removed from the Outpatient Waiting list;

We found good Practice, where Nurse Led clinics had seen patients before target dates but had not linked up processes/systems to remove patient from waiting list; Systems do not appear integrated to remove patients from waiting lists when discharged or seen by other clinicians, in different clinics.

YG Cardiology

We identified the following in reviewing the data:

- Patient, correctly included on overdue waiting list with a target date of 31st August 2018 (12 weeks overdue) - Appointment offered, 26th November 2018;

- Patient overdue by 5 months with a target date for follow up appointment of 3rd April 2018 - Appointment booked 30th October 2018 – We were advised that delays in issuing clinic appointments is due to clinic capacity issues – we have not corroborated this assertion;

- Patient target follow up date 17th July 2018 - No appointment offered due to clinic capacity;

- Patient target follow up date 6th July 2018 - Appointment booked for 20/11/18;

- Patient follow up target date 19th September 2018 - Appointment booked 5th November 2018;

- Patient follow up target date 31st August 2018 - Appointment booked 19th October 2018.

YG Urology

As part of our sample, we identified urgent overdue high risk cancer patients showing on the waiting list and escalated immediately to the DGM/Lead Site Manager:

- Follow up target date of 17th March 2017.

- Follow-up target appointment date 14th August 2017

We were advised that Leads were to take immediate action and confirmation of the outcome of both was requested by Internal Audit and the Secondary Care Medical Director. We were advised there is a list of high risk patients awaiting follow up appointments by the Site Speciality Manager and Interim Service Manager and this issue has been raised/escalated to senior management - We are unable to corroborate this assertion.

Other issues identified from our sample were:

- Patient showing on follow up waiting list, 17 months overdue with a target follow up appointment date of 8th May 2017 - We were advised by Site

Speciality Manager and Interim Service Manager that this follow up appointment is not urgent;

- Patient follow up appointment target date 20th September 2017, 13 months overdue - Advised unable to offer appointment due to clinic capacity issues;

- Patient follow up target date of 29th July 2016, 27 months overdue, with no follow up appointment offered due to clinic capacity issues. We were advised by the Site Speciality Manager and Interim Service Manager that Consultants have undertaken specific waiting list validation exercises but there is no regular validation;

- Patient follow up appointment target date 7th February 2018, 8 months overdue, advised clinic capacity issues;

- Patient follow up target date 25th January 2017, 20 months overdue; advised clinic capacity issues however no validation undertaken;

- Patient follow up target date 7th April 20, 18 months overdue, advised clinic capacity issues however no validation undertaken;

- Patient follow up target date 22nd May 2018, 5 months overdue, advised clinic capacity issues;

- Patient follow up target date 13th April 2018, 5 months overdue, advised clinic capacity issues.

YGC Cardiology

We identified the following:

- Follow up appointment target date, 6th March 2016 - Advised that WPAS system shows end of patient journey 17th February 2017 with no follow up indicated. This was escalated to DGM by Deputy General Manager, Unscheduled Care who has also flagged system issues to Informatics;

- Patient incorrectly showing on Outpatients Follow Up waiting list, but showing on WPAS as pending, awaiting diagnostic tests - Advised that 8 weeks set timeframe/office based decision on WPAS – the appointment directive box should equal to "awaiting diagnostics" and excluded from follow up waiting lists (until after diagnostic tests completed);

- Consultant letter not on patient file. System/process issues with incorrect follow target dates identified, incorrect clinic outcome and over reporting outpatient follow up data, patient pathway should have been set as "Active monitoring"; We were advised that the system shows the outcome box selected is "further investigation required". The letter stated "we will see patient in 6 months". Because of field selected target date would have been set at 11/7/18 (ie 8 weeks after due to above field selected). As part of an Office Based Decision, patient was added on 12/7/18 which put patient on to follow up waiting list with next appointment in 3 months which took target date to 12/10/18;

- Outpatient data incorrect, patient showing on incorrect list and currently showing patient needs follow up appointment. Patient should be pending on test results and may need an urgent follow up appointment/no follow up

depending on test results. Deputy General Manager, Unscheduled Care to investigate to address situation regarding patient follow up status and requirements;

- Patient follow up missed in line with Consultant requirement for patient to be seen in 6 months. We were advised the patient was included in additional, extensive validation work due to outpatient follow up system data issues as a consequence of the 14,000 extra patient details added to the outpatients follow up waiting list and the Office Based Decision issues errors recently identified;

- Patient on twice in error as pending (awaiting investigation & follow up outpatient overdue list) as previously noted from sample above;

- WPAS outcome input from clinic attendance shows further investigation Tests; advised this is incorrect and Patient records should have shown as a Day Case with 8 weeks pending/follow up appointment may or may not be needed;

- Patient on waiting list however patient seen in WXM and may not need to remain on waiting list. YGC need to confirm if patient should be seen by YGC Consultant and therefore remain on waiting list.

YGC Urology

- GP trigger (not validation process) to chase up follow up appointment (26th January 2018). Lead Site Manager to confirm follow up appointment position;

- Patient 6 months overdue (target follow up date, 10th February 2018);

- Backlog of typing by Consultants secretary with one instance where the appointment was on 30th June 2017 but letter typed 10th August 2017 (3 month review requested in June post radiology test). No evidence of Radiology diagnostic test being requested or carried out. No evidence of further action from Consultant/secretary as a pending outpatient follow up appointment. No follow up appointment issued by Booking Clerks. Advised the Site Lead to investigate immediately;

- From review of Patient file notes, patient waiting on second diagnostic test results carried out on 23rd November 2016 and a follow up appointment target date 24th November 2016. Marked as Urgent by GP (24th November 2016);

- Patient was originally a USC referral from GP. Patient file shows Operation Case report stated patient has elected to have further testing in 6/12 months and therefore biopsy cancelled by consultant. Follow up appointment has not been offered since June 2013. This patient details were escalated immediately during testing. DGM to be advised immediately by Site Lead involved during testing (9th October 2018).

- Target date on Outpatients follow Up list showing August 2016 and not as per Operation Case Report stating follow Up in 3 months. No confirmation to confirm consultant decision for discharge and therefore patient included in backlog as awaiting outpatients follow up appointment;

- 21st March 20 Consultant letter to GP stated more tests required with a follow up discussion at MDT meeting and follow up appointment with the Consultant

- No follow up timeframe stated on letter. No further details on patient file except reference to outpatients appointment on 5th February 2018. OPD on WPAS showing 5th December 2018 with a follow up in 12 months. Patient file notes refer to attendance on 5th February 2018;

- 10th July 2018 patient attended as a day case - Theatre Visit Operation notes form on file dated 10th July 2018 with document stating No Follow Up - Patient should not be included on backlog list for follow up;

- Patient follow up target date, 8th May 2018 however superseded by requirement for surgery (biopsy); At this point patient should have been taken off the outpatients follow up waiting list pending outcome of biopsy day case surgery. Patient cancelled biopsy appointment 6th July 2018 - Patient was on an Urgent Suspected Cancer pathway, Site Lead investigate/confirm actions.

We were advised that there is a large system backlog complicated by WPAS system data issues whereby Informatics staff informed management that patient data showing on the Outpatients waiting list maybe incorrect and that Senior Management (DGMs) and staff are currently reviewing each patient record to validate/remove from Outpatients Follow Up Waiting List. Urgent Suspected Cancer (USC) Outpatients data does not show USC, consequently overdue appointments are being managed via Outpatients follow Up waiting list data.

Actions taken to manage and address the Outpatient Backlog

We met with the Programme Manager – Outpatients, Service Transformation, to gain an understanding and overview of the Transforming Outpatients Programme work to address and improve Outpatient Appointments overall, in addition to the backlog.

We also met with the Executive Director of Public Health and the YGC Hospital Director with regards to the above. The YGC Hospital Director confirmed roles and responsibilities provided a detailed overview of the Transformation work. We were provided with comprehensive, well-structured governance overview, terms of reference, roles and responsibilities. The document provided "National Planned Care and Outpatients" detailed the National Care Programme, Outpatients Steering Group, the reporting mechanisms of the Transforming Outpatients Programme, National Planned Care Programme work and the Transforming Outpatients Programme Board. We were unclear where the Transforming Outpatients Programme Board reports to within the Health Board.

We were provided with National Follow up Guidelines, WHC/2017/024, Welsh Government Directive and National Planned Care Programme, clearly stating priorities on follow up with completion deadline set at March 2018. We were also provided with terms of reference in respect of Did Not Attend (DNA), Hospital Initiated Cancellations (HICs) and follow up programme workstreams to achieve Outpatient improvements: £2 million efficiency savings, cost avoidance and waiting list reduction. The Executive Director of Public Health chairs the Outpatients PRG that oversees detailed plans and directs the work of the Outpatients Planning Cell meeting.

We noted good practice with the above documentation clearly setting out priorities, accountability and reporting arrangements and with the development

and inclusion of the RAAID logs (Risk, Action, Attendee, Issue and Decision Logs).

7.   Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	4	1	0	5

Finding - ISS.1 - Outpatients Backlog Data Accuracy and Completeness (Control design)	Risk
From our testing, discussions with Informatics staff, Key Leads at each site and our review of Outpatients Backlog data, we found issues of concern regarding data quality but more importantly patients not being subject to follow-up by the target dates and patients incorrectly included on the follow-up lists. Outpatient follow up appointment data provided had no marker or flag as such, to indicate priority/urgency if an outpatient follow up appointment is an unsuspected Cancer(USC) /Urgently required follow up/overdue appointment; During sample testing at YGC we became aware and discussed further issues in respect of system input and recording of office based decisions in respect of outpatient follow up appointments on the WPAS system; Issues identified were outpatients follow up appointments incorrectly either being added to the waiting list (as a duplicate) or missed/not re booked. We were advised that there are further WPA system issues regarding Hospital Initiated cancellations, in terms of appointments cancelled & no system functionality operating to rebook the appointment. We are unclear where responsibility sits in terms of WPAS agreements to rectify and address system issues.	Patients may be offered and attend incorrect follow up appointments. Overdue outpatients figures reported to Welsh Government may be incorrect.
Recommendation	**Priority level**
A risk assessment is undertaken as a matter of priority to identify all overdue outpatient appointments which may either be a USC/urgent nature. Further validation needs to be completed to identify overdue follow up appointments which need to be issued as a matter of urgency for the patients	**High**

concerned. Where there are clinic capacity issues to allocate overdue appointments there needs to be a robust escalation process developed and followed with update/reporting assurance mechanism to senior Secondary Care Management.

Management Response	Responsible Officer/ Deadline
A specific data validation exercise will need to be undertaken to ensure all records are active followed by a clinical desk based review to prioritise and action care plans. Therefore, alongside presentation of this report, an assessment of the clinical and administrative resources required to meet this objective will need to be made as it is not possible to achieve the action without either substituting this activity for others or creating additional capacity. Initially, we need to identify the resource as a priority in order to define the timescales for the programme of work. The SOP detailed below (ISS.2) will incorporate escalation arrangements.	Associate Director of Planned Care. Date: 28/02/19 Secondary Care Medical Director (as Chair of Follow Up Clinical Safety and Improvement Group). Date: Final sign off at March meeting.

Finding - ISS.2 – No Overarching Procedures regarding Managing the Outpatients Backlog are in place (Operating effectiveness)	Risk
We were provided with WHC guidance directives (September 2017; April 2018), system screen shots, performance data, job descriptions, YG Cardiology Local	Patient Harm and non-compliance with WHC guidance;

Processes guidance, Transformation Programme overview and project documentation. There is no overarching Health Board guidance or Speciality Standard Operating Procedures in place to clearly set out priorities, procedures, outcomes, roles and responsibilities. We were unable to ascertain the overall Operational Outpatients Lead.	
Recommendation	**Priority level**
The Health Board develop operational guidance to ensure WHC guidance is adhered to and embedded to ensure Outpatient Follow up appointments Backlog is effectively monitored and managed and that patient care is of the highest, safest standard.	**High**
Management Response	**Responsible Officer/ Deadline**
Draft SOP has been developed at Ysbyty Gwynedd. This will be updated to incorporate WHC Guidelines and standardised for all delivery units. (This will be through the Follow Up Clinical Safety and Improvement Group).	Secondary Care Medical Director (as Chair of Follow Up Clinical Safety and Improvement Group). Date: Final sign off at March meeting.

Finding - ISS.3 - Management Oversight and Scrutiny (Control design)	**Risk**

We could not confirm that that Outpatients Follow Up appointments backlog has been reported regularly the Health Board/Committee and/or Secondary Care Senior Management Team. We were advised that oversight, monitoring and management is part of each hospital site Outpatients Planning Cell meetings. We were provided with Outpatients data performance tables and advised the data is discussed at Secondary Care Finance and Performance meetings but not received meeting documentation to confirm senior management oversight, scrutiny, actions agreed/completed and holding to account to national deadlines. We were advised that the Outpatients Backlog has been raised as a High Risk on the Secondary Care Risk Register but did not receive details to confirm this.	Patient Harm and ineffective reporting and oversight mechanisms.
Recommendation	**Priority level**
Management review the reporting arrangements for regular reporting and scrutiny of the outpatients backlog.	**High**
Management Response	**Responsible Officer/ Deadline**
The total number of overdue follow-up outpatients are reported within the corporate performance information, as part of the Timely Care National Standards metrics (DM62). However, detailed specialty and timing measures are not reported. The Planned Care Delivery Group is being constituted during January 2018 and will be taking reports from the newly formed clinically led Follow Up Clinical Safety and Improvement Group. This group was constituted in December and is developing a suite of reports to support its work.	Secondary Care Medical Director (as Chair of Follow Up Clinical Safety and Improvement Group). Date: First review of agreed metrics at March meeting.

Finding - ISS.4 – Transformation Programmes (Operating effectiveness)	Risk
Following our discussion with Senior Management and review of well structured, comprehensive Outpatients Transformation Programme documentation, we identified the following issues: • Accuracy, reliability and completeness of Outpatient Follow Up data; • Accountability and reporting mechanisms not defined at a senior corporate level for the Transforming Outpatients Programme Board.	Improvements and Outpatients Backlog is not reduced or properly managed.
Recommendation	**Priority level**
Governance arrangements for assurance reporting of the Transforming Outpatients Programme Board are clarified within the organisational reporting and accountability structure.	**Medium**
Management Response	**Responsible Officer/ Deadline**
This will be to the Planned Care Delivery Group.	Associate Director of Planned Care February 2019.

Finding - ISS.5 – Outpatient Follow up Waiting List - data sample Testing – YGC, YG, WXM hospital sites (Operating effectiveness)	Risk
From the Outpatients follow up appointment waiting List data sample tested, we identified a number of issues which have been documented for each site/speciality in our management summary above in this report.	Patient Harm.

In some instances we identified several urgent matters which were escalated to senior management immediately for urgent action. We requested confirmation/outcome of those urgently identified actions – this was also requested by the Secondary Care Medical Director.	
Recommendation	**Priority level**
Management undertake a focused data cleansing exercise to ensure Outpatients overdue follow up appointments only include patients waiting for follow up appointments along with ensuring Clinic Outcome forms are retained and scanned in to patient records to ensure a full audit trail.	**High**
Management Response	**Responsible Officer/ Deadline**
For large numbers of patients, as part of the follow-up outpatient recovery actions being overseen by the Planned Care Delivery Group, it is expected that a full data validation exercise will be undertaken to ensure all records are active. A clinical desk based review, a non face-to-face appointment and/or a face to face appointment will follow. This is linked to completion of cleansing data as articulated, recommendation ISS.1. Alongside presentation of this report, an assessment of the clinical and administrative resources required to meet this objective will need to be made as it is not possible to achieve the action without either substituting this activity for others or creating additional capacity; Development of the process and standards method for implementation across the sites with monitoring, oversight and scrutiny via the Planned Care Group; To be included in the Terms of Reference for the Group.	Associate Director of Planned Care Date: 31/03/19

Appendix B - Assurance opinion and action plan risk rating
Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Implementing the Falls Policy

Final Internal Audit Report

BCU 2018/19

December 2018

NHS Wales Shared Services Partnership

Limited
assurance

Contents   Page

Review reference:	BCU-1819-25
Report status:	Final Internal Audit Report
Fieldwork commencement:	15th June 2018
Fieldwork completion:	31st July 2018
Draft report issued:	19th September 2018
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Executive approval:	3rd December 2018
Auditor/s:	Principal Auditor
	Head of Internal Audit
Executive sign off:	Executive Director Nursing And Midwifery
Distribution:	Area Director Clinical Services (central)
	Head Of Clinical Audit & Effectiveness
	Falls Prevention Project Manager
	Board Secretary
	Deputy Board Secretary
	Compliance & Assurance Manager
	Finance Directors - Provider Services; and Commissioning & Strategy
Committee:	Audit Committee

ACKNOWLEDGEMENT

Disclaimer notice - Please note:

1. Introduction and Background

The relevant lead Executive Director for the assignment is the Executive Director Nursing and Midwifery.

When a patient falls it may lead to distress, injury, pain, anxiety and more often a loss of independence and confidence not only affecting the patient but also affecting the relatives, carers and hospital staff. Patients' safety has to be balanced against their rights to make their own decision about the risks that they are prepared to take, their dignity and their privacy.

Health care professionals have a duty of care to minimise risks to their patients. The Health Board aims to take all reasonable steps to ensure the safety and independence of its patients.

The 'Falls pathway' is designed to collate all the information regarding a patient in relation to their risk of falls and to create an individualised plan of care to be shared with them and their family. This should be shared with care/nursing/residential homes and/or GP to ensure the patient at risk of falling is appropriately cared for following discharge. During 2016-17 the Health Board reviewed the falls pathway and developed/launched a new Policy for the prevention and management of inpatient falls [NU06 – The prevention and management of adult in-patient falls].

The aim of the policy is to ensure the optimal prevention and management of falls in the inpatient setting for patients, who may be at risk of falls.

It was identified that on admission to hospital, that the generic nursing documentation used to asses every patient includes a Falls Assessment Screening Tool. This is contraindicated by NICE Guidance and standard practice regarding the Falls Policy is that the pathway is commenced on admission to a ward for all those over the age of 65 and also those over the age of 50 with a pre-existing condition that can cause falls, regardless of falls risk stratification.

A key decision has been taken to mandate the training on falls prevention for ward based staff. Increasing the awareness and knowledge of staff is vital to the success of the policy.

The Quality, Safety and Experience Committee (QSE) has received updates (Inpatient Falls Management) on the 11th July 2017 and 23rd January 2018.

Since the policy was introduced in 2016, the most recent update report to QSE in January 2018 updated the Committee on the findings of the National Audit of Inpatient Falls and notes that site teams were working on a formal response to the audit findings and developing an action plan by February 2018.

2. Scope and Objectives

The overall objective of the review was to ensure that the falls pathway has been implemented in all ward areas within the Health Board and is subject to regular review on a case by case basis.

In completing this review we considered:

- Following the publication of the National Audit of Impatient Falls Audit Report in November 2017, we will obtain copies of all action plans and review progress against these.

- Following updates (Inpatient Falls Management) provided to the Quality, Safety and Experience Committee, we will review the evidence which supports reported progress since the launch of the falls Policy – presented to QSE under agenda item QS17/133b.

- Review the DATIX reporting system, in particular the relationship between patients at risk of falls over 65 and the Reporting of Injuries Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR).

- Review the data in the HARMS dashboard for falls and working with key contacts review a sample of patient notes to confirm that the falls pathway documentation has been completed correctly.

3.   Associated Risks

The risks considered at the outset of the review are as follows:

- Patient Safety is compromised through lack of formal risk assessment;

- Staff are not compliant with Health Board mandatory training requirements; and

- Reputational risk through increased publicity of patients falling and associated litigation.

OPINION AND KEY FINDINGS

4.   Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Implementing the Falls strategy review is limited assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	National Audit of Impatient Falls Audit Report in November 2017			✓	
2	Progress since the Implementation of the falls Policy		✓		
3	Datix Reporting System and reporting of RIDDORs		✓		
4	Completion of Patient falls Pathway testing		✓		

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for implementing the Falls strategy.

Operation of System/Controls

The findings from the review have highlighted five issues that are classified as weakness in the operation of the designed system/control for implementing the Falls strategy.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

National Audit of Impatient Falls Audit Report in November 2017

All health boards participating in the National Clinical Audits of inpatient falls which took place in May 2017 were required to complete the National Clinical Audit & Outcome Review.

An action plan in response to the recommendations of the November 2017 Annual Report has been returned to Welsh Government alongside this a Welsh Government assurance pro-forma requirement has also been returned.

A Health Board draft Falls Prevention and Management Action Plan 2017-19 was due to be agreed at the strategic meeting on the 8th June 2018 [however the meeting was cancelled and is now due to be formally agreed in the strategic meeting planned for September 2018]. The plan details actions required from the last published report but its primary aim will be to provide the framework for the development of more detailed plans from each operational division.

Divisional plans from the Areas, secondary care and Mental health are in the process of being developed and should demonstrate how the high level priorities within the overarching plan for action actually translate into change in practice at operational level as this is the key to improving outcomes. This will allow progression towards the next step of being able to hold the divisions to account for implementing both the previously agreed falls policy and the requirements of the National audit.

In reviewing the reporting of the national audit through the Health Board's governance structure, we noted the following:

Quality, Safety & Experience Committee (QSE) 23rd January 2018 – Agenda item

Inpatient and community Falls Programme 3.1 National Audit of Inpatient Falls

"All three of BCUHBs acute hospitals participated in Round 2. The site teams are currently working on a formal response to the audit and an action plan will be available for each site in February"

Inpatient Falls Prevention Strategic Group Meeting Friday 9th February 2018 Agenda Point 8

"Development of divisional action plans Q&S committee have requested divisional action plans re: falls which will initially will go to the Quality and Safety group. Some work already done on action plans."

Progress since the implementation of the falls Policy

A report sent to the Quality, Safety & Experience Committee on the 11th July 2017 (QSE agenda item QS17/133b.) Titled improving the Prevention and Management of falls in North Wales was the basis for our testing. We focused on section *3.1 Progress since the launching of the Falls Policy*.

Our review of twelve wards (six acute; three mental health; three community) identified the following:

- The falls pathway had been implemented within all the wards that we visited. However we noted that there did not seem to be a consistent approach to the arrangements of the pathway within the patient notes – this led to difficulty in locating the required entry within the patient file.

- All general wards that were reviewed within the testing were monitoring their falls through the Harms Dashboard. The Harms dashboard acquires its patient falls information from the DATIX incident reporting system; the

information is then categorised into sections which provide the ward with a detailed live profile of their falls performance. Analysis is then clustered together providing a RAG rated overall score which is then used in conjunction with other collated data for example Health care Acquired Pressure Ulcers; Medication and Infection.

- At the time of the report the mental health wards were using a different monitoring system to Harms, however the information being analysed on the wards was comparable [recording falls through a patient falls management and measles charts wall mounted board].

The policy states the submission of a monthly report to the Quality Assurance Executive [renamed Quality and Safety Group (QSG)] and or Director of Nursing (Section 6.1 – Monitoring and escalation); We reviewed all QSG meetings from January 2018 and noted under the Harms Dashboard monthly reports containing patient falls figures were being sent up to April 2018, however no further evidence was noted from May 2018 onwards.

Terms of Reference (ToR) for the Strategic Falls Group and three most recent sets of minutes were reviewed. We noted that meetings are to be held on a bi-monthly basis, however since July 2017 only three meetings have taken place. Attendance has been identified as an issue within the minutes of the meeting which took place on the 9th February 2018.

Inpatient Falls Prevention Strategic Group Meeting 9th February 2018 Agenda point 9.3 Attendance

Area Director Clinical Services Central noted that attendance from some Divisional leads and some corporate departments was below what he expected. This will be reviewed again at the next meeting if commitment does not improve.

Evidence within the three sets of meetings evidences information concerning patient falls is being escalated from the areas/divisions. However at present there does not appear to be a consistent approach with regards to the reporting of local falls to the group.

We requested information from the lead officers responsible for falls management within the hospital/area/mental health regarding the monitoring and escalation process; we received five responses [two did not respond]. Of the five responses, evidence demonstrated that meetings are taking place [via different formats] with falls being discussed at local level and information/lessons learnt is being shared at ward level.

A summary of comments received are detailed below, however we have not corroborated these assertions:

- *Locally, we have set up monthly Multi-disciplinary table top review meeting where all of our fall resulting in harm are reviewed by a multi-disciplinary team which consists of members of the quality team, medical staff, nursing staff, therapies and pharmacy*

- *Six weekly Quality Improvement meetings unfortunately the last few have been cancelled due to hospital escalation/staffing issues however:*

> ➢ *Governance follow up all falls and all Falls are also discussed following the morning site safety huddle to establish harm/ appropriate measures in place.*
> ➢ *Governance provide monthly falls report for Matrons Governance.*

- *Weekly ward meetings taking place with a Multi-disciplinary team. Amend indent*

In accordance with Policy NU06 the Prevention and Management of Adult In-patient Falls, section 6.2, Training, notes the following:

To support policy implementation and the delivery of effective falls prevention activity all staff who work on an adult ward environment must undertake falls prevention training. All ward staff will receive mandatory falls training once every two years.

We noted that access to the training module was temporarily lost due to the migration to the Electronic Staff Record (ESR), consequently we cannot identify compliance that the training undertaken has met Policy requirements.

Also, in discussing with Sisters and staff there appears confusion whether the training is mandatory as the patient falls training is not included in the nurse's mandatory training list. When asked if all ward staff were trained and up to date in patient falls, we were unable to obtain a definitive answer in respect of undertaking patient falls training. Training boards situated on the wards containing mandatory training did not have patient falls training on them.

Datix Reporting System and reporting of RIDDORs

We looked at the association between the patients at risk of falls over 65 and the Reporting of Injuries Diseases and Dangerous Occurrences 2013 (RIDDOR).

Table 1 records patient falls within the date range of 1st May 2017 to the 30th April 2018 and classifies the falls which have been ticked yes within the reporting system as requiring reporting to the Health and Safety Executive (HSE).

Table 1 – Datix recorded patient falls from 1st May 2017 to 30th April 2018

RIDDOR reportable	BCUHB Central	BCUHB East	BCUHB West	No value	Total
No	1,639	1,403	1,576	0	4,618
Yes	4	5	9	0	18
*No value	106	141	65	0	312
Total	1,749	1,549	1,650	0	4,948

*No value indicates that that RIDDOR box has not been ticked within the system.

We then identified the falls that required reporting to the HSE, per RIDDOR, findings of which are included in Table 2 below. Our findings note that three were not reported to the HSE and eight had not had a Root Cause Analysis (RCA) completed.

Table 2 identifies a total population of eighteen, however seven have been removed from the audit process as they did not meet the criteria within the scope.

Table 2. Patient falls categorised as RIDDORs and RCA undertaken 1st May 2017 to the 30th April 2018

Incidents	RIDDOR reported to HSE		RCA undertaken	
11	No	3	No	8
	Yes	8	Yes	3
Findings				

- There is an inconsistency with the undertaking of the root cause analysis (RCA) process. The findings above are based on the completion of the Health and Safety RCA and not the root cause identified within the Welsh Government closure form.
- One incident through the Welsh Government closure form identifies that there was insufficient staff for 1-1 nursing.
- One incident through the Welsh Government closure form identifies that there was a lack of enhanced observation.

In reviewing the Patient Falls Project Managers report to the Inpatient Falls Prevention Strategic Group Meeting on the 21st July 2017, we noted the following

RCA doc - a lot of staff were unaware of what this was 26.1% of wards had the doc available and 21.7% had the doc but it was not visible to staff [Inpatient Falls Prevention Pathway Audit Results Agenda - Item 4]

Completion of Patient falls Pathway testing

The testing was based on four wards within each area, two from acute one from community and one from Mental Health. We were accompanied throughout the testing by clinical professionals as agreed and organised with the falls prevention project manager. Five patient notes were randomly chosen from each ward and within the notes the falls assessments were then scrutinised for completion. Whilst examining the patient falls documentation there was a common theme running throughout with regards to the findings therefore the results below have been clustered together below as overall findings.

Table 3. Sample testing of the patient falls pathway

Area	Wards visited	Patient Falls Assessments checked
East	4 (inc 1 MH & 1 community)	20
Central	4 (inc 1 MH & 1 community)	20
West	4 (inc 1 MH & 1 community)	20

Findings (findings were consistent throughout the Health Board)

- Signatures and Dates missing from sections of the patient falls assessment forms.
- Patient Assessment forms are not being reviewed.
- Variance section not completed if circumstances of the patient has changed.
- Patient assessment forms found to have been photocopied.
- Patient labels not attached to all of the sections.
- Visual and hearing issues identified within adult nursing assessment documentation however not acknowledged within patient falls assessment forms.
- Culpable medication identified within adult nursing assessment documentation however not acknowledged within patient falls assessment forms.
- Adult nursing assessment documentation identified incontinence however not acknowledged within patient falls assessment forms.
- Sections within the patient falls assessment forms for instance Medication, Visual and Hearing and mobility not fully complete.

Evidence of good practice when testing on wards

- Post Falls painting/posters on some of the walls.
- Mental Health development of a falls bundle on the intranet (needs to be linked in with the main falls page).
- Falls pathway printed in yellow making it easy to locate.
- All patient information leaflets signed and dated on one ward.
- Nursing/MDT comments identifies Datix Incident number every time the patient has suffered a fall making it easier to locate and confirming that the fall has been reported.
- Mental Health Falls lead identified in each area.
- Health Board falls intranet page has been developed but requires further development. Mental Health have developed a falls bundle which looks at all aspects of falls.

Having discussed with ward staff we sought clarity why some sections of the falls documentation was left blank. Staff stated that some sections may not be relevant to that particular patient, consequently this has the potential for misinterpretation and may impact on patient care.

Whilst no one-to-one patient care observations were identified within the sample testing and being outside the scope of the review. We did asked the question,

when on completion of the falls assessment it's been identified that the patient requires one to one care, was it always achievable.

The Response was varied but we noted:

- It was not always feasible on the general wards due to staffing issues.

- Staff stated that if the one to one was not achievable then alternative control measures were sought.

- If there were multiple one to ones on the ward then the ward would move all one to ones into the closet bay next to the nurse's station for close observations.

7.   Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	3	1	1	5

Finding - ISS.1 - Evidence of reporting progress since the launch of the falls policy - Reporting (Operating effectiveness)	Risk
The Falls Management Policy states the submission of a monthly report to the Quality Assurance Executive [renamed Quality and Safety Group (QSG)] and or Director of Nursing (Section 6.1 – Monitoring and escalation); We reviewed all QSG meetings from January 2018 and noted under the Harms Dashboard monthly reports containing patient falls figures were being sent up to April 2018, however no further evidence was noted from May 2018 onwards. Terms of Reference (ToR) for the Strategic Falls Group and three most recent sets of minutes were reviewed. We noted that meetings are to be held on a bi-monthly basis, however since July 2017 only three meetings have taken place. Attendance has been identified as an issue within the minutes of the meeting which took place on the 9th February 2018.	Assurance is not routinely provided to the Executive and Board.
Recommendation	**Priority level**
Regular reporting on falls management is consistent with the established requirements set-out in the Policy and defined groups accountable for implementing and monitoring.	Medium
Management Response	**Responsible Officer/ Deadline**
The revised TOR for the Falls group now identifies quarterly meetings for the group. Minutes of the Inpatient group will be sent to QSG following each meeting along with a summary report on activity.	Strategic Falls Group Chair/November 2018

Monthly falls performance reports to QSG will be provided through the three Area, three acute site and one MH&LD divisional exceptions reports to QSG. The In-patient Strategic Falls group acknowledges that attendance has deteriorated which has slowed the progression that could be made within in-patient falls prevention and management. Attempts have been made to encourage an increase in availability to attend these meetings. The Chair of the group will escalate this in writing to the Executive Director of Nursing (Executive lead) and agree a response. Furthermore the leadership of the group, the level of funded organisational subject expertise to support the group and its Terms of Reference will be reviewed by the Executive lead.	Strategic Falls Group Chair/December 2018

Finding - ISS.2 - Evidence of reporting progress since the launch of the falls policy - Training (Operating effectiveness)	**Risk**
In accordance with Policy NU06 the Prevention and Management of Adult In-patient Falls, section 6.2, Training "*….all staff who work on an adult ward environment must undertake falls prevention training. All ward staff will receive mandatory falls training once every two years.*" We were unable to confirm compliance that the training undertaken across the Health Board has met Policy requirements.	Staff not appropriately trained.
Recommendation	**Priority level**

Policy requirement is reviewed to ensure it is both achievable and suitable. Also falls management training is included as mandatory for all relevant staff within ESR.	High
Management Response	**Responsible Officer/ Deadline**
Training of staff in the area of falls prevention awareness is mandatory for ward based staff. It is the remit of clinical divisions to ensure that the mandatory training falls prevention awareness module on ESR (000 Preventing Falls in Hospitals) is cascaded and made available to all relevant staff. It is currently available on the ESR catalogue and will also be easily found via signposting from the BCUHB Intranet Falls Prevention Homepage once it is launched. Compliance reporting was initially difficult following the change from e-learning to ESR as the portal of access to the training.	Divisional Nurse/Medical/Therapy Directors /November 2018
The Falls group will review the access to the training and its ability to report compliance. The group will review the suitability of the module as a form of training and make a recommendation to the Executive lead as to possible other approaches, such as face to face training which have not been achievable to date due to lack of funding/ resources to support this model. To achieve this, Executive support will be required to establish a framework similar to that of other major harms prevention teams such as Infection Prevention and Tissue Viability.	Strategic Falls Group Chair/March 2019

Finding - ISS.3 - Review the DATIX reporting system and the reporting of patient falls (Operating effectiveness)	**Risk**

From our testing we identified that the Root Cause Analysis (RCA) documentation is not always being completed for lessons learnt to be identified and shared across the Health Board. RIDDOR requirements are not always complied with.	Recurrent issues of patients receiving harm due to lessons learnt not being identified and shared.
Recommendation	**Priority level**
Compliance with Health Board Falls Management Policy – Section 8.3.2 – *"A post falls root cause analysis template action record must be completed for all falls which cause harm"*.	High
Management Response	**Responsible Officer/ Deadline**
As part of the review of the NU06 policy and attached documents, it will be discussed whether the falls prevention specific RCA attached to this policy is surplus to requirements within the RIDDOR framework as other RCA tools have been seen to be used, thus fulfilling the reporting framework. Compliance with RCA completion will form part of the reporting schedule identified in recommendation ISS.1 above.	Strategic Falls Group Chair/March 2019

Finding - ISS.4 - Review the DATIX reporting system and the reporting of patient falls – Intranet (Operating effectiveness)	**Risk**
The falls intranet page has been developed but on review, a number of pages had no content detailed. In addition, when searching on falls, a number of different pages were identified with varying degrees of information.	Staff unable to further develop their own education on patient falls.

Recommendation	Priority level
Further development and co-ordination of the intranet as a key repository for all staff.	Low
Management Response	**Responsible Officer/ Deadline**
The Falls Prevention Homepage on the BCUHB intranet was under construction at time of audit, the intranet navigation regarding Falls Prevention was not efficient or comprehensive at the time. This is still an ongoing project in collaboration with the Integrated Care Coordinator, with a work stream action plan and end date of 31st December 2018. This will correlate with the 90 Day unscheduled care plan and allow a launch and awareness campaign of the Falls Prevention Homepage in January 2019.	Strategic Falls Group Chair/January 2019

Finding - ISS.5 - Evidence that staff are completing the patient falls pathway (Operating effectiveness)	Risk
Our ward based reviews identified: • Signatures and Dates missing from sections of the patient falls assessment forms. • Patient Assessment form are not being reviewed. • Variance section not completed if circumstances of the patient has changed. • Patient assessment forms found to have been photocopied. • Patient labels not attached to all of the sections.	Incomplete documentation resulting in potential risk of patient harm.

- Visual and hearing issues identified within adult nursing assessment documentation however not acknowledged within patient falls assessment forms.
- Culpable medication identified within adult nursing assessment documentation however not acknowledged within patient falls assessment forms.
- Adult nursing assessment documentation identified incontinence however not acknowledged within patient falls assessment forms.
- Sections within the patient falls assessment forms for instance Medication, Visual and Hearing and mobility not fully complete.

Recommendation	Priority level
Improved awareness to staff with regards to the importance of the completion of the documentation as well as the consequences.	High

Management Response	Responsible Officer/ Deadline
Clinical divisions must ensure completion of the appropriate documentation within the Falls Prevention Pathway and provide assurance through regular auditing of documentation in line with wider appropriate record keeping standards. Failure to maintain adequate falls assessment and management records should be captured as part of any serious fall SIR reports and reported as exception under the divisional reporting schedule to QSG as per recommendation ISS.1 above.	Divisional Nurse Directors/December 2018
The strategic falls group will seek assurance form clinical divisions of lessons learnt in relation to poor record keeping following audit reports and /or SIR reports.	Strategic Falls Group Chair/January 2019

Appendix B - Assurance opinion and action plan risk rating
Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Concerns, Complaints and Redress - Part 6: Redress

Final Internal Audit Report

BCU 2018/19

January 2019

NHS Wales Shared Services Partnership

Contents

Review reference: BCU-1819-22

Report status: Final Internal Audit Report
Fieldwork commencement: 2nd November 2018
Fieldwork completion: 18th December 2018
Draft report issued: 20th December 2018
Management response received: 30th January 2019
Final report issued: 31st January 2019
Auditor/s: Senior Internal Auditor
    Head of Internal Audit
Executive sign off: Executive Director of Nursing and
    Midwifery
Distribution: Assistant Director Service User Experience
    Associate Director Of Quality Assurance
    Head Of Investigation And Redress
    Board Secretary
    Deputy Board Secretary
    Finance Director Operational Finance
    Compliance & Assurance Manager

Committee: Audit Committee

Disclaimer notice - Please note:

1.   Introduction and Background

The relevant lead Executive Director for the assignment is the Executive Director of Nursing and Midwifery.

NHS Wales complaints procedures are governed by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. The Putting Things Right guidance document supports Welsh NHS Organisations interpret and apply the statutory requirements.

The Regulations require Welsh NHS organisations investigating a concern to consider whether an offer of redress (up to a limit of £25,000) should be made where they believe there may be a qualifying liability.

During the first half of the 2018/19 financial year (April through September 2018), the Health Board closed and settled thirty nine concerns/incidents by means of redress totalling £281,492.

2.   Scope and Objectives

The overall objective of the review was to establish whether there is a robust control environment in place within the Health Board to manage and support redress.

The review focussed on the following:

- Management and administration of redress;
- Supporting policies and guidance notes;
- Adherence to regulations;
- Engagement, review, and scrutiny.

3.   Associated Risks

The potential risks considered at the outset of this review were:

- Breach of regulations;
- Lack of oversight and engagement;
- Inequity to service users.

OPINION AND KEY FINDINGS

4.   Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Concerns - Redress review is limited assurance.

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

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

5.   Assurance Summary

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

Assurance Summary					
1	Process Management and Documentation				✔
2	Redress documentation				✔
3	Response timescale compliance		✔		
4	Datix administration			✔	

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weakness in the system control/design for Concerns - Redress.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as weakness in the operation of the designed system/control for Concerns - Redress.

6.   Summary of Audit Findings

The key findings are reported in the Management Action Plan.

To determine the robustness of controls in place we met with relevant key officers to discuss the process, management, administration, monitoring, and reporting of Redress.

For a sample of redress claims, we reviewed the extent to which practice complied with documented requirements.

Our sample comprised of ten random redress claims that were closed during quarter two (1st July 2018 through 30th September 2018) of the 2018/19 financial year. Of these ten redress claims eight had been settled by means of financial compensation, one had been deemed not suitable for redress as the damages would likely exceed the £25,000 threshold outlined in the guidance notes. For the remaining claim, whilst a breach of duty had initially been accepted, expert evidence proved otherwise. The total monetary value of our sample was £62,250.00.

Process management and documentation

The Health Board has in place the PTR01a Concerns Procedure policy document which underpins the requirements set forth in Putting Things Right and The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 statutory instrument. This provides a robust governance framework for the Health Board to operate and manage its incidents and concerns.

To support this the Health Board utilise DatixWeb (Datix) as their Incident Reporting and management solution, which includes the recording, managing, and documenting of redress claims. Each redress claim is also supported with a physical file, ensuring the retention of key documents.

Whilst concerns are managed and driven by Investigating Officers assigned from operational services, Clinical Governance teams, and/or the Corporate Concerns Team, working in compliance with policy requirements, redress cases are managed centrally by the Senior Concerns Manager – Redress.

The Concerns Management Procedure policy document states the following;

 "An initial assessment of redress will have been made by the central concerns team. It is the duty of the Lead Investigator to review this and decide whether it is correct."

However, we were advised that involvement is typically initiated following the drafting of the interim report, which is consistent with the process flow chart detailed in the policy document.

Redress claim documentation

For each of the ten redress claims in our sample we reviewed the following documents:

- Initial notification of concern;
- Holding letters;
- Interim reports per Regulation 26;
- Acceptance of qualifying liability;
- Communication of the decision per Regulation 33;
- Completion and retention of waiver forms;

- Completion of Appendix T;
- Retention of payment backing documentation;
- Variance between Legal and Risk advised quantum and final settlement.

We found no issues of significance with regards to the administration of redress claims documentation. The following findings were noted:

- Of the ten redress claims in our sample, nine related to concerns raised by patients, whilst one related to a reported incident.

- The aforementioned incident was subject to a full enquiry investigation, and as such some of the documentation reviewed (i.e. notification, holding letter and interim report) were superseded by the enquiry investigation report.

- Evidence of concern notification was retained for each concern in our sample.

- Holding letters were issued for eight of the nine relevant concerns reviewed.

- Regulation 26 Interim Reports were issued and retained for seven of the ten cases reviewed. In each instance the Interim Reports had been completed appropriately and approved by the Executive Director of Nursing and Midwifery.

- Qualifying liability in tort was noted in all interim reports reviewed. However we found one instance where a breach of duty was admitted in the interim report but was subsequently reversed following expert review. This was fully documented, and no payments were made.

- No interim report was issued for one case in our sample. Rather, the final communication of decision including the investigation report per Regulation 33 had been issued in the first instance.

- An interim report was not applicable for one case reviewed as it was apparent that the monetary value of damages would likely exceed the £25k threshold set for redress claims. This was communicated appropriately to the claimant.

- A report detailing the findings of the incident review and communicating the decision and/or offer per Regulation 33 was available for nine of the ten cases reviewed. The one exception was the case where the redress claim path was not followed due to likely value of damages exceeding the threshold for redress.

- In each instance the documentation had been completed comprehensively and had been authorised by the Executive Director of Nursing and Midwifery.

- In all instances where a financial offer of redress had been made, the offer was consistent with the advice of the Legal and Risk team.

- There were two instances within our review sample where the initial financial offer had been rejected by the claimants. Amended offers had

been made and subsequently accepted. In both instances, the process was transparent, fully documented and authorised.

- Where relevant, waiver forms had been completed and signed by the claimant (or representative), and retained.

- Appendix T documentation had been completed appropriately.

- All payment backing documentation and finance request forms had been retained, scrutinised, and authorised appropriately.

- All physical files reviewed were well organised, and were consistent between cases.

Response timescale compliance

Whilst completion of the redress documentation was in full compliance with the requirements set out in the relevant statutory instrument and supporting policy documentation, we found several instances in our sample where the stipulated timelines for responding to claimants were not adhered to.

The legislative and policy documentation states that an interim response under Regulation 26 must be issued within 30 working days of receipt of the concern, together with an interim report.

Where this is not possible, a letter must be sent to the person raising the concern informing them of the delay and the reasons why. An expected response date should be given with the intention of the interim response being sent within six months of receipt of the concern.

Following completion of the review the Health Board must communicate its decision to either offer redress or otherwise within twelve months from the initial receipt of the concern. Again provision is made for exceptional circumstances whereby the twelve month period cannot be achieved stipulating that the Health Board must notify the claimant of the delay and provide an expected date for the decision.

Once the offer of redress is made, claimants must respond to the offer within six months, or explain why they are unable to respond within this period.

We reviewed the dating of key documents for each claim in our sample against these requirements and found the following issues and limitations:

- None of the Regulation 26 interim reports reviewed had been issued within thirty days of concern notification.

- A holding letter explaining the process and reasons for delay had been issued for eight of the ten claims within our sample. However, none of these had been issued within thirty days of concern notification.

- The initial holding letters within our sample had been issued between 37 and 98 days following notification (with our sample average being 59 days).

- We found examples of subsequent holding letters having been sent keeping claimants apprised of how the investigations were progressing.

However these were not subject to our review as neither the Regulations nor the policy documentation made provision for these.

- Regulation 26 interim reports had been issued for seven of the ten claims in our review sample. Of these, only one interim report had been issued within six months of first notification. The remaining reports had been issued between 191 and 453 days following notification (with a sample average of 295 days).

- A report detailing the findings of the incident review and communicating the decision and offer to the claimant per Regulation 33 was available for nine of the ten cases reviewed. Of these, three had been issued within twelve months of the date of first notification in compliance with the statutory regulations.

- Whilst one further offer was issued within one month of the required twelve month period (22 days over), the five remaining examples in our sample were significantly outside the timelines specified in the Regulations.

- In these instances the offers were made 79, 118, 311, 429, and 673 days respectively over the initial twelve month period specified in the Regulation and policy documentation.

The above findings demonstrate significant deviation from the response time requirements specified in the Regulatory and policy documents.

A possible contributory factor to this is the delay between initial notification and drafting of the interim report, to engaging the redress process via notifying the concerns hub. We found that for our sample of cases, the concerns hub were informed on average 271 days following the initial notification.

The actual intervals varied between 34 and 702 days following notification. The latter related to the incident in our sample - removing this from our calculation reduced the average to 223 days following notification.

We noted that the three Regulation 33 offers that had been made within twelve months in compliance with the policy requirements, were amongst the four cases that had been referred to the hub early (i.e. within five months of initial notification).

Datix administration

From our sample of ten cases, we found three instances where the primary complaints chain date recorded in Datix did not match the date of first notification. The dates varied by two, six, and fourteen days respectively.

Whilst the above variances may not be considered material, it is imperative that the primary complaints date in Datix is accurate as all key reporting deadline dates are derived from this.

7.   Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - ISS.1 - Timescale compliance (Operating effectiveness)	Risk
We found several issues of significance with regard to compliance with the timescales for response specified in the statutory instrument and policy document. For our sample of concerns we found that: • None of the Regulation 26 interim reports reviewed had been issued within thirty days of concern notification. • Whilst holding letters explaining the process and reasons for delay had been issued for eight of the ten claims reviewed, none of these had been issued within thirty days of notification. • Of the seven Regulation 26 interim reports sent, only one had been issued within six months of first notification. • A report detailing the findings of the incident review and communicating the decision and offer to the claimant per Regulation 33 was available for nine of the ten cases reviewed. Of these, only three had been issued within twelve months of the date of first notification.	Failure to comply with statutory and policy requirements. Delayed resolution impacting patient wellbeing.
Recommendation	**Priority level**
Management must ensure compliance with relevant statutory and policy requirements. Management should consider whether controls in place are sufficiently robust to ensure future compliance.	**High**

Management Response	Responsible Officer/ Deadline
The Corporate Concerns Team to be restructured to provide a single lead for Complaints across BCUHB.	Assistant Director Service User Experience Completed December 2018
PTR1a, the procedure for the management of Concerns to be revised and updated to make it easier for staff to follow and drive the appropriate and timely decision making regarding qualifying liability.	Head of Complaints May 2019
The establishment of a weekly meeting lead by the Associate Director of Quality and Assurance to review complex and significantly overdue complaints.	Associate Director of Quality and Assurance In place
The weekly Corporate Concerns Hub provides weekly performance/monitoring reports for all divisions to support performance monitoring.	Head of Corporate Concerns Hub In place
All concerns are reviewed by the Head of Complaints on a weekly basis to drive progress and monitor progression of investigations into qualifying liability.	Head of Complaints In place
Further training regarding the investigation of complaints to determine Breach of duty of care and qualifying liability to be provide across BCUHB. This programme has commenced and is a rolling programme but it will take time to reach all appropriate staff.	Heads of Complaints, Incidents and Service User Experience April 2020

Finding - ISS.2 – Datix administration (Operating effectiveness)	Risk
From our sample of ten cases, we found three instances where the primary complaints chain date recorded in Datix did not match the date of first notification. The dates varied by two, six, and fourteen days respectively.	Lack of transparency. Incorrect dates impacting reporting.
Recommendation	**Priority level**
Whilst the variances in our sample were not material, it is imperative that the primary complaints date recorded in Datix is accurate as all key reporting deadline dates are derived from this. Management must ensure all dates recorded in Datix are accurate.	Low
Management Response	**Responsible Officer/ Deadline**
Reminder to all corporate concerns staff registering complaints that the date recorded on Datix must be the date that the HB first receive the complaint notification and not the date it is registered. The Corporate Concerns Hub will conduct a twice yearly snap shot audit and report the findings to the Head of Complaints.	Assistant Director Service User Experience 31st January 2019 Head of Corporate Concerns Hub July 31st for completion of first audit

Appendix B - Assurance opinion and action plan risk rating
Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Betsi Cadwaladr University Health Board

Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference?

Final Internal Audit Report

BCU 2018/19

December 2018

NHS Wales Shared Services Partnership

Limited
assurance

Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference?

Betsi Cadwaladr University Health Board

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Management response received:	27th November 2018
Final report issued:	27th November 2018
Auditor/s:	Head of Internal Audit
	Audit Manager – Capital
Executive sign off:	Director of Therapies and Health Sciences
Distribution:	Head Of Facilities Management
	Assistant Area Director of Therapy Services – East
	Head of Transforming Care team
	Director of Estates and Facilities
	Associate Director of Quality Assurance
	Board Secretary
	Deputy Board Secretary
	Finance Directors
	Compliance & Assurance Manager
Committee:	Audit Committee

ACKNOWLEDGEMENT

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

Disclaimer notice - Please note:

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

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

Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference?

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1.   Introduction and Background

In December 2015, the Wales Audit Office (WAO) issued to the Health Board its report on 'Hospital Catering and Patient Nutrition Follow-up review' that built on previous reports issued in 2010; 2011; and 2013 and included an update on the actions taken to implement the combined total of fifty-six recommendations.

The report stated that the *"Health Board has fully achieved 25 out of the 56 recommendations and suggestions previously set out in our national and local reports"* and detailed the analysis against each recommendation whether it had been achieved or on-track.

The Health Board has an *Improving Nutrition, Catering and Hydration Standards* (INCHS) Group, as well as the on-line Information Reporting Intelligence System which reports, under the Ward Quality & Safety Audit - Safe Care Theme, self-assessed compliance with Health & Care Standard 2.5 Nutrition and Hydration.

The nine self-assessment questions set by the Health Board cover the following:

- Are all registered and unregistered nursing staff (where appropriate) assisting with the meal time experience?

- Are patients prepared appropriately for meal times?

- Does the patient have an accurate and up to date Malnutrition Universal Screening Tool (MUST) score (weekly)?

- For patients with a fluid balance chart: have 24 hour cumulative balances been recorded?

- For patients with a food chart: has the chart been signed by a Registered Nurse every 24 hours?

- For patients with a medium or high risk MUST score is there an up to date, evaluated Acute Inpatient Nutrition care plan?

- For patients with fluid balance chart: is the fluid balance chart up to date?

- Is there documented evidence that the patient's mouth care assessment is completed?

- Is there evidence that mealtimes are calm without unnecessary interruptions?

Whilst the above focus on ward quality and safety, Standard 2.5 has broader expectations by which the Health Board also needs to assure itself it is delivering on.

The WAO review also considered the cost of patient and non-patient catering services coupled with performance and patient experience reporting to the Board/Sub Committee.

2.   Scope and Objectives

The objective of the review sought to identify whether the actions implemented, following the publication of the four Wales Audit Office reports and management

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action to implement the recommendations, have made a positive difference and delivered the outcomes as intended.

The scope of the review considered the following:

- The Governance, scrutiny and assurance through to the Board/Committee;

- Patient feedback regarding nutrition and catering services and where these are considered;

- Health & Care Standard 2.5 Nutrition and Hydration is monitored, with particular focus on the Ward Quality and Safety audit self-assessment within Safe Care;

- Performance data - how it is used/reported; and

- Financial/EFPMS costs of delivering patient and non-patient catering services.

We did not follow-up any of the fifty six recommendations to corroborate implementation and did not undertake any observational reviews to confirm controls are in place at the ward/Catering Department.

We did not follow-up specific progress relating to the Public Accounts Committee Hospital Catering and Patient Nutrition report (March 2017) which identified a number of recommendations for Health Boards and Trusts to take forward – We did note presentation of updates against the recommendations and detail this further in the report.

3.   Associated Risks

The risks considered at the outset of this review were:

- Implementation of agreed actions have not improved services to the patient;

- Health & Care Standard 2.5 is not achieved in delivering services;

- Patient and non-patient catering services are not achieving financial balance;

- Performance information is not scrutinised or routinely reported for assurance purposes.

OPINION AND KEY FINDINGS

4.   Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference? review is limited assurance.

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

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

5.   Assurance Summary

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

Assurance Summary					
1	Governance and reporting arrangements		✓		
2	Patient feedback			✓	
3	Ward quality and safety audit self-assessment		✓		
4	Performance data	✓			
5	Financial and operational performance data in delivering the catering service				✓

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

Design of Systems/Controls

The findings from the review has highlighted one issue that is classified as a weakness in the system control/design for the *Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference?* review.

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Operation of System/Controls

The findings from the review have highlighted five issues that are classified as a weakness in the operation of the designed system/control for the *Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference?* review.

6.   Summary of Audit Findings

'Hospital catering and patient nutrition is a key element in ensuring that people make a full and healthy recovery while in hospital. Patients should be well fed and hydrated in hospital, this should not be optional or, left to chance depending upon which hospital or health board you are in.

Without ensuring the availability of nutritious food and good hydration, there is a potential for patients to come to harm. Indeed, during our evidence session, the Chief Nursing Officer stressed that 'Nutrition and hydration are one of those things that, to be frank, is almost as important as the medication that people receive'.'[1]

This review has sought to evidence progress made across the five key areas considered in the report. It is based upon the information/documents provided by management and responses during discussions. We have relied solely on the documents, information and explanations provided and except where otherwise stated, we have not undertaken any work at ward/catering to verify the accuracy of data.

Overall, we cannot evidence performance data or assurance being routinely scrutinised and reported through the Committee structure to the Board.

Governance and reporting arrangements

There are a number of meetings established which can evidence discussing catering and nutrition, however there is no formal thread of assurance, through to the Health Board/Committee evidenced in the terms of reference (both approved and draft).

Policy

The review of the nursing policies and key documents intranet site records '*NU11 – Nutrition support clinical protocol for adults'* however on clicking the hyperlink, we were taken to the 'File not found' page.

We identified draft policy 'NU17 – Nutrition and Hydration Policy [V0.1]' included on the agenda of the Quality and Safety Group meeting of the 14th March 2018 where the meeting noted receipt with the Minutes stating "...was not discussed."

We discussed the status of the draft policy and were advised that this has not progressed. We also note in reviewing the nursing policies and guidance page

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[1] Chair's Foreword, Hospital Catering and Patient Nutrition report, National Assembly for Wales Public Accounts Committee, March 2017, P.7

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that reference NU17 is already in use and relates to a different subject.

<u>Improving Nutrition, Catering and Hydration Standards Group (INCHS)</u>

The INCHS group is the vehicle established to drive forward all matters relating to catering, nutrition and hydration standards.

We noted an intranet site for the group however the page is noted as last being updated on the 27th January 2014.

We were provided with its Terms of Reference (TOR) referenced '*4.12.15 INCHS ToR updated January 2017'* and note that accountability "…….*will report through the east governance structures"* and reporting "….*Issues of significance and an update briefing will be provided to the East Area Quality & Safety Group and escalated to the Quality Assurance Executive where relevant*." We cannot see evidence of formal issues of significance or minutes reported through East Area and confirmed that this does not happen [we noted this was due to several changes in the Area Director of Clinical Services post].

In reviewing the TOR we noted the following:

- There is no reference to the sub-groups it has established - Fundamentals: Improving Nutrition Catering and Hydration Standards (FINCH) and Adult Artificial Nutritional Support Pathways Task & Finish Group (ANG) ;

- Quorum is difficult to identify as the TOR do not specify posts e.g. Divisional representatives;

- Function – There are several key roles for the group but it is unclear how these are evidenced as being delivered - there is no cycle of business;

- We also noted the following detailed in the Function section which is a key thread of assurance upto the lead Executive Director "*To identify issues of significance that may impact on implementation, make recommendations to overcome and communicate these through agreed reporting structures – the Quality Assurance Executive"* – The Quality Assurance Executive has been re-formed into the Quality and Safety Group and does not identify INCHS for assurance reporting to it – This represents a significant risk for the Health Board noting the importance placed upon this area by the Public Accounts Committee (PAC).

Our review of the agenda and minutes of the group note lengthy and dynamic agendas with varying topics from the PAC audit update against recommendations; hydration toolkit roll-out; patient safety notice; all-Wales nutritional screening tool; catering updates and Community Health Council (CHC) updates, with a specific item on '*Issues of significance for the QSG'* listed.

With the exception of key individuals, we noted poor attendance at the meetings, with eleven (March 2018) and then seven for both June and September 2018 meetings – seventeen 'representatives' are noted for attendance.

It is noted that

<u>Fundamentals: Improving Nutrition Catering and Hydration Standards (FINCH)</u>

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We were provided with the TOR referenced '*07.02.18 FINCHS ToR January 2018'* but are unclear whether these have been considered and approved by INCHS.

In reviewing the TOR for FINCHS, we compared with INCHS and noted a number of its stated functions mirrored those of INCHS, recognising in other areas FINCH was very much geared towards a 'doing' group.

Quorum is difficult to identify as the TOR do not specify posts within its membership and also noted '*(awaiting confirmation)*' against *Lead for children's services; Service User; and Education – University representative.*

We noted reporting recorded "*….Issues of significance and an update briefing will be provided to the East Area Quality & Safety Group and escalated to the Quality Assurance Executive where relevant."* However there is no reference to formally reporting to INCHS, which does receive the minutes in full.

The review of agenda and minutes noted, overall, positive attendance but whether it is quorate cannot be determined.

There is evidence that a great deal of work is driven by and through the group, with actions assigned to individuals; however there is no action log which evidences implementation/update for the group. PAC updates actively considered along with emerging issues as they occur e.g. nutrition and hydration week; hydration toolkit; catering; developing finger food; International dysphagia diet standardisation initiative; malnutrition screening.

<u>Adult Artificial Nutritional Support Pathways Task & Finish Group (ANG)</u>

We were provided with the TOR referenced '*DRAFT 3.0 16/08/2017'* where its purpose is recorded as "*Development of the quality framework and key performance indicators related to artificial nutritional across BCUHB"* – It is unclear if these TOR have been considered by INCHS.

Quorum is difficult to identify as the TOR do not specify posts within its membership e.g. '*Radiology; Critical Care Lead / Representation'*.

The meeting is technical in nature with multi-disciplinary membership, however it is noted as reporting to the "*…Office of the Medical Director Business meeting on a Monthly basis, and at intervals to be agreed to the Quality & Safety Committee."*.

We were advised by the Chair of INCHS that a member on both INCHS and ANG provides a verbal update on issues of significance however there is no formal reporting to INCHS per the TOR provided.

The review of one agenda (February 2018) and minutes (February; April 2018) noted a clinically focused meeting with an action column assigning actions to individuals – we can find no action log provided within the agenda which indicate completeness of assigned action(s). We understand a meeting was held in July 2018 but no agenda or minutes have been provided.

We cannot confirm that meetings were quorate and noted poor evidenced attendance from the three Areas and Gastroenterology (three site attendance).

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Quality and Safety Group (QSG)

We were provided with '*Quality and Safety Group Draft TOR V0.5 Created 19.12.16*' which identifies five sub-groups established, none of which relate to catering, hydration or nutrition.

Appendix 1 details governance sub-structures with Table 1 within the TOR detailing pan-Health Board strategic groups established and reporting through an Health Board Director - INCHS is not identified as a group for routine reporting to QSG/lead Director.

In reviewing the agenda and minutes of all QSG meetings held in 2018, we identified two agenda items relating *BCUHB action plan in relation to the Public Accounts Committee (PAC) document: Hospital Catering and Patient Nutrition (March 2017)* (Item 18.02.03) and *Revised eating and drinking policy* (Item 18.02.04).

BCUHB action plan in relation to the Public Accounts Committee (PAC) document: Hospital Catering and Patient Nutrition (March 2017)

The purpose of the paper recorded "….*provide Health Board compliance status in relation to the PAC recommendations. The PAC recommendations were presented to QSG in May 2017 by [Assistant Area Director of Therapy Services – East] and the group members requested and action plan with timelines in relation to the recommendations and the Health Board's status*."

The paper detailed the Health Board's current update against the ten recommendations made by the PAC with Minute 18/02.03 recording "….*explained that there are 10 recommendations and the key issue for the HB will be how we address training (recommendations 6 and 7) in relation to nutrition and hydration, including the type of training, frequency……whether the training is mandated for relevant staff. At present there is no accurate status of nutrition related training….. Group agreed that a Senior nurse on should attend the INCH group to drive the work.*"

Revised eating and drinking policy

Minute 18/02.04 records "*The draft document was circulated ahead of the meeting for information and was not discussed.*"

Recognising the significance of the PAC recommendations and status, we were able to identify reporting of the issue, through the Quality Safety Group Assurance Report to the Quality, Safety and Experience Committee (QSE) on the 24th April 2018, under Item QS 18/74. Minute QS 18/74.1 notes "…..*The Committee Chair expressed concern at the length of time it was taking to respond to the Public Accounts Committee (PAC) hospital catering and patient nutrition action plan, and it was suggested that some form of training needed to be initiated…..*".

The QSE Action log notes a management response that "*QSG will receive further report in October and ensure that QSE are updated through Chair's report.*" – We have reviewed the QSG agenda 10th October 2018 and cannot see an update

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on the PAC recommendations as an agenda item.

We have raised the tracking of the PAC action plan recommendations with the Office of the Board Secretary who will now lead on ensuring the actions are subject to live tracking with operational management.

Training data – Food record chart

There is an all-Wales Food record chart training module where we were advised [and management believed] it was a mandatory training element for all nursing staff.

Management were subsequently advised it was not but are progressing this with Organisational Development for it to become mandatory as part of the refresh of required training.

We obtained details (image 1) from the Orientation and E-Learning department, Workforce and Organisational Development Directorate and noted poor completion rate for the period 1st August 2016 to 17th September 2018 where only sixty-eight individuals have completed the training and passed.

The issue of training is identified across two recommendations made by the PAC in its report [see Quality & Safety Group findings above].

Image 1: Extract from NHS Wales e-learning system – Food Record Chart

Please see below. This data is from 01-08-2016 – 17-09-2018

Course	Learning Object	Completed	Incomplete	Not Attempted	Passed	Withdrawn
000 NHS Wales - Food Record Chart	000 NHS Wales - Food Record Chart	11	13	6	68	6

Patient Feedback

There are several ways in which the Health Board captures patient feedback and the findings are detailed per heading.

- Ward monthly audits

Three specific questions are asked to a sample of patients as part of the ward Health & Care Standards Patient Experience Survey. Table 1 details the recorded findings – There is a 95% target compliance score.

Table 1: Patient experience survey October 2017 to September 2018

Health & Care Standards Patient Experience Survey	2017			2018								
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Q07: Throughout your stay, how often did you feel that you were provided with nutritious food and snacks?	94.8%	98.2%	94.5%	93.9%	92.2%	88.4%	94.4%	93.2%	91.3%	96.4%	88.3%	90.6%

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| Q08: Throughout your stay/attendance, how often did you feel that you were provided with fresh drinking water and plenty of drinks when you need them? | 99.7% | 96.4% | 97.8% | 98.0% | 98.1% | 99.7% | 100.0% | 99.6% | 97.5% | 99.4% | 96.2% | 98.8% |
| Q09: Throughout your stay, how often did you feel that you were given help with eating and drinking if you needed this? | 96.5% | 94.5% | 100.0% | 99.1% | 98.0% | 97.3% | 99.2% | 99.1% | 99.3% | 100.0% | 100.0% | 100.0% |

Source: Internal audit generated report via IRIS reporting system 9th October 2018 – Ward Quality and Safety Audit

It is evident from these findings that patients have regularly fed-back that there are opportunities for wards to improve the provision of nutritious food and snacks.

We have been unable to ascertain that ward managers/matrons are actively using this data to improve services and are unclear how they are held to account for non-achievement of the target.

- Patient experience surveys

The Service User Experience team (SUE) capture feedback through a variety of methods, both on-line and paper forms. For the period 1st April to 18th September 2018, SUE identified two hundred and twenty three comments concerning nutrition and hydration.

Breaking down the responses, one hundred and thirty nine (62%) provided positive feedback with eighty four (32%) responding with negative comments.

The questions focus on the seven Welsh Government national core questions and there is no specific question on nutrition and hydration, although there is the ability to capture free-text feedback from the following questions:

- What was good about your experience?
- Was there anything that could be improved?

We were provided with evidence that monthly patient experience reports are sent however we are unclear what evidence exists that operational management are acting on the information.

- Community Health Council (CHC) Foodwatch/Carewatch

We were provided with log where the Health Board has recorded twenty-seven CHC reports issued from April 2018, eighteen relating to Carewatch, which includes six questions under its *Eating and Drinking* section.

One theme we noted at two wards visited concerned the availability of cold

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drinking water for patients as opposed to tap water.

We asked what evidence was available to confirm that the stated actions in the returned CHC action plan are completed – we were not provided with any evidence which shows that the actions are implemented.

- Datix recording of concerns/incidents and complaints

We received two reports for the period 1st September 2017 to 31st August 2018 which identified the following:

Complaints – Eight were recorded in the period and all have been closed. Two related to an external provider; two related to gluten food availability; and four related to food quality/crockery. We noted closing comments for all bar two which did not have details recorded regarding action taken – these related to AM/MP complaints.

Incidents – Six were recorded in the period and have been closed. Two related to nutrition (clinical issues) in the community; one related to a fall in a dining room; one related to choice of food; and two related to the lack of liquid food at the same hospital.

Whilst there is a small number of complaints/incidents, we noted overriding findings relate to issues pertaining to availability/choice of food.

Ward quality and safety audit self-assessment

Each ward should complete a self-assessment against a set of questions which is then input into the NHS Wales Health & Care Monitoring system which is signed off by the sister that all metrics are included. The Matron should then quality assure and locks the return. Data is then drawn down to the data warehouse to populate the dashboard.

The Integrated Quality & Performance Report (IQPR) is the key assurance report presented to the Quality, Safety and Experience Committee but only core HARMS are included in reporting, these being Health acquired pressure ulcers; Falls; Medication errors and Infection prevention and control - Nothing is reported on catering, nutrition and hydration.

We note the Health Board is introducing ward accreditation from October/November 2018 and we have been provided with the draft questions, where 25 key questions are noted on nutrition and hydration which significantly broadens those currently self-assessed by the wards.

At the time of this review, the requirements for completing the ward quality and safety assessments remained live and for completion.

Our review of ward quality and safety findings for nutrition and hydration identify (as at 2nd October 2018), overall poor self-assessment scores from across the Health Board for January to September 2018 (target compliance is 95%).

Table 2 – Self assessment against Health & Care Standard 2.5

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		2018								
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Standard 2.5	Are all registered and unregistered nursing staff (where appropriate) assisting with the meal time experience?	97.8%	98.9%	98.9%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%
	Are patients prepared appropriately for meal times?	100.0%	100.0%	100.0%	100.0%	100.0%	97.8%	98.7%	100.0%	100.0%
	Does the patient have an accurate and up to date MUST score (weekly)?	84.6%	85.4%	84.4%	91.3%	92.1%	90.1%	78.4%	85.5%	85.6%
	For patients with a fluid balance chart: have 24 hour cumulative balances been recorded?	85.1%	82.9%	82.8%	86.7%	87.1%	82.2%	82.8%	80.9%	81.1%
	For patients with a food chart: has the chart been signed by a Registered Nurse every 24 hours?	76.5%	88.9%	78.2%	76.9%	85.6%	85.2%	92.8%	86.6%	82.8%
	For patients with a medium or high risk MUST score is there an up to date, evaluated Acute Inpatient Nutrition care plan?	86.8%	83.1%	79.1%	91.4%	87.0%	83.6%	89.5%	81.1%	80.6%
	For patients with fluid balance chart: is the fluid balance chart up to date?	98.8%	96.4%	95.9%	96.0%	97.9%	95.1%	93.7%	98.6%	89.0%
	Is there documented evidence that the patient's mouth care assessment is completed?	91.6%	94.8%	93.3%	92.4%	95.6%	96.5%	98.1%	95.3%	94.4%
	Is there evidence that mealtimes are calm without unnecessary interruptions?	86.8%	98.9%	96.8%	97.6%	97.8%	100.0%	96.0%	98.7%	95.9%

Source: IRIS reporting system report exported by Internal Audit, 3rd October 2018

We then sought to ascertain the number of wards that had completed the return for September 2018 and identified an alarming lack of returns completed.

Table 3 – September 2018 RAG rated self-assessment score by ward return

Safe Care - Standard 2.5

>95%		80%-95%		<80%	
WMH Mason	96.7%	WMH Medical Assessment	82.4%	YGC Ward 5	40.0%
WMH Acton (Rehab)	97.0%	WMH Bromfield	82.8%	WMH Erddig	42.4%
WMH Bersham	100.0%	WMH Morris	87.9%	WMH Pantomime	70.0%
WMH Ear, Nose & Throat	100.0%	YGC Ward 9	88.2%	WMH Acute Cardiac Unit	75.0%
WMH Evington COTE	100.0%	DOCH Cader and Mawddach	88.9%	YGC Ward 11	76.5%
MCH Delyn Ward	100.0%	MCH Clwyd Ward	88.9%	YPS Glasmor	76.7%
ECH Padarn	100.0%	WMH Surgical Admission	90.0%	YGC Ward 3	78.6%
ALH Morfa	100.0%	WMH Cunliffe	90.3%		
BBCH Dwyfor	100.0%	TCH Dyfi	92.3%		
BBCH Llyn	100.0%				
DECH Branwen	100.0%				

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DECH Gladstone	100.0%		YPS Cybi	93.5%
YG Ffrancon	100.0%		YGC Ward 14	93.8%
YGC Coronary Care Unit	100.0%			
YGC Surgical Assessment Unit	100.0%			

We saw similar poor returns submitted for June to August 2018 inclusive.

It is evident there is consistent non achievement of several expected 'controls' over the period for those wards that complete the return.

We were advised that no independent action is taken to corroborate the self-assessment. It is also not evident what action, if any, is taken to address non-achievement of the 95% target.

Performance data

Welsh Government have issued National Standard (Safe Care) DM25 – Nutrition and Hydration. On reviewing the report and seeking evidence with the Performance Directorate of its current status within the IQPR, this measure has still received no guidance from Welsh Government and is therefore not providing any performance data for Board/Committee scrutiny.

The Director of Estates and Facilities produces an annual report and quarterly presentations for the directorate's quarterly performance review with the Executive.

The reports/presentations we observed noted the following data reported:

- Untouched meals data;
- Plans to increase income from non-patient food;
- Food safety compliance - Primary authority scheme;
- Food hygiene ratings; and
- Catering service costs.

Whilst we recognise the reporting of this catering data by Facilities management, these reports are presented to management accountability meetings; we have been unable to identify any evidence that catering and nutrition data is formally reported to a Committee.

We also note that untouched meals is a Programme Management Office (PMO) project from a saving perspective but there is no understanding how this data is being used from a patient safety perspective on nutrition.

Financial and operational performance data in delivering the catering service

Estates and Facilities Performance Management System (EFPMS)

EFPMS is a comprehensive collection of estates and facilities data set by Welsh Government to improve the management of NHS estate in Wales. The data is

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directly input by NHS Wales Health Boards and Trusts and is used to facilitate and monitor improvements in performance in the health estate in Wales.

We obtained the current all-Wales EFPMS report relating to 2016/17 (2017/18 is set to be published in November 2018) and also obtained the Health Board's 2017/18 submission for comparative purpose.

In table 4, the review of this data identified the following:

Table 4: Comparison of EFPMS data – Health Board reports against 25 sites (26.6%) of the total of 94 sites pan NHS Wales

	Total gross cost non-patient catering (£)	Total gross cost patient catering (£)	Total non-patient income (£)	Net costs (contribution) non patient catering (£)	Total patient meals requested	Cost per patient meal (£)
2016/17						
Health Board total	1,847,386.74	9,314,235.16	1,978,724.88	-131,338.16	2,441,023	3.82
All-Wales average (8 organisations)	1,562,131.79	4,734,412.26	1,488,157.61	73,974.17	1,442,313	3.55
2017/18						
Health Board total	1,876,253.96	8,921,977.51	2,096,485.39	-220,231.43	2,516,758	4.02

Source: Health Board data obtained from Estates & Facilities. All-Wales data obtained from Specialist Estates Services.

In 2016/17, the Health Board's cost per patient meal is 27p more expensive than average but it does produce one million more meals than the average for NHS Wales Health Boards.

The Health Board significantly over-achieved its reported non-patient income compared to the all Wales average and also is one of only two Health Boards which has a positive contribution in delivering its non-patient catering service, thus generating income to offset its patient meal service.

We did note that Ysbyty Glan Clwyd did not cover its non-patient catering costs through income in 2016/17 or 2017/18 but recognise its ability to fully function this service has been hampered by the construction work on site.

For 2017/18 we sought to verify the reported income data for the three district general hospitals [which accounts for 89% of the total income generated] to the month 12 2017/18 finance report – Whilst we were able to verify Ysbyty Gwynedd (YG) and Ysbyty Glan Clwyd (YGC), we could not verify Ysbyty Wrexham Maelor (YWM) and identified a potential over-reporting of £96,070 which we have corroborated with the officer and confirmed the over-reporting, due in the main to a transposition error – This has been corrected on the 30th October 2018 in EFPMS.

Finance reports

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We obtained the month 12 report for 2017/18 and month 5 report for 2018/19 and reviewed the income received and overall financial position.

2017/18 identified an overall overspend for patient and non-patient catering service of £255,463, noting YWM non-patient catering cost centre recording a £166,216 overspend.

The review of month 5 2018/19 report noted the catering service is £50,876 overspent, with catering income overachieving by £85,397.83.

Noting the financial pressures placed upon the service, we have been unable to ascertain whether the Health Board has formally considered and committed to subsidising the provision of non-patient catering services i.e. is it a welfare service for staff/visitors or an income generation activity.

We note there is a PMO project established for catering income increase.

7.   Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	3	3	0	6

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Appendix A - Action Plan

Finding - ISS.1 - Reporting arrangements and assurance (Operating effectiveness)	Risk
Our review has identified the operational INCHS; FINCH and ANG groups are actively delivering this agenda but are working without direction and accountability to an executive/management group. With the exception of one item received at QSG and subsequently noted in the Chairs report to the QSE Committee [concerning ten recommendations made by the Public Accounts Committee in this area], no other matters of assurance are reported. In reviewing Terms of Reference, we identified a number of housekeeping issues that require addressing from accountability reporting through to detailed membership. The review of agenda and minutes noted poor attendance at INCHS with it and its sub-groups not having cycles of business/action logs per templates issued by the Office of the Board Secretary. Training records relating to the Food Record Chart e-learning is poor and there is no current Policy available for reference and direction.	Governance arrangements are ineffective and the Board receives no assurance on nutrition and hydration.
Recommendation	**Priority level**
The governance and assurance reporting arrangements relating to catering, nutrition and hydration are reviewed as soon as possible [including associated	High

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Appendix A - Action Plan

terms of reference/minutes/membership], ensuring it has the right structure and accountability in situ to deliver its responsibilities for meeting Health & Care Standard 2.5 and the recommendations in the Public Accounts Committee report.	
Management Response	**Responsible Officer/ Deadline**
The reporting structure for INCHS will be directly to the Quality and Safety Group (QSG) for the Health Board and this will be reflected in the Terms of Reference (TOR) for INCHS. The INCHS amended TOR will be reviewed at the next quarterly meeting on the 7th December 2018. Reporting arrangement for FINCH and the ANG will be reviewed at that meeting and the TOR will be reviewed following that. A new Board champion for nutrition will need to be identified as the previous representative has moved on to the position of vice Chair of the Health Board. Steven Grayston will pick that up directly with the previous incumbent.	Assistant Area Director of Therapy Services – East Reviewed TOR by January 2019

Finding - ISS.2 - Patient feedback - Community Health Council Foodwatch/Carewatch (Operating effectiveness)	**Risk**
The Community Health Council (CHC) have issued a number of reports under its Carewatch and Foodwatch reviews and produced relevant actions plans for individual wards/areas to take forward. We evidenced responses provided by ward management with defined dates aswell as some noted as 'on-going'.	Identified issues are not actioned, impacting on the quality of service to patients.

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We were unable to confirm that the management response/actions are actively monitored for implementation and to which forum this is reported.	

Recommendation	**Priority level**
All Foodwatch/Carewatch reports are subject to tracking and reporting to INCHS/FINCH [subject to any changes in governance structure] in order that issues relating to catering, nutrition and hydration are actively monitored and issues addressed.	Medium

Management Response	**Responsible Officer/ Deadline**
The arrangements for this are already provisionally in place subject to new agreed Foodwatch questions. The chair of INCHS will ensure a process is set up via the CHC lead on INCHS and that these are a standing agenda item at each INCHS meeting. Reporting will commence from June 2019	Assistant Area Director of Therapy Services – East with CHC lead June 2019

Finding - ISS.3 - Patient feedback - Health Board systems (Operating effectiveness)	**Risk**
The Health Board uses several tools and methods to capture patient feedback where there is a great deal of positivity on services provided. Our review of these relating to nutrition/catering/hydration identified a number where some patient feedback was not as expected. The process for evidencing	Learning from patient feedback is not evidenced as being acted on through improvements in on-going feedback.

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Appendix A - Action Plan

that operational management are acting on the feedback is not clear and this is evidenced through the Health & Care Standard patient experience survey where it was consistently not achieving a positive outcome when individuals responded to *"Throughout your stay, how often did you feel that you were provided with nutritious food and snacks?"*.	
Recommendation	**Priority level**
Using existing tools and reporting methodology, management regularly evidence review of output reports to identify where returns are not improving and put in place a process where these are subject to scrutiny – We would anticipate this being a key role of INCHS to monitor and hold services to account.	Medium
Management Response	**Responsible Officer/ Deadline**
Service user reports will be reviewed at each INCHS and link in with ward accreditation reviews. New reporting structures will be established and in place by June 2019.	Assistant Area Director of Therapy Services – East/ Head of Transforming Care Team June 2019

Finding - ISS.4 - Ward quality and safety self-assessment (Design effectiveness)	**Risk**

Wales Audit Office report: Hospital Catering and Patient
Nutrition Follow up review – Have the agreed actions
made a positive difference?

Final Internal Audit Report

Betsi Cadwaladr University Health Board

Appendix A - Action Plan

Whilst noting the HARMS dashboard is the key quality and safety assurance data reported across the Health Board and Committees, it does not include matters pertaining to nutrition and hydration. At the time of our review all wards were required to complete a self-assessment against Health & Care Standard 2.5 and the findings note poor scores against a number of expected controls with poor ward engagement in the process.	Patient care affected through poor nutrition and hydration compliance at wards.
Recommendation	**Priority level**
Whilst noting the planned introduction of Ward accreditation and advised this will replace the self-assessment against the standard, management ensure there are adequate controls in situ to monitor progress between the initial accreditation and follow-up visit.	High
Management Response	**Responsible Officer/ Deadline**
A process will be set up to between ward accreditation and INCHS whereby reports can be reviewed at INCHS and reviewed appropriately, with concerns escalated and managed appropriately. This will be discussed in INCHS on 7th December 2018 and a reporting structure established from there.	Assistant Area Director of Therapy Services – East/ Head of Transforming Care Team By March 2019

Finding - ISS.5 - Catering, hydration and nutrition performance - Reporting to the Board/Committee (Operating effectiveness)	**Risk**
With the exception where the Director of Estates and Facilities provides updates through the quarterly accountability meetings and through an annual report,	No data reported on nutrition and hydration to the Health Board.

Wales Audit Office report: Hospital Catering and Patient
Nutrition Follow up review – Have the agreed actions
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Appendix A - Action Plan

we can find no performance data reported on catering, nutrition and hydration through the Board's Committee structure. We note Welsh Government National Standard (Safe Care) DM 25 – Nutrition and Hydration is set for reporting but no guidance has been issued at the time of this review.	
Recommendation	**Priority level**
Management review the current collection of catering, nutrition and hydration data and identify where it could/should be reported and frequency for assurance purposes.	High
Management Response	**Responsible Officer/ Deadline**
The following performance reports will be reviewed and made available to QSG: • Catering waste reports • Ward accreditation scores relating to nutrition (once agreed process is in place, as above) • Compliance with mandatory training e-learning FRC package This will form an agenda item at INCHS on the 7th December 2018 (next quarterly meeting) and the mechanism for obtaining the information and reporting arrangements will be identified from that meeting. Reporting arrangements will be in place by June 2019.	Assistant Area Director of Therapy Services – East (Chair of INCHS) June 2019

Finding - ISS.6 - Financial/EFPMS data - service delivery (Operating effectiveness)	**Risk**

Wales Audit Office report: Hospital Catering and Patient Nutrition Follow up review – Have the agreed actions made a positive difference?

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Final Internal Audit Report

Appendix A - Action Plan

The Health Board performs well compared to the all-Wales EFPMS average in achieving income from non-patient catering activity. However, the overall finance reports record the service overspending against its allocated budget, including some areas where there is non-achievement against income targets. We have been unable to corroborate whether the Health Board has formally adopted a position to subsidise the catering service and view it as a welfare function as opposed to an income generation activity.	The service is unable to cover all operational costs.
Recommendation	**Priority level**
The Health Board reviews the requirements for non-patient catering services and whether it formally subsidises as welfare service or an income generation activity.	Medium
Management Response	**Responsible Officer/ Deadline**
A paper will be presented to the Executive Management Group (EMG) by the Director of Estates & Facilities to determine the direction the organisation wants to go in regards to the provision of Non Patient Retail Catering. If the EMG agree that the service should be provided as a subsidies service a Health Board policy will be required to underpin the operational and financial requirements of the service being delivered.	Head of Facilities Management Services 31st January 2019

Wales Audit Office report: Hospital Catering and Patient
Nutrition Follow up review – Have the agreed actions
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Appendix B - Assurance opinion and action plan risk rating
Audit Assurance Ratings

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

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

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

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

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

Prioritisation of Recommendations

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

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

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

Audit Committee 14th March 2019	GIG CYMRU NHS WALES	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
	To improve health and provide excellent care	

Report Title:	**Clinical Audit Report**
Report Author:	Dr M Maxwell - Senior Associate Medical Director/1000 lives Clinical Lead Mr Trevor Smith – Head of Clinical audit and Effectiveness Mr Adrian Thomas, Executive Director Of Therapies & Health Sciences
Responsible Director:	Mr Adrian Thomas, Executive Director Of Therapies & Health Sciences
Public or In Committee	Public
Purpose of Report:	The Joint Audit Quality and Safety (JAQS) meeting in October 2018 raised a number of concerns in relation to the level of Assurance of the effectiveness of Clinical Audit. This paper has been prepared to address the issues raised.
Approval / Scrutiny Route Prior to Presentation:	The report has been to the Executive Team Meeting. It will also have been to the Health Board Quality and Safety Group meeting on the 13th March and is scheduled for the Quality, Safety and Experience Committee on the 19th March
Governance issues / risks:	Clinical audit should provide assurance that service delivery is safe and support improved service delivery both within and beyond professional, departmental and organisational boundaries. This paper recommends changes that will deliver improved assurance at all levels.
Financial Implications:	None indicated at this time.
Recommendation:	The Committee is asked to approve the Report and Recommendations.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√

3.To support children to have the best start in life	√	3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences	√		

Special Measures Improvement Framework Theme/Expectation addressed by this paper
Due to the scope and breadth of the topics included in Clinical Audit all of the themes are of relevance.

This is due to the wide reach of Divisional / Specialty services involved in the audit cycle. Patient and carer feedback is sought for some projects ('Engagement'); 'Strategic & Service Planning' influenced by findings; 'Governance' structures that support and are influenced by this activity; Local service and Corporate 'Leadership' required to support engagement with the projects and resultant improvement activity.

http://www.wales.nhs.uk/sitesplus/861/page/81806

Equality Impact Assessment
N/A
http://howis.wales.nhs.uk/sitesplus/861/page/47193)

Clinical Audit Proposal: Governance Processes and Assurance

Situation

This paper has been prepared to address the issues raised by the Joint Audit Quality and Safety (JAQS) meeting in October 2018 in relation to improving assurance of the effectiveness of clinical audit.

The Wales Audit Office structured assessment 2017 recommended that the Health Board's programme of clinical audit needed to align with the priorities and risks identified in the Health Board's Quality Strategy, be more explicit in regards to patient/quality outcomes to understand the added value of clinical audit. This recommendation was repeated in the structured assessment 2018 as the expected progress had not been made within the timeframe. The Health Board has agreed that there will be a structured process for planning clinical audit based on the analysis of clinical risk and aligned to the Health Board's Quality Improvement Strategy by September 2019.

Background

Clinical audit is one of a number of tools used to support quality improvement. It helps to determine whether a service is delivering best practice by measuring practice against defined evidence based standards that should deliver good patient outcomes.

Within the Health Board there are three levels of Clinical Audit:

Tier 1 – National: These are nationally mandated by the Welsh Government's National Clinical Audit and Outcome Review Advisory Committee and are drawn from the UK National Clinical Audit and Patient Outcomes Panel (NCAPOP) under the auspices of the Health Quality Improvement Partnership (HQIP) and mainly administered by the Royal College's. These audits usually measure our services against a national standard or are performed to allow national provision of a service to be understood and benchmarked. The Welsh Government specify an annual list of the projects mandated for all Health Boards within the National Clinical Audit and Outcome Review Plan (NCAORP).

Tier 2 – Corporate: These are the BCUHB wide audits that the organisation has made the decision to undertake to support its service improvement plans and/or agreed priorities. These clinical audits should be aligned to the priorities set out within the Health Board's Quality Improvement Strategy. The Quality Safety and Experience Committee are responsible for approving the clinical audit plan identified at this level to support risk management and service improvement.

Tier 3 – Divisional: These are clinical audits that should form part of a prioritised programme at a local level; whether this be Divisional, individual department or specialty level. Often, these cover topics that clinicians have chosen to support a local specialist service or personal interest aligned to further education. These audits may be more important in some specialist areas where there are no mandated national audits or there is a key risk. Clinical audit should be used as a key part of professional

development recognising that this may cover a wider clinical network for example Dermatology.

HQIP has developed 10 'simple rules' for NHS Boards that support mature governance arrangements and effective clinical audit[i]:

1. Strategic alignment of audit to the Board's agenda
2. Ensuring audit is one of a range of quality improvement tools
3. Ensuring that there is a mix of both national and local priorities
4. Audit should be sufficiently resourced to deliver the programme
5. There is a rolling programme with an underpinning plan that ensures resources are effectively deployed.
6. The assurance needs to be set against the benchmark of national guidance and /or benchmarked against similar organisations; with an agreed understanding of acceptable variation.
7. Where possible audit should cross boundaries and encompass the whole patient pathway.
8. Audit results should be publically available and reports patient friendly, with patients and stakeholder engaged throughout the audit process.
9. Audit should be published alongside outcome data and evaluations.
10. Underpinning education and training is available to staff to generate capacity

Corporate Clinical Audit Team

A review has been undertaken of the current structure and configuration of the Corporate Clinical Audit Team. The team is managed by the Executive Director of Therapies and Health Sciences.

Corporate Clinical Audit Team

Role	Banding	WTE	Remit
Head of Clinical Audit and Effectiveness (CA&E)	8a	1.0	HB
Administration Assistant: CA&E	3	1.0	HB
Clinical Audit & Effectiveness Manager	7	(1.0) Vacant	HB
Clinical Effectiveness Facilitator: NICE &AWMSG	5	1.0	HB
Integrated Care Pathway Lead	6	0.8	HB
Integrated Care Pathway Assistant	3	0.8	HB
CA&E Facilitators	5	1. 8	WM/HB
CA& E Facilitators	5	2.0	YGC/HB
CA&E Facilitators	5	2.0	YG/HB

In 2017 it was determined that the Clinical Audit Team would be deployed primarily to support Tier 1 and Tier 2 clinical audits. Tier 3 clinical audits would only be supported if any capacity remained or if topics were demonstrated to link to Tier 1/2.

Key issues identified include

- The Head of Clinical Audit and Effectiveness (CA&E) is the only member of the department with a clinical background.
- Staff work predominantly within acute services.
- Primary care receive limited support for Tier 1 audits by staff from within the Area Team Governance Structure.
- Administrative posts within the acute hospital sites also support clinical audit with data capture and entry e.g. Myocardial Infarction National Audit Programme and the Trauma Audit Research Network. This resource is variable between sites and is not managed by the Corporate Clinical Audit Team.

There is a central repository for all Tier 1 and Tier 2 clinical audits, with an associated work plan. It is the role of the CA&E facilitators to liaise with the clinical leads regarding the submission of data. The subsequent report is sent to the relevant clinical lead for action; they receive an action plan and updates on the audit progress, although there can be some inconsistency in this. Following earlier discussion with the clinical executives, there is a focus upon Tier 1 and 2 activity and the engagement with Tier 3 is restricted to registration on the database. Responsibility for design and supervision is with the local supervisor and/or local audit lead. Whilst Tier 3 audits are registered there is little evidence recorded of the audit cycle being completed and the benefits being realised.

The review has identified variation in roles and responsibilities which need to be re-aligned to better meet the needs of the organisation and its key strategic priorities and risks.

Current Governance Arrangements

What is in place currently?

There is information on the Health Board's website which provides contact information for the Clinical Audit Team, clinical audit registration forms, links to the national audit annual plan, the latest corporate clinical audits and an on line e-learning package.

There is an electronic repository with the latest Tier 1 audit reports and action plans and a separate repository for the Tier 2 clinical audits which have been supported by the corporate clinical audit team. For example, consent, discharge letters and case note review).

Each national audit has a designated Health Board Clinical Lead supported by a Clinical Lead from the relevant speciality on each site or area. There are a variety of ways in which this work is overseen. This is aligned to the nature of the clinical audit being undertaken. For example specialty forum (Renal Network), topic-specific BCUHB groups (such as Diabetes at the Diabetes Programme Delivery Group), departmental meetings (e.g. National Hip Fracture Database).

The governance and oversight arrangements at a divisional or service level are variable and whilst some are mature and effective, others appear to be still evolving and require strengthening. For example, maternity services have robust arrangements in place and their audit plan is monitored within the Division; the lead maintains a

database of audits and ensures they are presented at the departmental meetings with SBAR development and follow up including re-audit. HMP Berwyn also has a quarterly Health and Well Being Clinical Governance Meeting attended by a member of the corporate audit team.

However, a review of the arrangements at hospital site and area team level have identified variability in clinical engagement, follow through of actions and alignment with corporate priorities.

The BCU-wide Clinical Effectiveness and Audit Sub Group (CEASG) Chaired by the Executive Director of Therapies and Health Sciences supports the Executive led Quality and Safety Group in discharging its responsibilities for clinical effectiveness. This includes clinical audits, receiving site and/or area reports. It also ensures the NCAORP assurance reporting forms have been returned to Welsh Government; CEASG meets bimonthly.

In September 2017 the Audit Committee approved a framework in relation to the function of clinical audit within the Health Board, the framework sets out the specific role of the Audit Committee alongside that of the Quality, Safety and Experience Committee in relation to clinical audit so that their roles and responsibilities were clear. In summary, QSE Committee are required to ensure there is an effective function in place and Audit Committee are required to provide assurance to the Board that the function is effective. The paper also confirmed that the Quality and Safety Group are responsible for determining the content of the Corporate Clinical Audit Plan, taking into account the priorities set out in the Quality Improvement Strategy reflecting on complaints and concerns and other patient feedback.

The review of the current governance structure has identified that

- The internal governance structure could be simplified as it is overly complex potentially leading to confusion and duplication about reporting lines.
- Hospital and Area arrangements require review and realignment to reflect changes in organisational structure.
- The Secondary Care Quality and Safety Group and CEASG need to develop a reporting arrangement so that there is sufficient oversight of clinical audit.
- The content and nature of reporting to QSE and Audit Committee needs to better reflect the outcomes as well as the activity of clinical audit and demonstrate alignment with organisational priorities and risks.

Assessment

There is a wide variation in the management of clinical audit, and whilst some parts of the governance and reporting arrangements are robust, this is not consistent. Therefore the assurance that audit is an effective tool for improving services could be improved.

There is no overarching procedure setting out the Health Board expectations around clinical audit including the risk assessment process to determine Tier 2 audits.

Corporate resources are supporting Tier 1 and 2 audits, the majority of which are positioned within secondary care; this means Area Teams and Primary Care are largely unsupported. The Health Board needs to be assured that clinical audit is being used effectively across the whole organisation.

The Board and its Committees are not yet receiving full assurance that there are robust systems in place to ensure the audit cycle is being followed. There needs to be more robust evidence of improvement and where necessary, risk assessment and mitigation associated with the audit findings.

The current clinical audit plan has limited strategic alignment, with a predominantly externally driven agenda (Tier 1 audits) and it is not evident that all Tier 2 clinical audits are aligned with the corporate risks and priorities.

Recommendations

Recommendation	Lead	Planned Outcome	Deadline	Progress Update 7.3.19
Review corporate Clinical Audit Team structure	Adrian Thomas	Ensure team have the capacity and capability to deliver the agreed work programme across the whole organisation including primary care	September 2019	Baseline review completed and this will form part of the exercise to align quality improvement activity across the Health Board.
Develop a BCU wide clinical audit procedure	Head of Clinical Audit	Support staff with a clear governance framework for clinical audit	July 2019	Initial review of similar procedures from other NHS organisations completed
Embed clinical audit within BCU Quality Improvement activities	Adrian Thomas / Exec Team	Drive improvement in areas of key risk	July 2019	A review and realignment of all quality improvement activity has been commenced by Executive Team
Review and revise the governance and reporting arrangements for clinical audit (from ward to Board)	Adrian Thomas/ Clinical Execs	Strengthen accountability and address gaps and omissions and reduce duplication	June 2019	Baseline review completed options for revised structure drafted for consideration initially by QSG in March 2019. A common reporting template will also be considered once finalised a consistent terms of reference will be shared for adoption across operational sites
Improve tracking of Improvement plans.	Adrian Thomas	Improve tracking, reporting and trajectory planning against improvement plans for Clinical Audits.	September 2019	Discussion with Mr D Harries, Internal Audit, indicated that using Team Tracker to track Tier 1 Clinical Audit was not feasible. It was suggested that the system could be used for Tier 2. However as this would require a separate instance the cost needs to be investigated and comparison against other systems made.

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Audit Committee 14.3.19	GIG CYMRU NHS WALES	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
	To improve health and provide excellent care	

Title:	**Wales Audit Office Reports**
Author:	Andrew Doughton, Wales Audit Office
Responsible Director:	Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Purpose of the report:	The documents for audit committee include the regular audit update alongside reports finalised since the last audit committee: • The update provides progress relating to the financial audit and performance audit programmes • The Annual Audit Plan provides detail on the programme of work to audit the 2018/19 accounts and prospective performance audit reviews • The Annual Audit Report provides the summary of work reported during 2018 and since the publication of the 2017 Annual Audit Report. • Use of locum and agency staff – national facts only report • Preparation for a no-deal Brexit.
Approval / Scrutiny Route	Local reports are cleared through formal audit clearance processes with representatives of the Executive Team. National report clearance processes are agreed with the appointed national key contact for the work.
Governance issues and risks	*Specific risks, issues and recommendations are identified in the report.*
Financial Implications	Not applicable.
Recommendation:	The Audit Committee is requested to: • Note the content of the audit progress update. • Receive the Annual Audit Plan • Receive and discuss the Annual Audit Report • Receive and discuss the Use of locum and agency report • Receive and discuss the Preparation for a no-deal Brexit report

Health Board's Well-being Object*ives* *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	WFGA Sustainable Development Principle *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	√

2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services		5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper • Governance – Annual audit report			
Equality Impact Assessment Not applicable			

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

Date issued: March 2019

Contents

About this document

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

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

Financial audit update

3 Since the last update, the audit of the Health Board's 2017-18 Charitable Funds financial statements has been completed and the Auditor General issued an unqualified opinion on 8 January 2019, following approval by the Charitable Funds Committee. This concluded the planned outputs for 2017-18 which were all delivered in accordance with planned timetables.

4 The key matters arising from the 2017-18 audit were summarised in the Annual Audit Report which will be presented to the Audit Committee and Board in March 2019.

5 The 2018-19 financial audit planning work is underway and has informed the Audit plan for 2019. The planned key outputs and milestones from financial audit outputs and milestones are summarised in Exhibit 1 below.

Exhibit 1: Delivering the 2018-19 financial audit work

Planned Output	Planned Start Date	Planned Reporting Date	Report Finalised
Audit Plan	January 2019	March 2019	March 2019
Audit of Financial Statements report	May 2019	May 2019	
Opinion on the Financial Statements	May 2019	June 2019	
Whole of Government Accounts submission	May 2019	June 2019	
Audit of Charitable Funds Financial Statements report	July 2019	September 2019	
Opinion on the Charitable Funds Financial Statements	September 2019	September 2019	

Source: Wales Audit Office

Performance audit update

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

Exhibit 2: Performance audit update

Work completed in last six months (links to the report, where available, are in red)				
Topic	**Key findings**	**Date finalised**	**Executive Lead**	**Received at Audit Committee/ other**
Primary Care	The Health Board is making reasonable progress in delivering its recently developed plans for primary care, but many aspects of performance remain worse than average and significant workforce and financial challenges remain. The report focusses on strategic planning, investment, workforce, oversight and performance.	November 2018	Director of Primary Care and Community Services	Audit Committee 11 December 2018
NHS Structured Assessment	Our work found that while the Health Board is strengthening its governance and management arrangements, it continues to struggle to develop financially sustainable medium-term plans and improve priority areas of performance	November 2018	Chief Executive Officer	Audit Committee 11 December 2018
Cross-cutting review	Our work found that whilst the Integrated Care Fund is having some positive impacts, there are also a number of challenges that the Regional Partnership Board needs to manage. Findings include: • the fund has had a positive impact although it is unclear whether partnership working would continue if the fund ceased to exist; • the fund has not always been used strategically to develop services based on need; and • there is general agreement that the fund is supporting the right projects but very few projects are being mainstreamed into core services.	Fieldwork complete and locally reported. National report due May 2019		Regional partnership leadership group (October 2018) and Regional Partnership Board (November 2018)

Ongoing work and work due to start in 2019				
Topic	**Focus of the work**	**Status**	**Executive Lead**	**Expected date of final report**
Orthopaedic Services follow-up	This work will examine the progress made in orthopaedic services since our 2015 all-Wales review. This will assess whether recommendations and areas we identified for improvement have been effectively responded to and to determine whether health boards are developing arrangements to help manage the demand on, and supply of, orthopaedic services.	Terms of reference issued	Gill Harris	August 2019
Clinical coding follow-up	We will review the progress made in responding to the recommendations set out in the 2014 review of clinical coding arrangements. This review will assess the extent to which there have been improvements in raising the profile of clinical coding, the timeliness and quality of clinical coding data, and the quality of the medical records, which are the predominant source of the coding process.	Drafting report	Evan Moore	April 2019
Operating theatres – follow-up (Local work)	We will undertake a follow-up review of our previous reports on operating theatres, with an increased focus on economy and efficiency of services. We will consider the developments made by the Health Board since our previous reviews, opportunities for further improvement and identify barriers that may affect progress.	Fieldwork ongoing	Gill Harris	May 2019
Review of legacy systems and infrastructure (Local work)	This work will focus on risks and opportunities for improvement in relation to old, out-of-date, unsupported, or difficult to support: • hardware infrastructure; and • operational and clinical systems (software licensing and support).	Scoping meeting complete	Evan Moore	June 2019

Ongoing work and work due to start in 2019				
Topic	Focus of the work	Status	Executive Lead	Expected date of final report
Structured Assessment	We will assess progress that is being made in embedding sound arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management.	Not yet started	Gary Doherty	December 2019
Quality Governance arrangements	As an extension of the structured assessment work, we will undertake a specific review of quality governance arrangements and how these underpin the work of quality and safety committees. This will include examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting.	Not yet started	Gill Harris	November 2019
Well Being of Future Generations (Wales) Act 2015	The work will consider the Health Board's overall corporate approach to applying the 'Sustainable Development Principle' and 'Five Ways of Working'. We will seek to examine one of the Health Board's well-being objectives in more detail, reviewing the steps that have been taken to achieve that objective. This work will inform will inform the report that the Auditor General must prepare for the National Assembly by May 2020.	Not started	TBC	TBC
Local audit reviews	We will undertake thematic performance audit work that reflects issues specific to the Health Board. This will be agreed following completion of local audit planning.	TBC	TBC	TBC

Source: Wales Audit Office

Other Auditor General studies

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

Exhibit 3: Other Auditor General Studies and reports

Recent publications / planned publications	
Topic	**Update**
Radiology services November 2018	The Auditor General for Wales' report found that waiting time targets for radiology examinations are currently being met and our work has shown that radiology services are generally well managed.
Use of locum and agency staff – January 2019	This report sets out key facts about the use of agency staff by NHS bodies in Wales, including: • expenditure; • analyses by health bodies of underlying reasons; • national initiatives to control this type of spending; and • challenges that lie ahead. The report was accompanied by an interactive data tool, which provides comparisons across NHS Wales over time and by specialty and cost types.
Preparations in Wales for a 'no deal' Brexit – February 2019	The Auditor General found that public bodies are developing new structures for managing the consequences of Brexit alongside long-standing arrangements. Overall, most public bodies across Wales are clearly taking their 'no-deal' Brexit planning seriously. Many have significantly ramped up their activity since summer 2018, when a 'no-deal' outcome started looking more possible. Public services reported a lack of capacity to manage Brexit, which is also having a significant knock-on impact on other service areas. Most are absorbing Brexit preparations within, or on top of, their day jobs. In the NHS, our wider audit work has identified ongoing concerns about management capacity in relation to transforming services. This same cadre of management staff is being called on to prepare for and manage the implications of a 'no-deal' Brexit. Most bodies reported to us that their work on Brexit was having an adverse impact on other areas. Across NHS Wales, individual organisations have been helped in understanding their exposure to risks and possible opportunities by work by Public Health Wales and through work on supply chains related to medical devices and clinical consumables carried out by Deloitte. The NHS is putting place detailed plans, working with UK partners, to manage those risks it has identified.

Good Practice Exchange

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

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

Exhibit 4: Good Practice Exchange

Recent and forthcoming events
Recent events
Preparations in Wales for a no-deal Brexit - This event is aimed at all non-executive officers and councillors, including those who have a governance and scrutiny role in the Welsh public sector.
Forthcoming events
Young people influencing decisions about what matters to them - The focus of this event will be how can organisations best design and deliver services together with young people to help them meet those challenges. March 28th 2019, 09:30 - 15:30 - Glasdir Rural Development Centre, Llanrwst.
Webinar: Let's talk cyber security - The aim of this interactive webinar is to equip board and non-executive members with the necessary tools and knowledge to seek assurance that their organisation has the necessary cyber security arrangements in place. March 26th 2019 - 12:00pm - 1:15pm

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

2019 Audit Plan – **Betsi Cadwaladr University Local Health Board**

Wales Audit Office
Swyddfa Archwilio Cymru

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Contents

2019 Audit Plan

Summary

1   As your external auditor, my objective is to carry out an audit which discharges my statutory duties as Auditor General and fulfils my obligations under the Code of Audit Practice, namely to:

- examine and certify whether your financial statements are 'true and fair' and lay them before the National Assembly together with any report that I make on them;

- satisfy myself that the expenditure and income reported in your accounts have been incurred or received lawfully and in accordance with the authorities which govern them; and

- assess whether you have made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

2   The purpose of this plan is to set out my proposed work, when it will be undertaken, how much it will cost and who will undertake it.

3   There have been no limitations imposed on me in planning the scope of this audit.

4   My responsibilities, along with those of management and those charged with governance, are set out in Appendix 1.

Financial audit

5   It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on their 'truth and fairness' and the regularity of the expenditure and income within them. Appendix 1 sets out my responsibilities in full.

6   The audit work we undertake to fulfil our responsibilities responds to our assessment of risks. This understanding allows us to develop an audit approach which focuses on addressing specific risks whilst providing assurance for the financial statements as a whole. Our audit approach consists of three phases as set out in Exhibit 1.

Exhibit 1: my financial audit approach
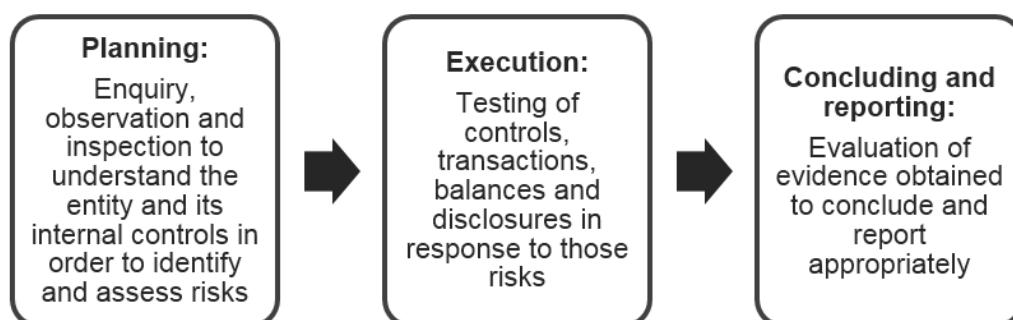
7   The risks of material misstatement which I consider to be significant, and which
        therefore require special audit consideration, are set out in Exhibit 2 along with the
        work I intend to undertake to address them.

Exhibit 2: Financial audit risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk [ISA 240.26-27].	My audit team will consider the completeness of miscellaneous income.
The Board will once again fail to meet its first financial duty to break even over a three-year period. The position at month 9 shows a year-to-date deficit of £30.2 million and a forecast year-end deficit of £42 million. This combined with the outturns for 2016-17 and 2017-18, predicts a three-year deficit of £110.6 million. As a result I will be qualifying my regularity audit opinion and placing a substantive report on the financial statements highlighting the failure. The current financial pressures on the Board increase the risk that management judgements and estimates could be biased to ensure the forecast deficit does not worsen further.	My audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias.

Financial audit risks	Proposed audit response
Other areas of audit attention	
New accounting standards IFRS 9 on financial instruments applies from 1 April 2018 and brings in a new principles-based approach for the classification and measurement of financial assets. It also introduces a new impairment methodology for financial assets based on expected losses rather than incurred losses. This will result in earlier recognition of expected credit losses and will impact on how the Health Board calculates its bad debt provision. IFRS 15 on revenue from contracts with customers introduces a principles-based five-step model for recognising revenue arising from contracts with customers. It is based on a core principle requiring revenue recognition to depict the transfer of promised goods or services to the customer in an amount that reflects the consideration the body expects to be entitled to, in exchange for those goods or services. It will also require more extensive accounts disclosures than are currently required.	My audit team will assess the likely impacts of the new IFRSs and undertake work to respond to any identified risks of material misstatement.

8   I do not seek to obtain absolute assurance on the truth, fairness and regularity of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit Committee prior to completion of the audit.

9   For reporting purposes, we will treat any misstatements below a 'trivial' level (set at 5% of materiality) as not requiring consideration by those charged with governance and therefore we will not report them.

10   My fees and planned timescales for completion of the audit are based on the following assumptions:

- that the financial statements are provided in accordance with the agreed timescales, to the quality expected and have been subject to a robust quality assurance review;

- that information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];
- that appropriate accommodation and facilities are provided to enable my audit team to deliver our audit in an efficient manner;
- that all appropriate officials will be available during the audit;
- that you have all the necessary controls and checks in place to enable the Accountable Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- that Internal Audit's planned programme of work is complete and management has responded to issues that may have affected the financial statements.

11   I am also responsible for the audit of the Health Board's charitable funds accounts. The audit will be undertaken in accordance with the timescales agreed with the Health Board and the Charity Commission. My audit fee for this work is included in Exhibit 4.

Performance audit

12   It is my responsibility to satisfy myself that the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance work each year.

13   I set out in this section, the programme of performance audit work to be undertaken at the Health Board. The content of the programme is informed by an ongoing analysis of the risks and challenges facing NHS Wales as a whole, as well as consideration of issues and risks that are specific to the Health Board. I have also taken account of the work programme of Healthcare Inspectorate Wales (HIW)[2, 3].

14   The topics I plan to examine as part of my 2019 performance audit work are summarised in Exhibit 3.

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[1] The agreed audit deliverables document sets out the expected working paper requirements to support the financial statements and include timescales and responsibilities

[2] An operational protocol between HIW and the Auditor General sets out how the two organisations will work together, March 2015

[3] Wales Audit Office, **Working Together to Provide Assurance describes the collective arrangements the AGW and HIW make use of to review governance arrangements in the NHS**, November 2016

Exhibit 3: contents of my 2019 performance audit work programme

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured Assessment will continue to form the basis of the work I do at each NHS body to examine the existence of proper arrangements for the efficient, effective and economical use of resources. Building on previous years' work, I will seek to describe the progress that is being made in embedding sound arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management.
All Wales Thematic Reviews	**Quality Governance arrangements** As an extension of my structured assessment work, I plan to undertake a specific thematic review of quality governance arrangements and how these underpin the work of quality and safety committees. In recent years my structured assessment work across Wales has pointed to various challenges with such governance arrangements. I therefore intend to undertake a review that will allow my team to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting. I shall scope this work in discussion with NHS bodies, and Healthcare Inspectorate Wales. In designing this work I will also seek to build in an ability to compare and contrast approaches to quality governance across NHS bodies. **Well Being of Future Generations (Wales) Act 2015** The Well-being of Future Generations (Wales) Act 2015 became law in April 2016. The Act requires me to report every five years to the National Assembly on how public bodies apply the sustainability principles. During the first half of 2019, I plan to undertake work at the Health Board that will inform the report I must prepare for the National Assembly by May 2020. My work will consider the Health Board's overall corporate approach to applying the 'Sustainable Development Principle' and 'Five Ways of Working'. My team will also seek to examine one of the Health Board's well-being objectives in more detail, reviewing the steps that have been taken to achieve that objective. When selecting which well-being objectives to review, I will aim to do so in such a way that maximises my ability to compare and contrast approaches across NHS bodies.
Locally focused work	I will also undertake thematic performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers and the Audit Committee, and will be reflected in the regular updates that are produced for the audit committee.

Theme	Approach/key areas of focus
Implementing previous audit recommendations	The examination of governance arrangements I undertake as part of my structured assessment work includes a review of the arrangements that the Health Board has in place to track progress against my previous audit recommendations. This allows my team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables me to more explicitly measure the impact my work is having.

15   The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with the Health Board, are set out in Appendix 2.

Fee, audit team and timetable

Fee

16   Your estimated fee for 2019 is set out in Exhibit 4. There have been some small changes to my fees rates for 2019 however my audit teams will continue to drive efficiency in their audits to ensure any resulting increases will not be passed onto you. This figure represents a 6.6% decrease compared to the fee set out in the 2018 annual audit plan. For financial audit work, the fee reduction arises from the continuation of efficiencies in our audit approach which we are able to pass onto the Health Board. For performance audit work, the reduction reflects that I am not expecting to undertake a joint review with Healthcare Inspectorate Wales in the next 12 months. I will however keep this under review during the year and also consider such requirements as part of future year's audit planning.

Exhibit 4: audit fee

Audit area	Proposed fee for 2019 (£)[4]	Actual fee for 2018 (£)
Financial accounts work		
• Health Board Accounts	244,750	249,750
• Charitable Funds Accounts	10,250	10,250
Financial Audit work total	**255,000**	**260,000**

[4] The fees shown in this document are exclusive of VAT, which is no longer charged to you.

Performance audit work:

• Structured Assessment	64,348	64,348
• All-Wales thematic reviews[5]	65,963	71,220
• Local projects	42,610	62,385
Performance audit work total	**172,921**	**197,953**
Total fee	**427,921**	**457,953**

17   Planning will be ongoing, and changes to my programme of audit work and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance.

18   Further information on my fee scales and fee setting can be found on our website.

Audit team

19   The main members of my local audit team, together with their contact details, are summarised in Exhibit 5.

Exhibit 5: my local audit team

Name	Role	Contact number	E-mail address
Mike Usher	Engagement Director and Engagement Lead – Financial Audit	02920 320568	mike.usher@audit.wales
Dave Thomas	Engagement Lead – Performance Audit	02920 320604	dave.thomas@audit.wales
Amanda Hughes	Financial Audit Manager	07969 919986	amanda.hughes@audit.wales
Andrew Doughton	Performance Audit Lead	07812 094642	andrew.doughton@audit.wales

20   I can confirm that my team members are all independent of the Health Board and your officers. In addition, I am not aware of any potential conflicts of interest that I need to bring to your attention.

[5] As detailed in the respective audit plans.

Staff secondment

21   A trainee accountant employed by the Wales Audit Office has been seconded to the Health Board for the period 9 January 2019 to 31 May 2019. This secondment is part of an initiative funded by the Welsh Consolidated Fund designed to allow trainee accountants to broaden their skills and to gain experience of working across different parts of the Welsh public sector.

22   In order to safeguard against any potential threats to auditor independence and objectivity, the Wales Audit Office and the Health Board have agreed the following arrangements:

- secondees will not perform duties prohibited by the FRC's Revised Ethical Standard 2016 and will not be able to exercise discretionary authority to commit the Board to a particular position or accounting treatment;

- the secondee will undertake tasks at a relatively junior level, will be properly supervised and will not undertake a management role or be involved in the decision taking of the Board; and

- the secondment will be for a short period of time within the meaning of the FRC's Revised Ethical Standard 2016.

Timetable

23   I will provide reports, or other outputs as agreed, to the Health Board covering the areas of work identified in this document. My key milestones are set out in Exhibit 6.

Exhibit 6: timetable

Planned output	Work undertaken	Report finalised
2019 Audit Plan	December 2018 to February 2019	March 2019
Financial accounts work: • Health Board Audit of Financial Statements Report • Health Board Opinion on Financial Statements • Charitable Funds Audit of Financial Statements Report and Opinion on the Charitable Funds Accounts	January to June 2019 July 2019 to September 2019	May 2019 June 2019 September 2019
Performance work: • Structured Assessment • Governance arrangements underpinning quality and safety committees	Timescales for individual projects will be discussed with the Board and detailed within the specific project briefings produced for each study.	

Planned output	Work undertaken	Report finalised
• Implementing the Well Being of Future Generations Act • Local project work		
Annual Audit Report for 2019	November to December 2019	January 2020
2020 Audit Plan	December 2019 to February 2020	March 2020

Future developments to my audit work

24   Details of other future developments, including forthcoming changes to key International Financial Reporting Standards (IFRS) and, for charitable funds, future changes to UK Generally Accepted Accounting Practice (UK GAAP), the Wales Audit Office's Good Practice Exchange seminars and my planned work on the readiness of the Welsh public sector for Brexit, are set out in Appendix 3. This appendix also contains relevant information on data protection legislation.

Appendix 1

Respective responsibilities

My powers and duty to undertake your financial audit are set out in the Public Audit (Wales) Act 2004. It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on:

- their 'truth and fairness', providing assurance that they:
    - are free from material misstatement, whether caused by fraud or error;
    - comply with the statutory and other applicable requirements; and
    - comply with all relevant requirements for accounting presentation and disclosure.
- whether the remuneration report is properly prepared.
- the regularity of the expenditure and income.
- the consistency of other information presented with the financial statements.

It must also state by exception if the Annual Governance Statement does not comply with requirements, if proper accounting records have not been kept, if disclosures required for remuneration and other transactions have not been made or if I have not received all the information and explanations I require.

In addition, I may place a substantive report on the financial statements if I wish to make additional observations on any matters within them.

My powers to undertake performance audit work at the Health Board are set out in the Government of Wales Acts 1998 and 2006 and this work also discharges my duty under the Public Audit (Wales) Act 2004 to satisfy myself that the body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

My audit work does not relieve management and those charged with governance of their responsibilities which include:

- the preparation of the financial statements and annual report in accordance with applicable accounting standards and guidance;
- the keeping of proper accounting records;
- ensuring the regularity of financial transactions; and
- securing value for money in the use of resources.

Appendix 2

Performance audit work in last year's audit plan still in progress

Exhibit 7: 2018 performance audit work still in progress

Performance audit project	Status	Comment
Orthopaedic Services (Follow up)	Commencing data collection	Data collection has started, and analysis will inform onsite fieldwork which is due to commence in April 2019.
Clinical Coding (Follow up)	Reporting	Fieldwork complete, reporting expected in March 2019.
Follow up review of hospital theatres	Fieldwork ongoing	Set up meeting held in January, on-site fieldwork to commence in March with reporting planned for May 2019.
Review of legacy IT systems and infrastructure	Scoping	Set up meeting scheduled for 13 February.

Appendix 3

Other future developments

Forthcoming key IFRS changes

Exhibit 8: changes to IFRS standards

Standard	Effective date	Further details
IFRS 16 Leases	Expected in 2020-21	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.

Future changes to UK GAAP (relevant to charitable funds accounts)

Following the introduction of the new UK GAAP accounting regime in 2015-16, and the replacement of the Financial Reporting Standard for Smaller Entities (FRSSE) by Section 1A of FRS 102 in 2016-17, there will be no substantive changes to FRS 102 until 2019-20. Any changes made then are expected to be limited in nature.

More significant amendments are expected from 2022-23, reflecting recent changes in International Financial Reporting Standards, including accounting for financial instrument and leases.

Good Practice Exchange (GPX)

The Wales Audit Office's GPX helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face to face and resources shared on line. Further information, including details of forthcoming GPX events and outputs from past seminars.

Brexit: preparations for the United Kingdom's departure from membership of the European Union

In accordance with Article 50 of the Treaty of Rome, on 29 March 2019 the United Kingdom will cease to be a member of the European Union. Negotiations are continuing, and it currently remains unclear whether agreement will be reached on a transition period to 31 December 2020, or whether a 'no deal' immediate exit will take place next March.

The Auditor General has commenced a programme of work looking at the arrangements that the devolved public sector in Wales, including all NHS bodies, is putting in place to prepare for, and respond to, Britain's exit from the European Union. This will take the form of a high-level overview to establish what is being put in place across the Welsh public sector, and what the key issues are from the perspectives of different parts of the Welsh public service.

The Auditor General intends to carry out this initial work in two tranches. In autumn 2018, he issued a call for evidence to compile a baseline summary of arrangements being put in place. On 19 February, the Auditor General issued a report[6] on preparations in Wales for a 'no deal' Brexit. This will be followed up by further audit fieldwork during the rest of 2019.

Data Protection Legislation

Data protection legislation, including the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) has introduced updated requirements for processing personal data.

The Auditor General for Wales' (AGW's) access rights are not affected by the new data protection legislation or the Digital Economy Act, which also grants data sharing powers. Information about the AGW's access rights is available in the Guide to Legislation, as well as the shorter Access Rights leaflet which can be found on our website.

Fair Processing (Privacy) Notices provided to your employees, contractors and service users should include reference to the collecting and sharing of data with the AGW in connection with his audit work and studies.

Our own general fair processing notice is available on our website and, where appropriate, we shall provide further fair processing notices in connection with our work.

Where it is necessary to transfer information, we ask that this is done securely, through suitable methods such as hand to hand transfer of data using memory sticks or other secure means. We can accept password protected files if the password protection is strong, and the password is communicated to us separately and by a different means to the information, such as SMS text message.

If you would like to discuss any of the matters raised above, our Data Protection Officer can be contacted at martin.peters@audit.wales

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[6] Preparations in Wales for a 'no deal' Brexit

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Annual Audit Report 2018 – **Betsi Cadwaladr University Health Board**

Audit year: 2017-18

Date issued: February 2019

Document reference: 1047A2019-20

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

This report was prepared for the Auditor General by Mike Usher, Dave Thomas, Amanda Hughes and Andrew Doughton.

Contents

Summary report

About this report

1   This report summarises the findings from the audit work I have undertaken at Betsi Cadwaladr University Health Board (the Health Board) during 2018. I did that work to carry out my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

    a)   examine and certify the accounts submitted to me by the Health Board, and to lay them before the National Assembly;

    b)   satisfy myself that the expenditure and income to which the accounts relate have been applied to the purposes intended and in accordance with the authorities which govern it; and

    c)   satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

2   I have reported my findings under the following headings:

- Key messages
- Audit of accounts
- Arrangements for securing economy, efficiency and effectiveness in the use of resources

3   I have issued several reports to the Health Board this year. This annual audit report is a summary of the issues presented in these more detailed reports, a list of which is included in Appendix 1.

4   Appendix 2 presents the latest estimate on the audit fee that I will need to charge to cover the actual costs of undertaking my work at the Health Board, alongside the original fee that was set out in the 2018 Audit Plan.

5   Appendix 3 sets out the significant financial audit risks highlighted in my 2018 Audit Plan and how they were addressed through the audit.

6   The Chief Executive and the Director of Finance have agreed this report is factually accurate. We will present it to the Audit Committee on 14 March 2019. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange wider publication of this report. We will make the report available to the public on the Wales Audit Office website after the Board have considered it.

7   I would like to thank the Health Board's staff and members for their help and co-operation during the audit work my team has undertaken over the last 12 months.

Key messages

Audit of accounts

8   I have concluded that the Health Board's accounts were properly prepared and materially accurate, and my work did not identify any material weaknesses in the Health Board's internal controls relevant to my audit of the accounts. I have therefore issued an unqualified 'true and fair' opinion on their preparation.

9   However, in issuing this unqualified opinion, I brought some issues to the attention of officers and the Audit Committee. These relate to accounting for the quinquennial revaluation of fixed assets and some issues that highlighted inconsistencies in accounting treatment and concerns over the accuracy of income and expenditure accruals.

10   The Health Board did not achieve financial balance for the three-year period ending 31 March 2018 and so I have issued a qualified opinion on the regularity of the financial transactions within its 2017-18 accounts.

11   Alongside my audit opinion, I placed a substantive report on the Health Board's financial statements to highlight its continued failures to achieve financial balance and to have an approved three-year plan in place.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

12   My 2018 structured assessment work at the Health Board has found that:

- While the Health Board is strengthening its governance and management arrangements, it continues to struggle to develop financially sustainable medium-term plans and improve priority areas of performance.

- While strategic planning arrangements are developing, these have yet to result in an approvable Integrated Medium-Term Plan and the Health Board's approach to monitoring the delivery of its existing plans has not been strong enough.

- The Health Board is continuing to experience significant challenges in managing its workforce, finances and physical assets, and it needs to develop a more transformational approach to improve service performance and efficiency.

13   My wider programme of work indicates that the Health Board is responding to risks and opportunities, but continues to face several challenges:

- The Health Board is making reasonable progress in delivering its recently developed plans for primary care, but many aspects of performance remain worse than average and significant workforce and financial challenges remain.

- My emerging findings on the Integrated Care Fund are showing some challenges.

14   The Health Board is participating in the National Fraud Initiative and has made good use of the data matches released in 2017.

15   These findings above are considered further in the detailed section of this report.

16   During the year, I also reported on Follow-up outpatient services, Radiology services and NHS Informatic Services at an all Wales level. My engagement team presented these reports to audit committee and highlighted the national and local aspects of good practice and any areas for improvement. Any recommendations made in my national reports and relevant to the local Health Board are routinely adopted into the Health Board's recommendation tracking system.

Detailed report

Audit of accounts

17   This section of the report summarises the findings from my audit of the Health Board's financial statements for 2017-18. These statements are how the organisation shows its financial performance and sets out its net operating costs, recognised gains and losses, and cash flows. Preparing the statements is an essential element in demonstrating appropriate stewardship of public money.

18   In examining the Health Board's financial statements, I must give an opinion on:

- whether they give a true and fair view of the financial position of the Health Board and of its income and expenditure for the period in question;

- whether they are prepared in accordance with statutory and other requirements, and meet the relevant requirements for accounting presentation and disclosure;

- whether that part of the remuneration report to be audited is properly prepared;

- whether the other information provided with the financial statements (usually the annual report) is consistent with them; and

- the regularity of the expenditure and income in the financial statements.

19   In giving this opinion, I have complied with my Code of Audit Practice and the International Standards on Auditing (ISAs).

I have issued an unqualified opinion on the accuracy and proper preparation of the 2017-18 financial statements of the Health Board, although in doing so, I have brought some issues to the attention of officers and the Audit Committee

20   I have concluded that the Health Board's accounts were properly prepared and materially accurate, and my work did not identify any material weaknesses in the Health Board's internal controls relevant to my audit of the accounts. I have therefore issued an unqualified 'true and fair' opinion on their preparation.

21   The draft financial statements were available to me by the submission deadline of 27 April 2018 which was a significant achievement by the Finance team especially given that key members of that team had left the Health Board during the accounts preparation window.

22   I reviewed those internal controls that I considered to be relevant to the audit to help me identify, assess and respond to the risks of material misstatement in the accounts. I did not consider them for the purposes of expressing an opinion on the operating effectiveness of internal control. My review did not identify any significant deficiencies in the Health Board's internal controls.

23   I must report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit Committee on 31 May 2018. Exhibit 1 summarises the key issues set out in that report.

Exhibit 1: issues identified in the Audit of Financial Statements Report

The following table summarises and provides comments on the key issues identified.

Issue	Auditors' comments
Uncorrected misstatements	There were no uncorrected misstatements contained within the financial statements.
Corrected misstatements	There were a number of corrected misstatements which were set out in Appendix 4 of my report.
Other significant issues	There were some concerns about the qualitative aspects of the Health Board's accounting practices: • transactions reflecting the impact of the quinquennial revaluation of fixed assets had not been accounted for or disclosed correctly in Note 11.1 (Property, Plant and Equipment) to the accounts; and • there were a number of issues identified that highlighted inconsistencies in accounting treatment and concerns over the accuracy of income and expenditure accruals.

24   As part of my financial audit, I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the financial position of the Health Board at 31 March 2018 and the return was prepared in accordance with the Treasury's instructions.

25   My separate audit of the charitable funds held on trust financial statements was completed with satisfactory results, and I issued an unqualified opinion on the charitable funds financial statements in January 2019. There were no issues arising from my audit work.

I have issued a qualified audit opinion on the regularity of the financial transactions within the financial statements of the Health Board and placed a substantive report alongside this opinion to highlight its failure to meet its statutory financial duties

26   The Health Board's financial transactions must be in accordance with authorities that govern them. It must have the powers to receive the income and incur the expenditure that it has. Our work reviews these powers and tests that there are no

material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

27   Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion. As the Health Board did not achieve financial balance for the three-year period ending 31 March 2018, I issued a qualified opinion on the regularity of the financial transactions within its 2017-18 accounts. The Health Board breached its revenue resource limit by spending £88.147 million over the £4,163 million that it was authorised to spend in the three-year period 2015-16 to 2017-18.

28   I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. Due to the Health Board's failure to meet its financial duties I issued a substantive report setting out the factual details: it failed its duty to achieve financial balance (as set out above) and it does not have an approved three-year Integrated Medium-Term Plan in place. The Health Board, which was placed in Special Measures in October 2015, was once again not in a position to submit a three-year plan for approval by the Minister. Instead, and as in previous years, the Health Board operated under annual planning arrangements, with the agreement of the Welsh Government.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

29   I have a statutory requirement to satisfy myself that NHS bodies have proper arrangements in place to secure efficiency, effectiveness and economy in the use of their resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- assessing the effectiveness of the Health Board's governance and assurance arrangements;
- reviewing the Health Board's approach to strategic planning;
- examining the arrangements in place for managing the Health Board's resources including its finances, workforce, assets and procurement;
- specific work on Primary Care services and regional partnership working; and
- assessing the application of data-matching as part of the National Fraud Initiative (NFI).

30   My conclusions based on this work are set out below.

While the Health Board is strengthening its governance and management arrangements, it continues to struggle to develop financially sustainable medium-term plans and improve priority areas of performance

31   My structured assessment work examined the Health Board's governance arrangements, the way in which the Board and its sub-committees conduct their business, and the extent to which organisational structures are supporting good governance and clear accountabilities. I also looked at the information that the Board and its committees receive to help it oversee and challenge performance and monitor the achievement of organisational objectives. I found the following.

32   **The Health Board has good arrangements to support board and committee effectiveness, and shows recent signs of strengthened scrutiny, but needs to develop a strong focus on fewer, but key priorities.** My work found good operational governance arrangements and committee scrutiny has been good and continues to strengthen. The Board has also set out a clearer picture of the strategic direction. However, until recently, the quality of challenge at a board level has been variable. The Health Board has a range of significant challenges and risks that it is facing, but it needs focus on the key aspects which would result in greatest performance improvement. The executive team recognises this and is taking this forward with the wider Board.

33   **Work is still on-going to develop a board assurance framework and supporting risk management processes; this is now helpfully supported by a comprehensive underpinning legislative assurance framework.** As part of its board assurance framework development, the Health Board is logically linking its current objectives and its required assurances using a board assurance map, although this has taken some time. Supporting this, the Health Board has developed a comprehensive legislative assurance framework which will help provide assurance in key statutory areas. The Board's strategic risk management arrangements are, in general, fit to support the operation of the Board and its committees and it is continuing to refine these arrangements by clarifying risk appetite and reviewing its risk management strategy in December 2018.

34   **While formal internal controls are in place, there needs to be stronger accountability for the delivery of financial, performance and service change plans within divisions.** My work found that there is a well-focussed programme of work for Internal Audit, Local Counter Fraud service and the Post-Payment Verification team. I also considered the clinical audit programme and found that clinical audit planning and reporting needs to be strengthened. Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions are current and are reviewed in line with national and local requirements. There are also improving arrangements for declarations of interests and gifts and hospitality. The Health Board is taking a proactive approach to preparing and responding to

the requirements of the General Data Protection Regulations (GDPR) and addressing recent Information Commissioners Office (ICO) recommendations.

The Health Board continues to strengthen its quality governance arrangements including better escalation of risks and issues and its wider roll-out the harms quality dashboard is helping to improve and reduce infection rates. 'Putting Things Right' processes and complaints response arrangements are slowly improving, but there is more to do to ensure timeliness of response and ensure lessons are learnt and applied across operational services and sites. In respect of the Health Board's performance management, I found that whilst the Health Board's performance framework is clear, logical and formal, it has not resulted in the required improvements in performance. I found a need to strengthen accountability and focus more on the timeliness and impact of remedial action for poor performance. I also agree with the Board's own assessment that the formats of performance reports make it hard to focus on the priorities and recognise it is working to improve this.

35   **Gaps in management capacity have limited the extent and pace of improvement, particularly in secondary care, but changes to executive roles and lines of accountability create a better spread of responsibilities across the executive team.** While there has not been significant change to the operational structure, revised lines of executive accountability provide a better spread of responsibility amongst the Executive Directors. In previous years' work, I highlighted concerns about capacity within services and the ability to secure improvements and service change. The Health Board, with financial support from the Welsh Government, is strengthening the management capacity in its Secondary Care Division, with a clinical, nursing and management triumvirate introduced to focus on emergency and urgent care access. These arrangements should help strengthen clinical engagement, which remains an ongoing challenge, and provide capacity and capability to drive service management and improvement.

36   **The Health Board has an embedded process for tracking Internal Audit and External Audit recommendations and reporting actions and progress to the Audit Committee.** The Health Board's monitoring system allows the progress against target deadlines to be reported, enabling the Audit Committee to challenge senior management where progress is not sufficient. My structured assessment review this year indicates a number of areas where the Health Board is making progress against my previous recommendations. However, there remains more to do before these actions are completed in full. Those areas outstanding and in progress include:

- strengthening financial savings and efficiency approaches;
- improving clinical audit planning and reporting;
- building change management capacity and capability;
- strengthening recruitment approaches; and
- further strengthening approaches for applying lessons learnt from incidents and complaints.

While strategic planning arrangements are developing, these have yet to result in an approvable Integrated Medium-Term Plan and the Health Board's approach to monitoring the delivery of its existing plans has not been strong enough

37   My work examined how the Board engages partners and sets strategic direction for the organisation. I also assessed how well the Health Board plans the delivery of its objectives, whether plans are sufficiently joined up and how progress in delivering the plans is monitored. My findings are set out below.

38   **The Health Board's engagement approach continues to develop and inform strategy development but there is a need for greater clarity on the shape of services**. The Health Board has continued its regular public engagement approach as part of its 2017-19 engagement strategy and focused on building public confidence, driving greater public and patient involvement. It has used this to inform its ten-year 'Living Healthier Staying Well[1]' strategy, which the Health Board approved in March 2018. The strategy identifies three main programmes of Health Improvement and Health Inequalities, Care Closer to Home and care for more serious health needs. While the strategy provides a high-level intent for the direction of travel for services, it doesn't provide the detail on the shape of services which will be needed when the Health Board develops its implementation plans.

39   **I found that the Health Board has strengthened its planning approach but it has not yet been able to generate an approvable IMTP; it has the ambition to do this for the 2019-22 IMTP although this will present a significant challenge for the Health Board.** Throughout 2017, the Health Board had a clear and agreed planning approach, but it didn't result in an approved IMTP in 2018. The Health Board has since been working to an annual operating plan and it also prepared a three-year plan. While there is still no agreed clinical strategy, it is positive that there are a growing number of clinical plans for individual services which are at various stages of development. It is important, however, that greater clarity is provided around the future models of care. The Health Board is now starting to prepare its 2019-22 IMTP although this is likely to present a significant challenge, particularly in relation to the financial position.

40   **Arrangements to monitor delivery of the annual operating plan have not ensured effective delivery of it.** As part of my structured assessment review I considered the level of scrutiny on Annual Operating Plan (AOP) delivery. I found that scrutiny arrangements are in place at a committee level, but board level oversight of AOP delivery is limited, progress reports are often lengthy, and scrutiny, support and challenge of officers did not result in improved delivery of plans. Of the 615 actions in the 2017-18 annual operating plan, only just over half were delivered and performance was broadly similar for the first Quarter of 2018-19.

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[1] 'Living Healthier Staying Well' www.bcugetinvolved.wales/lhsw

The Health Board is continuing to experience significant challenges in managing its workforce, finances and physical assets, and it needs to develop a more transformational approach to improve service performance and efficiency

41　My Structured Assessment work examined the Health Board's arrangements for managing its workforce, its finances and other physical assets, in supporting the efficient, effective and economical use of resources. I also considered the arrangements for procuring goods and services, and the action the being taken to maximise efficiency and productivity. My findings are set out below.

42　**Whilst aspects of financial governance and management are improving, the Health Board is projecting a significant year end deficit and is still some way from being able to reach a position of financial balance.** The Health Board's financial position remains a significant and long-term challenge. For the year 2017-18, the Health Board reported a £38.8 million deficit against the revenue resource limit and this contributed to a growing three-year cumulative deficit of £88.1 million at the end of March 2018. For 2018-19 it is predicting an annual £35 million deficit.

43　Our annual accounts work has consistently identified that the Health Board has adequate budgetary financial management and control arrangements which ensure accurate recording and propriety over its income and expenditure. However, irrespective of the sufficiency of these controls the Health Board is not able to contain its net expenditure to within its allocation. Factors include growth in service demand, the high cost of out of county specialist placements and the non-delivery of some planned cost efficiencies. The finance team has continued to support budget holders and the newly developing turnaround function is adopting improving approaches to help strengthen financial savings arrangements, but this needs to focus more on achieving recurring savings, productivity and efficiency. My work also identified good operational procurement arrangements, but also potential to adopt a more strategic approach to use procurement to help deliver wellbeing of future generation objectives and to deliver better overall long-term value.

44　**My work found that new executive leadership and a commitment to develop a workforce strategy by the end of 2018 create an opportunity to address a number of existing and challenging workforce issues.** In particular, issues relating to medical, nursing and allied healthcare staff vacancies remains a significant concern. The Health Board has continued with its ongoing Train.Work.Live.[2] recruitment approach and it has also developed a new retention process to reduce the staff turnover rate. The Health Board must meet requirements of the Nurse Staffing (Wales) Act 2016 and while it has put arrangements in place, nursing staff shortfalls present ongoing challenges. The Health Board is taking a proactive approach for staff development and has good mandated training uptake and a range of leadership and management training

[2] Train work live www.trainworklivenorthwales.co.uk/

programmes. In addition, there are a range of staff engagement approaches in place which are showing a positive impact as demonstrated in the recent biennial NHS staff survey. The Health Board has a newly appointed Director of Workforce and OD. With the appointment has come greater clarity on the function and structure of the workforce teams and their priorities as well as an aim to develop a workforce strategy to inform the 2019-22 IMTP.

45 **Within a context of a large legacy estate and asset base and limited discretionary capital, day-to-day administration and maintenance of assets is managed reasonably well, but there is a need for a more strategic approach**. The Health Board has a large legacy estate and asset base, and while some of this is relatively new or recently refurbished, I found that some parts of the current estate are unlikely to support new service models, promote efficient ways of working and will be difficult to bring up to the required environmental standards. This is demonstrated by the level of high-risk estate maintenance backlog, currently estimated at £49 million. The Health Board has no over-arching asset or estate management strategy, although this is in development. In the absence of a strategy, the Health Board has used asset management and prioritisation arrangements to support both proactive and reactive approaches to operational asset management.

46 **The Health Board is not delivering against key access targets and service productivity and efficiency needs to be improved.** Whilst some performance metrics have improved, achievement of waiting time targets remain a significant challenge. The Health Board is failing to deliver against its four-hour emergency department target having recorded a significant deterioration over the summer. Follow-up outpatients is a growing concern for the Health Board. My work this year has also considered the Health Board's efficiency and productivity arrangements. This indicated that the Health Board actively engages in benchmarking exercises and clubs to identify areas where there are inefficiencies, but it needs to become better at securing improvements in efficiency and productivity.

47 **There is a good strategic approach in the informatics service, but this will require focussed investment and there also needs to be stronger oversight on the effect of national system risks on the Health Board**. The Health Board has an agreed five-year strategic outline programme for informatics which is currently being redrafted and reprioritised in line with overall Health Board priorities and budget availability. Overall informatics resources were increased in 2017-18 and the new server rooms at the Wrexham Maelor and Glan Clwyd sites are a positive investment. However, there remain several risks relating to medical records storage, and delays relating to the national roll-out of systems.

My wider programme of work indicates that the Health Board is responding to risks and opportunities, but continues to face several challenges

The Health Board is making reasonable progress in delivering its recently developed plans for primary care, but many aspects of performance remain worse than average and significant workforce and financial challenges remain

48   I found that the Health Board has a planning framework for primary care but not a detailed delivery plan and its capacity to support cluster working is stretched and still at an early stage of development. It is developing its Care Closer to Home programme that is aligned to the national plan and the Health Board can point to some specific examples of shifting resources towards primary care, but several factors are hampering large-scale change. It is well recognised that workforce challenges pose a significant threat to the sustainability of GP practices and the Health Board is being stretched by needing to directly manage several practices. The Health Board is in the early stages of implementing multi-professional primary care teams as part of its plans to develop primary care and in response to challenges caused by a shortfall in GPs and growing list sizes. However, there are barriers to further progress including a shortage of non-medical professionals. The Health Board has recognised the need to strengthen primary care leadership and has recently has recruited a Director of Primary and Community Care.

My emerging findings on the Integrated Care Fund are showing that whilst the Fund is having some positive impacts, there are also a number of challenges that the Regional Partnership Board needs to manage

49   I have completed the fieldwork for my cross-sector Integrated Care Fund review. I intend to prepare a national summary report early in 2019, setting out my all-Wales findings. My audit team has already presented local findings to Regional Partnership Boards. Key messages for the North Wales Regional Partnership Board are as follows:

- The Integrated Care Fund (the fund) has had a positive impact in bringing organisations together across North Wales, although it is unclear whether partnership working would continue if the fund ceased to exist, and a number of members identified a preference to work at sub-regional level.

- Due to the annual nature of the fund, the region recognises that it has not always used the fund strategically to develop services based on need, with scope to strengthen aspects of project management for the projects supported by the fund.

- Decisions surrounding the use of the fund are largely delegated to sub-groups of the regional partnership board, but the level of understanding within partner organisations of the work of the North Wales Regional

Partnership Board and its sub-groups, including what the fund is being used for and its impact, needs to improve.

- There is general agreement that the fund is supporting the right projects and having a positive impact on service users, but like other regional partnership boards across Wales, very few projects are being mainstreamed into core services. The North Wales region is attempting to demonstrate outcomes more clearly, but this presents an ongoing challenge.

The Health Board has made effective use of the National Fraud Initiative to detect fraud and overpayments

50   The National Fraud Initiative (NFI) is a biennial data-matching exercise that helps detect fraud and overpayments by matching data across organisations and systems to help public bodies identify potentially fraudulent or erroneous claims and transactions. It is a highly effective tool in detecting and preventing fraud and overpayments and helping organisations to strengthen their anti-fraud and corruption arrangements.

51   In January 2017, the Health Board received 896 high-risk data-matches from the 2016 data matching exercise. The Health Board has made good progress in reviewing them and while no frauds had been identified, the review of the matches helped to provide assurance that its counter-fraud arrangements were working effectively. In October 2018, participating bodies submitted data for the next data matching exercise. The outcomes of this exercise will be available early in 2019.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2018.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	May 2018
Opinion on the Financial Statements	June 2018
Audit of the Charity Financial Statements Report	December 2018
Opinion on the Charity Financial Statements	January 2018
Performance audit reports	
Structured Assessment 2018	December 2018
Primary Care	November 2018
Other reports	
2018 Audit Plan	April 2018

Exhibit 3: performance audit work still underway

There are also a number of performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Clinical coding follow-up	March 2019
Orthopaedic Services follow-up	October 2019
Operating Theatres follow-up	May 2019
Review of legacy IT systems and infrastructure	June 2019

Appendix 2

Audit fee

The 2018 Audit Plan set out the proposed audit fee of £457,953 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is consistent with the fee set out in the outline. I will keep this under review and inform the Health Board if this changes.

Appendix 3

Significant financial audit risks

Exhibit 4: significant audit risks

My 2018 Audit Plan set out the significant financial audit risks for 2018. The table below lists these risks and sets out how they were addressed as part of the audit.

Significant audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.	I completed focussed audit testing as planned on the relevant areas of the financial statements. No evidence found of biased judgements or estimates.
There is an inherent risk of material misstatement due to fraud in revenue recognition and as such this is treated as a significant risk [ISA 240.26-27].	My audit team will consider the completeness of miscellaneous income.	I completed audit work as planned and no evidence was found of material misstatement due to fraud in revenue recognition.
It is highly probable that the Health Board will fail to meet its statutory financial duties. The month 10 position showed a year-to-date deficit of £34.735 million and forecast a year-end deficit of £36 million. I am likely to place a substantive report on the financial statements, explaining the failure and the circumstances under which it arose. The current financial pressures on the Health	My audit team will focus its testing on areas of the financial statements which could contain reporting bias.	I reviewed the Health Board's financial management arrangements, significant financial standing issues and areas of the financial statements which could contain financial balance. The Health Board reported an overspend against resource allocation of £38.8 million and a cumulative overspend over the three-year period 2015-15 to 2017-18 of £88.1 million. As a result, the Health Board failed to meet its first statutory financial duty.

Significant audit risk	Proposed audit response	Work done and outcome
Board increase the risk that management judgements and estimates could be biased in an effort to achieve any financial duties set.		
There is a significant risk that the Health Board will face severe pressures on its cash position at the year-end. A shortfall of cash is likely to increase creditor payment times and impact adversely on Public Sector Payment Policy (PSPP) performance.	My audit team will audit the PSPP performance bearing in mind the cash pressures on the Health Board.	I completed audit testing as planned and concluded that in all material respects, its performance was correctly stated.
I have identified a number of disclosures as being material by nature. These include the disclosure of Related Parties and the Remuneration note.	My audit team will design detailed testing to obtain the required assurance that disclosures identified as material by nature are complete, accurate and in line with the requirements of the Manual for Accounts issued by the Welsh Government.	I completed focussed audit testing as planned on the disclosures deemed material by nature. I concluded that the disclosures were complete, accurate and in line with the requirements of the Manual for Accounts issued by the Welsh Government.

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There is an interactive version of this document, please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Expenditure on agency staff by NHS Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

This report has been prepared for presentation to the National Assembly under the Government of Wales Act 1998.

The Wales Audit Office study team comprised Nicholas Raynor, James Ralph, Nigel Blewitt and Huw Lloyd Jones under the direction of Mike Usher.

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Contents

Introduction

The NHS in Wales employs almost 80,000 full-time equivalent staff, excluding General Practitioners and those employed directly by General Practices, spending £3.62 billion on pay in 2017-18.

But NHS Wales also needs to use additional staff to supplement the full-time workforce so that they can continue to deliver services when:

• key posts are vacant;

• staff are on sick leave, on holiday or absent for some other reason; or

• demand for services increases because of, for example, winter pressures.

The seven Local Health Boards and three NHS Trusts (collectively referred to as health bodies in this report) secure the services of temporary staff from:

• substantive staff paid overtime to work additional shifts;

• internal staff banks, which typically include staff who have substantive contracts at the health body or at a neighbouring health body, as well as other suitably qualified staff who prefer to be able to choose where and when they work;

• private-sector agencies, who charge a fee for supplying staff; and

• people who enter into a direct contract with the health bodies on ad hoc terms of engagement. Some of these people may also have substantive contracts within the NHS.

Staff working on a temporary basis generally cost more for a shift than a person of the same grade who has a substantive contract. Staff supplied by agencies tend to be the most costly source of temporary staff. NHS bodies in Wales collectively spent over £160 million on agency staff in 2016-17, more than four times the equivalent figure for 2012-13. There have also been large increases in agency expenditure in other UK countries.

The scale and rapid growth of expenditure on agency staffing have created considerable media and public interest, not least because of the financial pressures faced by NHS bodies. NHS Wales has responded through a range of national and local initiatives aimed at reducing demand and controlling costs.

This report sets out key facts about the use of agency staff by NHS bodies in Wales, including:

- expenditure;

- analyses by health bodies of underlying reasons;

- national initiatives to control this type of spending; and

- challenges that lie ahead.

The report, together with the data tool we have developed, aims to:

- offer insight, enabling readers to conduct their own analyses; and

- promote improvement by sharing information about initiatives to curb spending on agency staff and highlighting issues for the NHS to consider when developing future initiatives aimed at managing agency expenditure.

It does not attempt to evaluate the use of agency staff or the effectiveness of the actions taken to control costs. This report and information gathered when preparing it will also be used to inform the planning of the Auditor General's forward programme of national and local audit work.

Agency expenditure in **2017-18**

£135.7m

Proportion of agency expenditure by staff group in **2017-18**

Medical and dental
44%

Nurses and registered midwives
38%

Other
18%
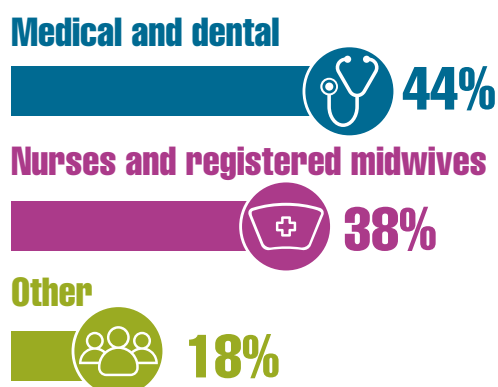
Agency expenditure as a proportion of total NHS pay in **2017-18**

3.7%
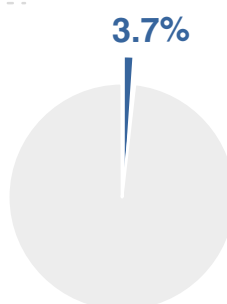
About **82%** of agency expenditure in **2018-19** is providing cover for vacant positions

Part 1 – Expenditure on agency staff by NHS Wales has increased markedly in recent years

Agency expenditure in 2017-18 was £135.7 million, a rise of 171% over seven years. (See Definition of agency expenditure on page 9). After a period of stability, it grew significantly after 2013-14, peaking at £164.4 million in 2016-17. (See Expenditure on agency staffing on page 10)

On average, health bodies in Wales have spent nearly half their total agency expenditure on medical and dental staff since 2014-15 and a further third on nurses and midwives. (See Distribution of agency expenditure on page 13)

Agency expenditure as a proportion of total pay increased from 1.6% of total pay in 2013-14 to 4.7% in 2016-17, before falling to 3.7% in 2017-18. (See Agency expenditure as a percentage of total pay expenditure on page 14)

Real term growth in total pay expenditure has outpaced the growth in staff numbers in recent years, reflecting the sharp increase in agency expenditure. (See Real-term growth in total pay expenditure and staff numbers on page 16)

Factors that have contributed to the rise in agency expenditure include:

- escalating hourly rates of pay charged by agencies and individuals engaged directly by health bodies;

- increase in demand for services;

- skill shortages;

- difficulties recruiting and retaining staff;

- meeting the requirements of the Nurse Staffing Levels Act (Wales) 2016; and

- individuals choosing to work through agencies.

But there is no national analysis of just how much each of these factors has contributed to the increase in agency spending. (See Factors that have contributed to increased agency expenditure on page 18)

Definition of agency expenditure

The definition of 'agency expenditure' in this report is set out below. It is the definition provided in Welsh Health Circular WHC 2018/017, '2018-19 LHB & Trust Monthly Financial Monitoring Return Guidance' that is used by Local Health Boards (LHBs) and NHS Trusts (Trusts) to report on agency and locums (paid at a premium) expenditure in their monthly financial monitoring returns to Welsh Government.

Agency expenditure includes:

- staff not employed by the LHB or Trust and therefore not in receipt of payments through its payroll. This would include staff employed through Agencies, Self Employed Individuals etc.

- staff employed by another NHS organisation who are undertaking sessional work within the LHB or Trust, and again are not in receipt of payments through the LHB's or Trust's payroll for whom the work is being undertaken, which are paid at a premium.

Expenditure excludes:

- staff that are employed by the LHB or Trust, who undertake additional work on a temporary basis for another department within the same LHB or Trust or at another hospital site within the same LHB or Trust.

- any staff employed on a temporary basis or fixed term contract but who are in receipt of payment through a LHB's or Trust's payroll, on terms and conditions defined by that LHB or Trust.

  Locums 'paid at a premium' are those paid above the rate of the substantive post holder.

The above definition, and all data in this report, exclude doctors and dentists who are General Practitioners, because they are independent NHS contractors. The analysis also excludes staff who are employed directly by General Practices.

Expenditure on agency staffing

Expenditure on agency staff was relatively stable until 2013-14, after which there was a sharp increase, with expenditure peaking at £164.4 million in 2016-17.

Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

This link opens a data tool that will allow analysis of expenditure on agency staff at each health body over the period 2010-11 to 2017-18. To access it please visit https://www.audit.wales/publication/ expenditure-agency-staff-nhs-wales ⬈

There was a fall in total agency expenditure in 2017-18 of £28.7 million. Expenditure fell in all staff categories except one.

Exhibit 2: NHS expenditure in Wales on agency staff by staff group for 2016-17 and 2017-18
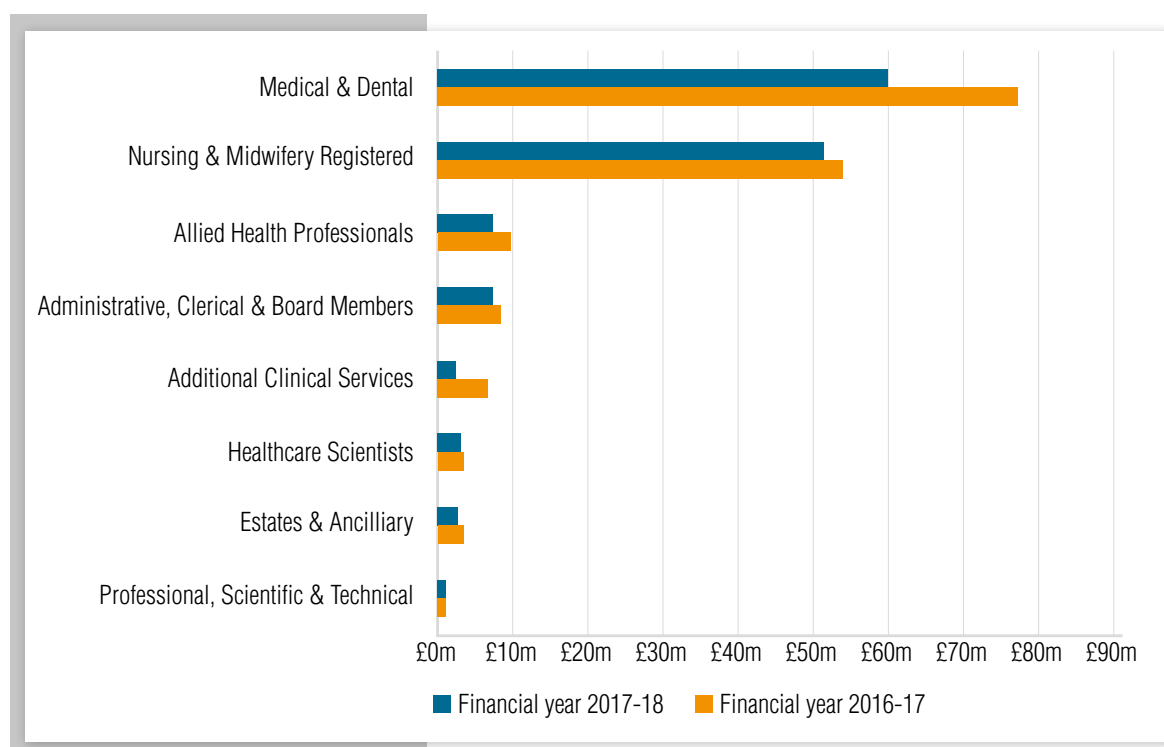
Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

The largest reduction in expenditure was for Medical and Dental agency staff, where expenditure fell by over £17 million. There was a further reduction of £2.4 million in expenditure on Nursing and Midwifery agency staff. However, the scale of reduction varied widely between health bodies.

This link opens a data tool that will allow analysis of the changes in expenditure on the different agency staff groups at each health body between 2016-17 and 2017-18. To access it please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales ⤢

A reduction in agency expenditure may be offset by increases in other elements of the NHS pay bill, but a breakdown of variable pay elements is not provided in the financial monitoring returns submitted by health bodies to Welsh Government.

The reported falls in agency expenditure may, in part, be because changes to the method of paying agency staff and locums result in expenditure falling outside the definition of agency expenditure in the monthly financial returns to Welsh Government.

A national working group (the Medical Workforce Efficiency Group) is leading a project to improve the consistency of coding locum variable pay.

Distribution of agency expenditure

Health bodies use agencies to provide all types of staff, but expenditure on doctors and nurses represents about 80% of total agency expenditure.

Although total agency expenditure increased significantly between 2014-15 and 2016-17, Exhibit 3 shows that the proportion spent on each staff group has remained broadly constant.

Exhibit 3: the distribution of agency expenditure by staff group between 2014-15 and 2017-18
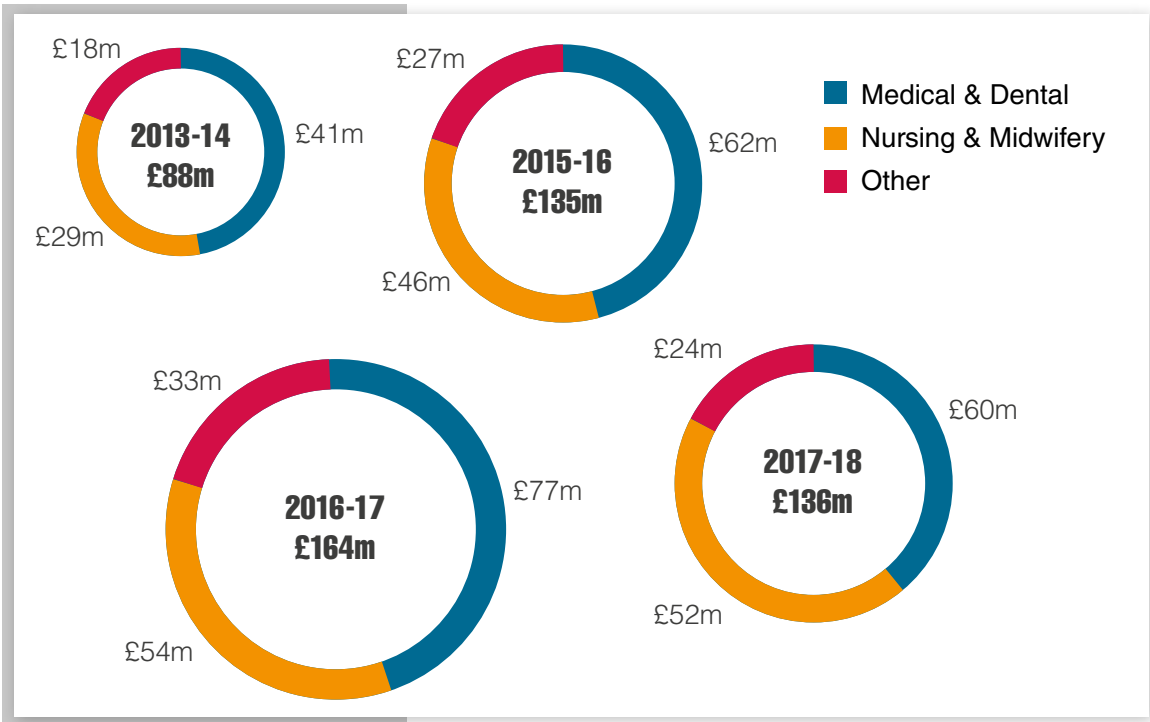
Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

Agency expenditure as a percentage of total pay expenditure

In 2010-11, expenditure on agency staff represented only 1.7% of total pay across the 10 health bodies in Wales. By 2016-17, the proportion had increased to 4.7%, before falling to 3.7% in 2017-18.

In most health bodies in Wales, there was a significant growth in expenditure on agency pay as a proportion of total pay between 2014-15 and 2016-17, followed by a small decrease in 2017-18.

Exhibit 4: total expenditure on agency staff as a proportion of total pay in the six largest health bodies in Wales between 2010-11 and 2017-18
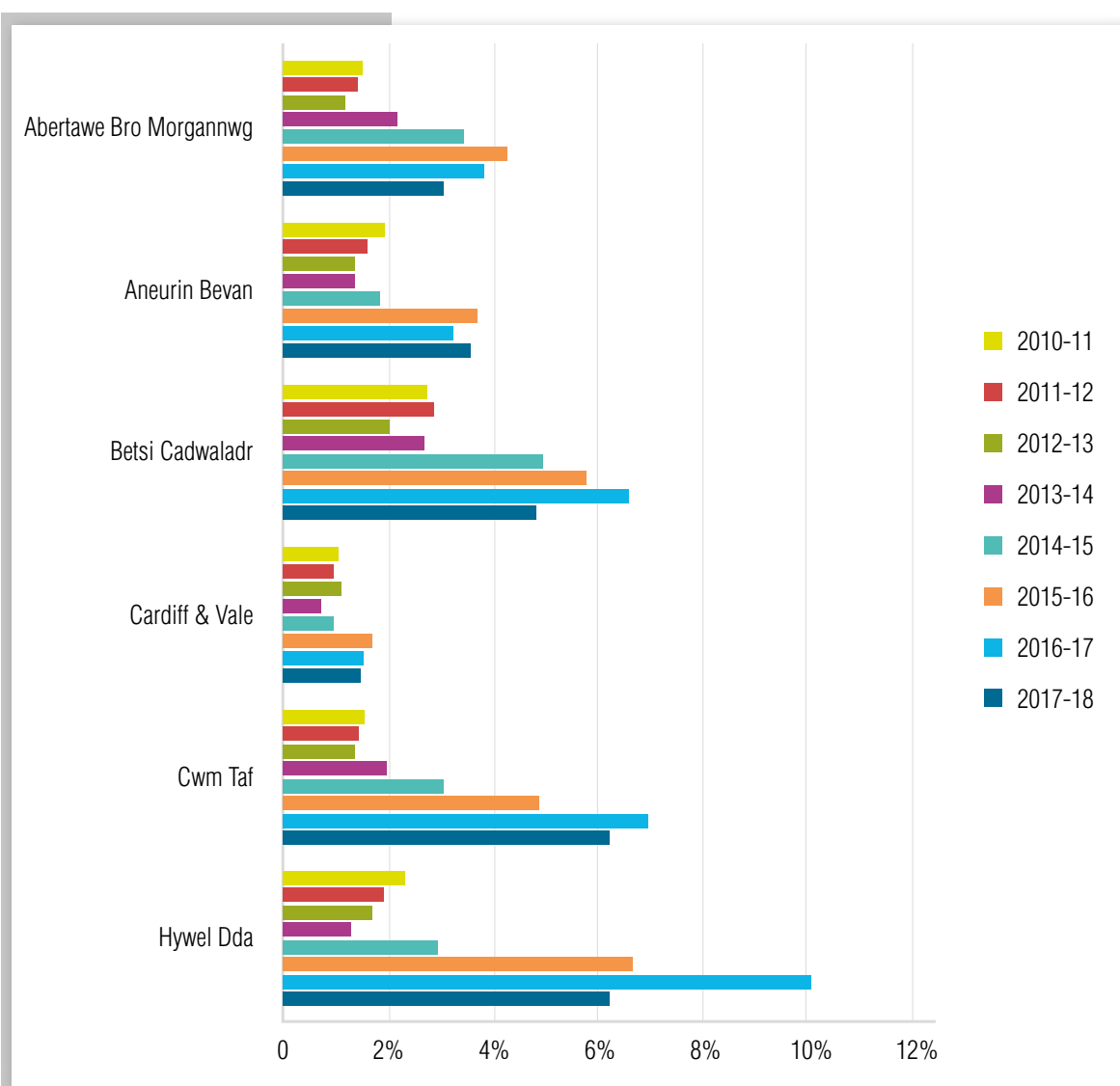
Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership
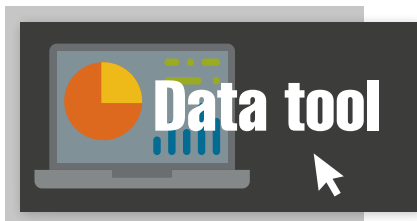
This link opens a data tool that will allow analysis of total agency expenditure as a percentage of total pay expenditure at each health body between 2010-11 and 2017-18. https://www.audit.wales/publication/ expenditure-agency-staff-nhs-wales

Significant increases in NHS expenditure on agency staff have not been confined to Wales, with high levels also being seen in England and Scotland. The scale of expenditure across the United Kingdom is different, but the trend in agency expenditure as a proportion of total pay expenditure is similar.

Exhibit 5: total agency expenditure as a proportion of total NHS pay in Wales, England, Scotland and Northern Ireland between 2012-13 and 2017-18
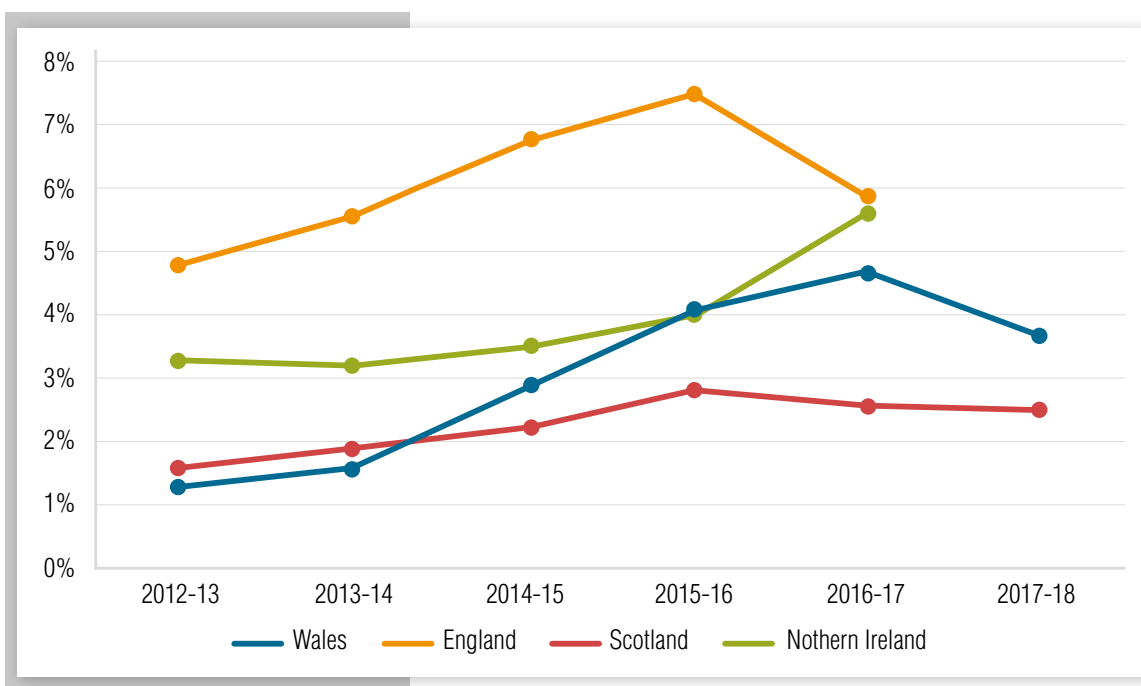
Note: The data for 2017-18 are not yet available for England and Northern Ireland.

Sources: Data received and collated by NHS Wales Shared Services Partnership, the National Audit Office, Audit Scotland and the Northern Ireland Audit Office from financial returns and accounts

Real-term growth in total pay expenditure and staff numbers

On 30 September 2017 the NHS in Wales employed almost 80,000 full-time equivalent staff, excluding General Practitioners and those employed directly by General Practices.

The composition of the workforce is shown in Exhibit 6.

Exhibit 6: number of full-time equivalent staff directly employed by health bodies in Wales by staff group on 30 September 2017

Staff group	Number of full-time equivalent staff at 30 September 2017	Proportion of workforce
Medical and dental staff	6,321	8.1%
Nursing, midwifery and health visiting staff	29,524	37.9%
Administration and estates staff	17,384	22.3%
Scientific, therapeutic and technical staff	12,799	16.4%
Health care assistants and other support staff	9,704	12.5%
Ambulance staff	2,084	2.7%
Other non-medical staff	101	0.1%
Total	**77,917**	**100%**

Source: NHS staff by staff group and year, StatsWales

The NHS workforce increased by 7.5% between September 2010 and September 2017. Medical and dental full-time equivalent staff numbers increased by 12.1% during this period and nursing, midwifery and health visiting staff increased by 4.7%.

Total pay expenditure increased from £2.92 billion in 2010-11 to £3.62 billion in 2017-18, an increase of almost 24% in cash terms. Exhibit 7 shows real-term growth in total pay expenditure since 2010-11 and compares it with the increase in full-time equivalent staff numbers. The graph shows that, from 2014-15, both staff numbers and total pay began to increase, with total pay in real terms accelerating more quickly than full-time equivalent staff numbers.

Exhibit 7: real-terms comparison of full-time equivalent staff numbers against total NHS pay expenditure in Wales between 2010-11 and 2017-18
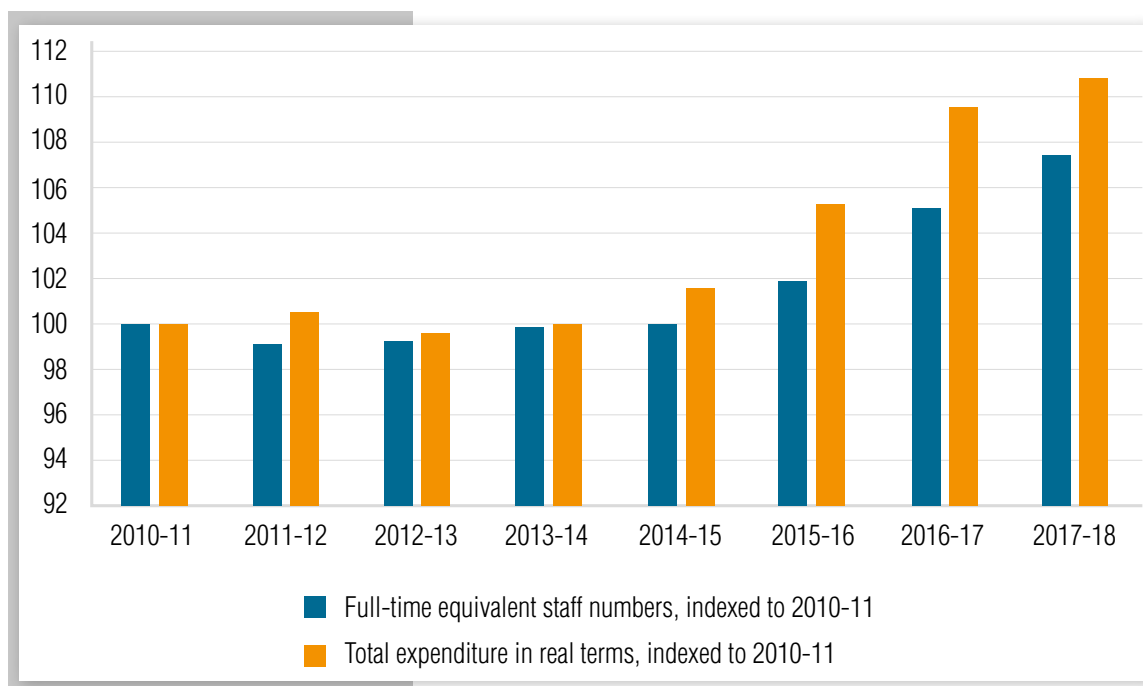
Source: Wales Audit Office calculations, drawing on data provided by Workforce, Education & Development Services, NHS Wales Shared Services Partnership

The growth in total pay expenditure relative to staff numbers shown in Exhibit 7 cannot be explained by pay inflation among staff on substantive contracts, given that NHS staff have faced pay caps in recent years. Although not the only possible explanation, the growth in total pay is consistent with a significant increase in expenditure on temporary staff, whether via agencies or from other sources.

Factors that have contributed to increased agency expenditure

The increase in expenditure on agency staffing is due to a range of factors that include:

- escalating hourly pay rates;

- increases in demand for services and changes to the way in which health services are delivered;

- skill shortages;

- difficulties recruiting and retaining staff;

- levels of sickness absence;

- the need to comply with the requirements of the Nurse Staffing Levels Act (2016); and

- actions taken in England to drive down agency expenditure making it more attractive to agencies to focus more directly on the market in Wales.

We were told that increasing numbers of doctors and nurses choose to work for agencies or on a self-employed basis rather than being employed directly by the NHS.

Anecdotal evidence suggests that the lack of public sector pay growth has been a key factor for people registering with agencies for additional shifts or simply leaving substantive posts to work for an agency.

Findings published in the National Institute of Economic and Social Research report 'Use of Agency Workers in the Public Sector', produced in 2017, suggest that other factors attracting individuals to agency work include:

- valuing highly the preference for flexible working and improved work-life balance, with the opportunity to pick and choose shifts to suit their needs;

- dissatisfaction with working conditions and workloads within the NHS;

- being paid more quickly, as agencies generally make weekly payments; and

- younger generations attaching less importance to job security and pensions, and their desire to experience career breaks.

Part 2 – About 80% of agency expenditure is providing cover for vacant positions, but information on the number of agency staff used is limited

Financial projections by health bodies indicate that £90 million (77% of total forecast agency expenditure) will be spent to cover vacant posts in 2018-19.

For the first six months of 2018-19 about 82% of total agency expenditure was covering vacancies, with most of the remainder covering additional activity and sickness absence. (See Reasons for using agency staff in 2018-19 on page 20).

Each health body holds data on how many agency staff they use, and why. But there is still no all-Wales analysis of how many doctors, nurses and other staff are being hired through agencies, their specialties and their grades. The NHS is developing arrangements at an all-Wales level to better understand nursing and medical agency usage, which are the two largest areas of spend. (See Availability of information about agency staff used on page 21)

Reasons for using agency staff in 2018-19

The NHS in Wales has only recently begun to analyse at a national level the reason for each instance of hiring agency staff.

The financial position of individual organisations and the overall financial health of NHS Wales is monitored using monthly financial returns submitted by each health body to Welsh Government. Since April 2018 these financial returns require health bodies to provide an analysis of the reasons for incurring agency expenditure.

Most of those we spoke to in preparing this report were confident that the need to cover vacant posts accounted for most expenditure on agency staff. The financial returns by health bodies bear out this confidence.

- 77% of forecast agency expenditure for 2018-19, reported by health bodies at the end of April 2018, was to cover vacant posts; and

- 82% of the £66.8 million spent on agency staff during the first six months of 2018-19 was covering vacancies. Six per cent of the reported agency expenditure reflected the need to cover for sickness absence, while 8% was needed for additional activity.

Vacancies are reported at a national level based on 'advertised' posts. NHS Wales acknowledges that this reported data about the number and nature of vacancies is only a proxy for the true number of vacancies and does not give the true vacancy position.

Most organisations do not have a defined substantive staff complement to give a baseline to measure vacancies. Reporting vacancy rates based on 'advertised' posts can lead to:

- 'double counting' of vacancies because posts may be advertised more than once before they are filled; and

- vacant positions not being reported if the position is not being recruited to.

We found that, despite the reported link between agency expenditure and vacancies, there is no correlation between month-to-month changes in the number of advertised vacancies and corresponding fluctuations in agency spend.

Availability of information about agency staff used

Health bodies hold data on how many agency staff they use, who the individuals are and what they are used for. But this data is not collected in a common NHS-wide system, nor is it shared with other health bodies.

By not sharing information there is a risk that individuals may work excessive hours across different health boards, potentially putting patient safety at risk. Also, it is harder for NHS Wales to prevent fraudulent practices, such as people working for agencies whilst on sickness absence from their NHS employer.

Data produced at a national level on agency usage is limited but is developing. To better understand the use of agency doctors and nurses, which are the two largest areas of agency spend:

- spending data on agency nurses that is collected by a sub-group of the Temporary Nurse Staffing Capacity Steering Group is being converted to whole-time equivalent staff for each agency supplier since April 2017. This gives a better understanding of the volume of agency staff engaged as well as the cost. However, the data is collected independently of the financial monitoring returns submitted by health bodies to Welsh Government and is not consistent with the agency spend reported by Welsh Government.

- health bodies are submitting data about their use of agency and locum doctors to Welsh Government following the introduction of Welsh Health Circular 2017-042 'Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales' in October 2017 (see National Initiative – Controlling the cost of medical and dental agency staff on page 26 for detail on the Circular). However, the data reflects 'bookings' made in the month rather than expenditure incurred. The bookings may be worked and paid for over a period covering more than one month or may not be worked in full if it is a 'call off' booking.

Part 3 – NHS Wales is seeking to reduce the demand for agency staff as well as controlling the price it pays for them

In seeking to reduce agency expenditure, NHS Wales bodies generally deploy a two-pronged combination of:

- reducing the need to hire agency staff; and

- where they are hired, paying less than before to do so.

NHS managers generally hire agency staff only as a last resort. Initiatives at individual health bodies to reduce the demand for agency staff focus mainly on: recruiting and retaining more staff; reducing sickness absence; and improving rota management and job planning.

NHS Wales has put in motion a number of national workforce initiatives aimed at increasing the attraction of the health service as an employer and therefore reducing the demand for agency staff. (See National workforce developments on page 23)

The demand for agency staff has fuelled competition between health bodies and driven up rates of agency pay, particularly in areas of skill shortages. Health bodies are working together via all-Wales working groups to control the cost of using nursing and medical agency staff. In this report we profile two national initiatives:

- the introduction in 2017 of capped rates of pay for nursing agencies with a focus on eradicating 'off-contract' agency usage, led by the Temporary Nurse Staffing Capacity Steering Group. (See National Initiative – Controlling the cost of nursing agency staff on page 24)

- the introduction of arrangements in November 2017 to drive down both the volume of medical and dental agency and locum use and its cost, which took account of detailed work undertaken by the Medical Workforce Efficiency Group. (See National Initiative – Controlling the cost of medical and dental agency staff on page 26)
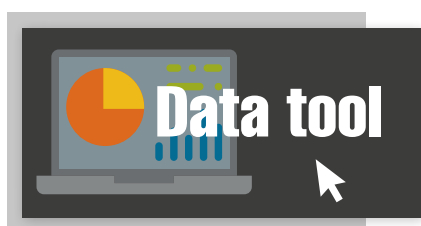
This link opens a data tool that will allow analysis of expenditure on Medical & Dental and Nursing & Midwifery agency staff at the six largest health bodies between 2012-13 and 2017-18. To access it please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

National workforce developments

National workforce developments and initiatives aimed at increasing the attractiveness of NHS Wales as an employer, and therefore reducing the demand for agency staff, include:

- the recent creation of the special health authority Health Education and Improvement Wales whose key functions include: education and training, workforce development and modernisation, leadership development, strategic workforce planning, workforce intelligence, careers and widening access.

- the campaign to attract high calibre health professionals by promoting Wales as an excellent place for doctors and dentist to train. The campaign[1] promotes initiatives such as:

  — the Less Than Full-Time Training policy⬀;

  — the Wales Clinical Academic Track (WCAT)⬀ scheme; and

  — the new education contract for junior doctors⬀ which ring-fences time for learning opportunities during the working week to support career development, a UK first.

- The Train Work Live⬀ national campaign launched in 2016 to promote Wales as an attractive place to work for GPs and other doctors.

- The recent pay agreements for the NHS Wales workforce. The pay deals agreed for doctors, nurses and other NHS staff include a range of pay and non-pay measures aimed at providing better terms and conditions for NHS Wales staff and thereby improving recruitment and retention within the workforce.

1 https://www.walesdeanery.org/future-doctors-and-dentists-–-come-and-train-wales/future-doctors-and-dentists-–-come-and-train⬀

National Initiative – Controlling the cost of nursing agency staff

Framework agreements for supplying agency nurses have been in place since 2006. Such agreements avoid the need for each health body to conduct procurement exercises before hiring agency staff. The current All Wales Agency Framework Contract came into effect on 1 April 2017 and introduced capped hourly rates of pay to nursing agencies. The contract has a duration of 24 months with the option to extend for up to a further two years.

Suppliers of agency nurses through a framework contract are referred to as 'on-contract' agencies. Agencies that are not part of a framework contract, referred to as 'off-contract' agencies, generally have a higher hourly charge to health bodies than 'on-contract' agencies.

The Temporary Nurse Staffing Capacity Steering Group was set up in 2015 to explore how health bodies in Wales can work together to address the growing concern over high cost and escalating nursing agency spend. The group aims to eradicate the use of 'off-contract' agencies to meet the demand within NHS Wales for temporary nurses.

Exhibit 8 shows there has been a reduction in the proportion of nursing agency expenditure. 'Off-contract' agency spend across Wales fell from 65% at the beginning of the 2016-17 financial year to an average of 14% for the 2017-18 financial year.

Exhibit 8: proportion of nursing agency expenditure spent with 'off-contract' and 'on-contract' agencies
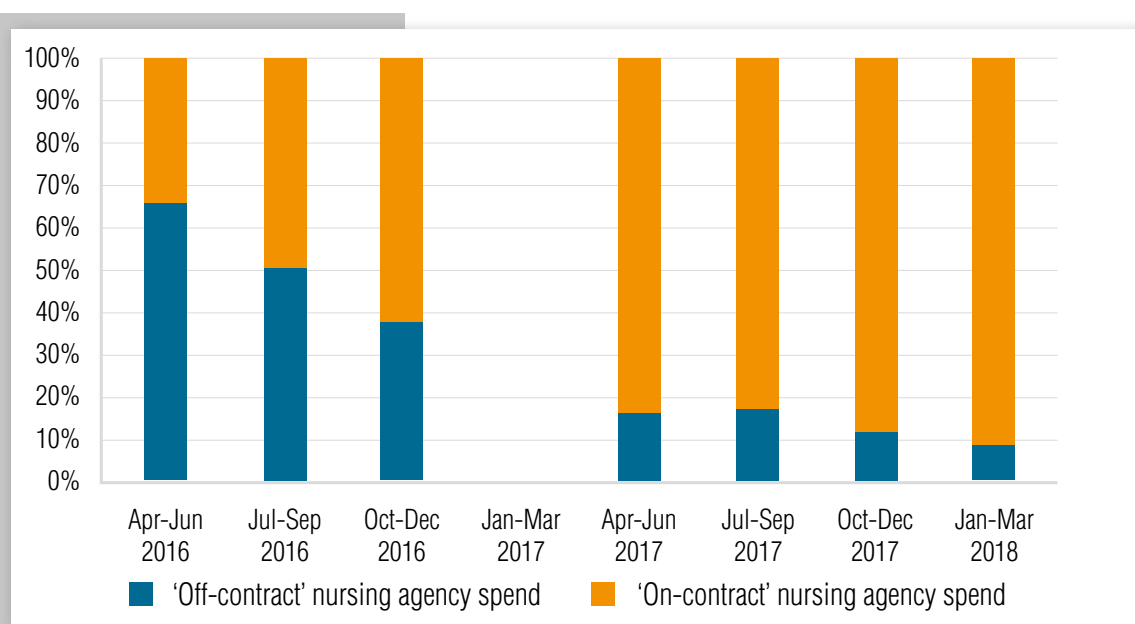
Note: Data for the period January 2017 to March 2017 is not available.

Source: NHS Wales Shared Services Partnership

We were told that two main factors have been instrumental in achieving this significant and consistent decrease in the use of 'off-contract' nursing agencies:

- the commitment from health bodies to use agencies on the framework contract as much as possible and not to breach the contract's capped rates; and

- setting capped rates that are deemed to be good but not excessive so that the framework contract can supply the agency nurses needed.

Despite the success in reducing the proportion of 'off-contract' agency expenditure, Exhibit 9 shows that agency expenditure on nurses and midwives in the first two quarters of 2018-19 is greater than it was in the corresponding periods in 2016-17 and 2017-18. Data is not available to fully explain the reasons for expenditure increasing.

Exhibit 9: expenditure on Nursing and Midwifery Registered agency staff from April 2016 to September 2018
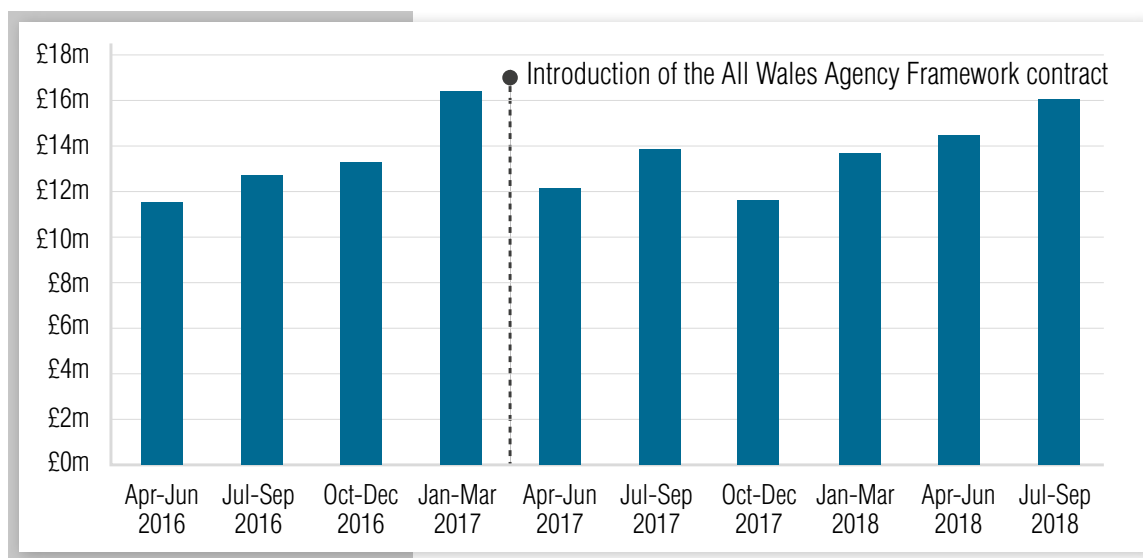
Source: Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

National Initiative – Controlling the cost of medical and dental agency staff

Welsh Government issued Welsh Health Circular 2017-042, 'Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales' (the Circular) in October 2017.

The Circular sets out the arrangements for:

'a programme of coherent and coordinated system-wide action across the NHS in Wales aiming to drive down agency and locum deployment and expenditure whilst maintaining the delivery of a safe and sustainable service across Wales'.

The programme aims to:

'encourage return of people to the NHS labour market so improving regular workforce supply and quality and consistency of care to patients; increasing the equity and transparency of reward systems and reduction of internal wage competition; and reduce the overall spend whilst we focus on the underlying causes'.

The Circular was developed by Welsh Government in partnership with the NHS in Wales, taking account of detailed work undertaken by the Medical Workforce Efficiency Group. This group was established in 2017 with aims and objectives that, if achieved, should reduce both reliance on and cost of agency doctors across NHS Wales. The membership of this group is drawn from Welsh health bodies and NHS Wales Shared Services Partnership.

The Circular sets out a national control framework of limits and targets for agency and locum deployment and expenditure, clearly defining the respective roles and responsibilities of Welsh Government and health bodies, and setting out a performance management regime at local and national levels.

A key feature of the control framework is the introduction of price caps for all medical and dental agency workers. The framework includes provision for health bodies to override the price caps under prescribed circumstances, which is not the case for nursing agency staff.

The Circular has improved controls over the authorisation of expenditure. The price caps can only be breached following internal escalation processes that require authorisation at Executive level following a robust risk assessment of the impact on patient safety.

The Circular refers to the establishment of a Workforce Delivery Unit to provide central capacity for scrutiny, identifying and sharing effective practices and targeted interventions to tackle specific issues or priorities. The Workforce Delivery Unit would also analyse the monthly data returns submitted by health bodies on medical and dental agency usage set out in the Circular 2017. The Workforce Delivery Unit had not been established at the end of our fieldwork.

Exhibit 10 shows that since the introduction of the Circular in November 2017, expenditure on medical and dental agency workers has reduced. However, the lack of data available means that NHS Wales is unable to ascribe the entire fall in expenditure to the impact of the Circular. Other factors may have contributed to this reduction, such as the hiring of fewer staff and the use of alternative temporary staffing solutions.

Exhibit 10: expenditure on Medical and Dental agency staff from October 2016 to September 2018
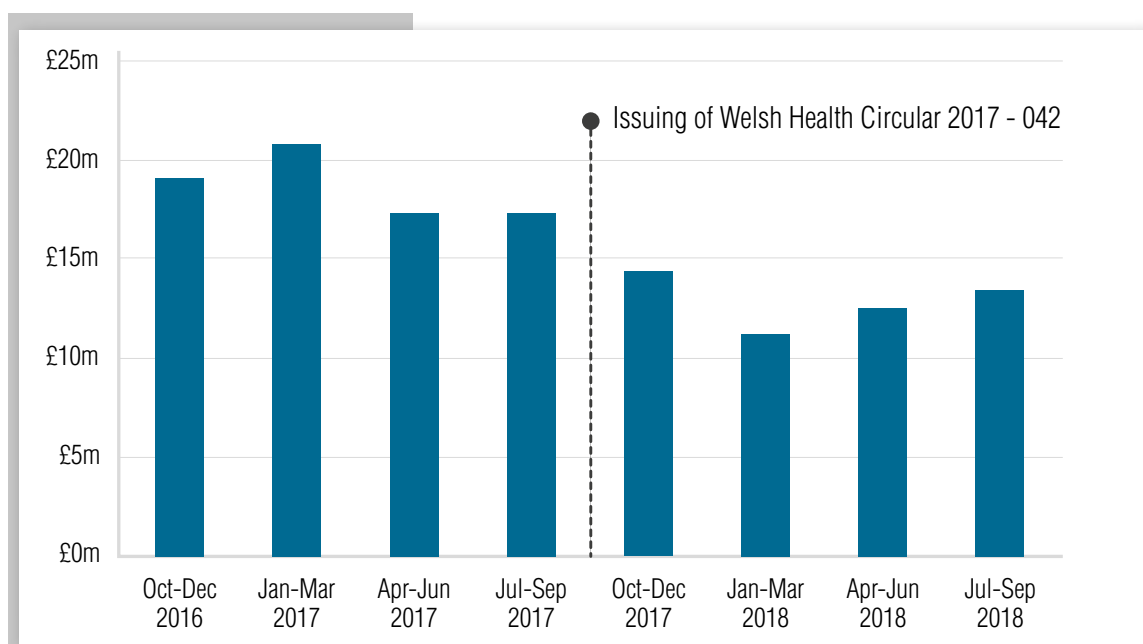
Sources: Workforce, Education & Development Services, NHS Wales Shared Services Partnership, and Welsh Government

Part 4 – We identified two key challenges to improving the management of agency staffing expenditure

This report does not attempt to evaluate the effectiveness of the actions taken to control the use of agency staff. However, we have identified two factors that we consider key to underpinning the management of agency expenditure in the wider context of temporary staffing across NHS Wales.

1   To gain a deeper understanding of the root causes of agency spend NHS Wales needs consistent and comparable data at an all-Wales level on:

  • the volume, nature and cost of agency staff used; and

  • the impact of changes in agency expenditure on other temporary staffing costs, such as overtime and internal staff banks. (See Developing all-Wales information to better understand and manage agency expenditure and usage on page 29)

2   The working groups established by NHS Wales to reduce nursing and medical agency costs are delivering much of what they set out to achieve. But the next steps in managing agency expenditure are expected to require the consistent implementation of difficult decisions across Wales. To achieve this, future projects to manage agency and other temporary staffing expenditure will therefore need strong leadership and the capacity to drive change in a timely fashion. (See Leadership of future initiatives to manage agency and other temporary staffing expenditure on page 30)

Developing all-Wales information to better understand and manage agency expenditure and usage

Information on agency cost and usage at a national level is limited. Data is held by individual organisations but is not easily accessible in a consistent form.

We consider that action to further develop two data-related themes is necessary to manage agency expenditure more effectively at a national level.

1

The ability to access and share consistent and comparable data held by individual NHS organisations at an all-Wales level.

This will allow information to be produced that is detailed enough to understand and explain:

- the volume of agency staff used;

- the frequency and regularity with which they are used;

- the roles they fill;

- the reason for needing them; and

- the cost.

Such information has the potential to inform and significantly enhance workforce planning across NHS Wales.

2

The ability to assess agency spend and usage data in the context of other temporary staffing costs.

A fall in agency spend or usage may lead to increases in other areas of temporary staffing such as overtime and internal bank working.

NHS Wales needs to be capable of evaluating reductions in agency expenditure and fully understanding consequential changes in agency expenditure on other forms of temporary staffing.

Leadership of future initiatives to manage agency and other temporary staffing expenditure

The Temporary Nurse Staffing Capacity Steering Group and Medical Workforce Efficiency Group have made positive contributions to reducing agency expenditure and are delivering much of what they set out to achieve. The groups rely heavily on the commitment of members and on partnership working. But, at times progress with developing and implementing change is hampered by:

• difficulties in reaching consensus before making decisions; and

• the lack of staff capacity to carry out work outside meetings of the groups.

In our view, a step change is needed to drive forward projects focusing on managing temporary staffing expenditure with greater pace and consistency.

Future national projects that are set up to manage expenditure on agency and other temporary staffing, such as developing the capacity and usage of staff banks, will need:

• leadership of sufficient seniority and membership of sufficient authority to make difficult decisions and drive change in a consistent way across the whole of NHS Wales;

• the financial, staffing and technological support needed to support and deliver the work; and

• a structure that is closely linked with wider workforce planning considerations.
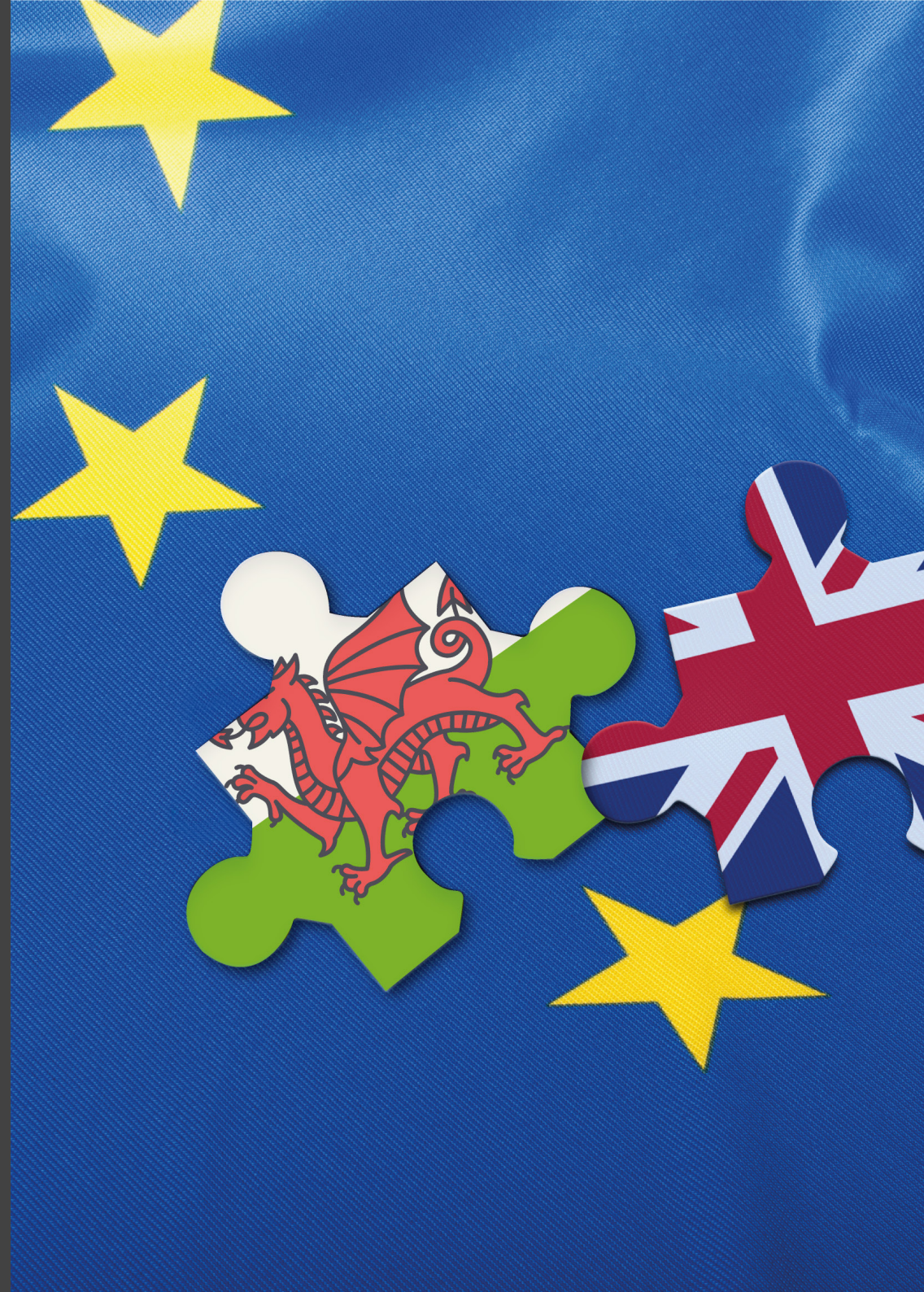
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Archwilydd Cyffredinol Cymru
Auditor General for Wales

Preparations in Wales for a 'no-deal' Brexit

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

This report has been prepared for presentation to the National Assembly
under the Government of Wales Act 2006 and Public Audit (Wales) Act 2004.

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About this report

1   In autumn 2018, I decided to review Welsh public bodies' arrangements to manage the implications, risks and opportunities of Brexit. In working out the scope of my work, I have been mindful of the Welsh Government's view that the impacts of Brexit on Wales cannot be fully mitigated and that many relevant policy areas are reserved to the UK Government. I am of course also aware of the ongoing political uncertainties about the form of Brexit and that Brexit is a new challenge for all public bodies, so there is no 'off the shelf' map or toolkit of what to do. As such, I do not expect every public body to have exhaustive plans for every implication, risk and opportunity of Brexit.

2   In November 2018, we invited the Chief Executives of devolved public bodies in Wales to share with us evidence of their preparations for Brexit. All have now replied, and most also completed a self-assessment. In addition, we have carried out detailed fieldwork looking at the Welsh Government's own preparations and arrangements for Brexit, taking account of its wider leadership role across the Welsh public sector.

3   When I decided to carry out this work, I originally planned to produce a report in late summer 2019. But I also recognised that I might need to report sooner if a 'no-deal' Brexit (Box 1) in March looked to be a significant probability. With only a very short time to go, Parliament is yet to ratify the Withdrawal Agreement that the UK Government has negotiated with the European Union (EU). The legal position is that the UK will leave the European Union at 11pm on 29 March 2019, regardless of whether the Withdrawal Agreement is ratified. There are several ways in which that could change. But at the time of publication, there is still a significant chance of a 'no-deal' Brexit.

Box 1: what is a 'no-deal' Brexit?

A 'no-deal' Brexit means that the UK leaves the EU without a Withdrawal Agreement in place. There would be no transition phase or agreement on the future relationship. The UK would stop being part of the single market and customs union and would no longer be part of EU trade agreements with the rest of the world. It would trade on World Trade Organisation rules until it negotiates new trade and customs agreements. As a result, new checks would need to be carried out on goods leaving the UK and those entering, with potential consequences for ports and disruption to supply chains.[1] New arrangements would need to be put in place for industries that currently operate under EU rules and regulatory bodies.

The UK Government, EU and Welsh Government have each produced advice and information[2] setting out the potential consequences of a 'no-deal' Brexit. The UK Government expects to reach agreement with the EU on specific issues to avoid the most disruptive consequences of a 'no-deal' Brexit. In December 2018, the European Commission announced that it would introduce temporary measures in some areas, such as citizens rights, carriage of freight and aviation to mitigate some of the impacts of a 'no-deal' Brexit.

4   As Auditor General for Wales, I have no view on the political discussions or policy decisions about the form that Brexit should take. But I do have a role in providing assurance on the Welsh public sector's approach to managing the implications of a 'no-deal' Brexit. Given that 29 March is getting ever closer and the window for acting is narrowing, I am setting out in this paper my early views on the evidence I have gathered, together with some key messages for public bodies, to help with their planning in the coming weeks and months.

5   My findings come with some significant caveats on the nature of the work I have carried out (Box 2).

1   The UK Government has said that it will initially put in place 'transitional simplified procedures' for goods arriving from the EU. The EU has said it will apply its rules to all imports from and all exports to the UK.

2   UK Government notices can be found at https://www.gov.uk/government/collections/how-to-prepare-if-the-uk-leaves-the-eu-with-no-deal; The Welsh Government's advice and information can be found at https://beta.gov.wales/preparing-wales; The EU's December 2018 contingency notice is at https://ec.europa.eu/info/publications/communication-19-december-2018-preparing-withdrawal-united-kingdom-european-union-30-march-2019-implementing-commissions-contingency-action-plan_en

Box 2: caveats on the remit, scope and evidence used to underpin my work

- **Remit:** My work has covered the devolved bodies. Many of the key implications of Brexit relate to non-devolved issues, such as immigration, customs and border control. I have looked at how Welsh public bodies are engaging with UK authorities, but it is not my role to comment on the effectiveness of UK Government arrangements. The National Audit Office has produced several reports on UK Government Departments' preparations for Brexit[3]. The latest of these reports have shown that in some areas that impact Wales, there are likely to be significant challenges in a no-deal scenario. In particular, the National Audit Office's (NAO) October 2018 report on the UK border found that 'If there is no withdrawal agreement, the government has recognised that the border will be 'less than optimal'. [The NAO agrees] with this assessment, and it may take some time for a fully functioning border to be put in place. Individuals and businesses will feel the impact of a sub-optimal border to varying degrees. The government is putting in place coping responses where it can. How effective they will be remains to be seen.'[4]

- **Scope:** Brexit is extremely complex and there remain unknown potential consequences. My work has taken a high-level overview of whether Welsh public bodies have arrangements in place to identify and manage the implications, risks and opportunities. I have not examined in depth or tested the quality and effectiveness of those arrangements nor whether they are likely to work in practice. It would be impractical to carry out such in depth work across all public bodies and all potential areas of risk and opportunity in a reasonable timeframe.

- **Evidence:** Much of the evidence on which I have based my findings was gathered in November and December 2018. The quality of the evidence provided is variable, and some bodies provided only limited detail. I am conscious that events are moving fast, and that further work is being done as planning for a 'no-deal' Brexit gets accelerated. More detail on the methods used in this work is in Appendix 3.

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3   https://www.nao.org.uk/search/pi_area/exiting-the-eu/type/report
4   National Audit Office, **The UK border: preparedness for EU exit**, (October 2018)

My overall view and key messages:

6   Overall, most public bodies across Wales are clearly taking their 'no-deal' Brexit planning seriously. Many have significantly ramped up their activity since summer 2018, when a 'no-deal' outcome started looking more possible. The Welsh Government has taken a clear lead in planning for a no-deal Brexit, working with the UK Government. However, the picture varies across the Welsh public sector. Some bodies have done a lot of preparation. Others reported that continuing uncertainty meant they had made only limited preparations so far. There are still major challenges and uncertainties that all Welsh public bodies are grappling with. Many bodies are struggling to find the dedicated capacity to plan for Brexit and are undertaking work on top of the day job. The Welsh Government and many public bodies have been clear that it is not possible to fully mitigate the impacts of a 'no-deal' Brexit, especially on the Welsh economy. There is still some considerable way to go to turn the planning into reality, to finalise plans, test arrangements and to make sure that they are resilient. As 'no-deal' planning accelerates and contingency plans start to be activated in the coming weeks, I have set out some key messages for public services across Wales (Figure 1).

Figure 1: Auditor General's key messages for Welsh public services

Uncertainty cannot be an excuse for inaction, and audit must not be viewed as a barrier to effective planning for Brexit

- **I will not criticise reasonable 'no-deal' Brexit expenditure as wasteful:** It appears there are some concerns that I would give Welsh public bodies a hard time for spending money and time planning for a 'no-deal' Brexit. There is a view that, because the outcome is unclear, and some spending may turn out not to have been required if the 'no-deal' scenario does not materialise, I will criticise that as waste.

  At the end of January 2019, I wrote to all Chief Executives of public bodies, to say clearly that I will not criticise anybody for taking reasonable steps to prepare for and mitigate Brexit related risks. Brexit poses some unprecedented challenges, and opportunities, that must be planned for. As long as a 'no-deal' Brexit remains a possibility, acting to manage potentially significant implications before it becomes too late is not a waste of money.

Further strengthen and deepen the 'one public service' approach to preparations

- **Plan together:** One of the positive things I have seen and heard is that Brexit planning has spurred organisations to work across silos and there are many good examples of public services working together to understand and plan for a 'no-deal' Brexit. Nonetheless, there remains scope for greater collaboration in developing and delivering plans to manage common issues and risks. With weeks to go to a possible 'no-deal' Brexit, the Welsh Government has a key role in increasing the frequency with which various national forums meet to ensure a consistent and coherent pan-public service response.

- **Share capacity and resources:** Brexit is taking place against the context of an extended period of financial austerity in public services. Many bodies are concerned that they lack the staff and expertise required to plan effectively for, and manage the consequences of, Brexit. In my view, there is scope to share better the capacity and expertise that does exist, both within and between the different sectors in our public service and in partnership with the private and third sectors. Public bodies should also look to the available transition funding to build a shared pool of staff, to help fill the capacity gaps that exist and to work across bodies and sectors.

- **Test plans and learn together:** The UK Government has stated that a 'no-deal' Brexit could create disruption over a six-week period or even longer. Existing civil contingency arrangements are robust but are generally used for short-term emergencies such as extreme weather, and for large one-off events such as the NATO summit in Newport. To the greatest extent possible, I would like to see public bodies build on existing collaborative work to help ensure the continued resilience of national and local contingency plans against longer time-frames. Welsh public bodies should also build on their contacts with other parts of the UK to exchange lessons from planning and testing across the UK.

Strengthen civic leadership on preparations for a 'no-deal' Brexit

- **Strengthen scrutiny:** The evidence we received suggests that cabinets, scrutiny committees and boards now need to ramp up their own activity in providing independent and democratic oversight and scrutiny of Brexit planning and action. Across the majority of Welsh public bodies, and with the exception of the Welsh Government itself, Brexit preparations have been led by executive teams with limited non-executive input or challenge.

- **Communicate and engage openly and clearly with the public.** Public bodies across Wales have generally been waiting to engage with the public until they have greater certainty on the outcome of Brexit. However, with the date getting close, it is vital that public bodies start having conversations with the public and key stakeholders, to help avoid unnecessary panic and disruption. Many people are naturally worried about stories about shortages of certain goods. Small changes in individual behaviour such as stockpiling medicines, fuel and food can have significant consequences at a population level. Many EU citizens living and working in Wales will also want to know what will happen to them.

  It is crucial that public bodies have a clear, measured and consistent story to tell the public about the potential impacts of a 'no-deal' Brexit, and the plans that are being made. The Welsh Government's online 'Preparing Wales' site provides a helpful starting place and it is now important that all public bodies help to spread those messages to the public and communities that they work with and are available to deal with the public's queries about what will happen.

Key findings

7   **Public bodies are developing new structures for managing the consequences of Brexit alongside long-standing arrangements.** There are a range of national and regional committees and working groups to deal with specific aspects of Brexit, some of which have been specially created. There are tried and tested national and regional arrangements for civil emergencies and contingency planning. These forums are leading planning for some elements of a 'no-deal' Brexit. However, individual bodies' arrangements vary considerably (Figure 2). In most public bodies, Brexit preparations are largely led by officers. There is a risk of a gap in civic leadership if there is not clear ownership and scrutiny of plans by elected councillors and independent members of boards. The Welsh Government has taken positive steps to engage public service leaders through the Partnership Council, which held a special meeting on Brexit in January 2019. As contingency plans become firmer and we move closer to implementation, I would like to see a further strengthening of scrutiny by councillors in local government and by independent members of boards across NHS Wales and the central government bodies.

Figure 2: arrangements for responding to Brexit across devolved Welsh public services

- **Pan public sector arrangements**

  There are separate pan-public sector arrangements for civil contingencies and for what the Welsh Government calls the 'new normal' of a different set of post-Brexit rules and systems.

  The **Wales Resilience Group** chaired by the First Minister, provides national leadership on civil contingency. It has two sub-groups. The **Wales Resilience Forum** brings together all the emergency services. The **Wales Risk Group** brings together Public Health Wales, the four chairs of the Local Resilience Forums (see description below) and the Welsh Government.

  There are several forums on Brexit that involve different parts of the public sector. There include the European Advisory Group, Council for Economic Development; Environment and Rural Affairs Brexit roundtable and a very recently set up Local Government (EU) Preparedness Advisory Panel.

  Existing groups are also being used to discuss plans for Brexit, including the Partnership Council, which brings together political leaders from local government and leaders in other public bodies and the third sector, the Workforce Partnership Council, Faith Forum and the Third Sector Partnership Council.

  Welsh Government policy divisions have a range of national forums through which they co-ordinate pan-public service action and engagement with other stakeholders to prepare for Brexit in specific policy areas.

  The Welsh Local Government Association and the Welsh NHS Confederation both also have arrangements for bringing together bodies within their sectors to share information on planning for Brexit.
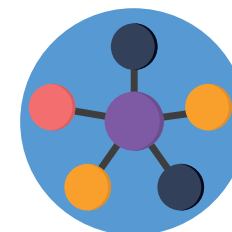
- **Internal Welsh Government arrangements**

  The Welsh Government has a governance framework for Brexit preparedness work (see diagram in Appendix 2).

  A Cabinet Sub-Committee on European Transition provides political direction.

  The European Transition Officials Group brings together policy leads from across the Welsh Government. The Group has six cross-cutting sub-groups. These cover funding, frameworks, economy, preparedness, communications and legislation.

  There are also dedicated Brexit teams in each policy area working on preparations for Brexit, who are liaising with their counterparts around the UK. The European Transition Team organises the overall programme of Brexit work. It checks that work in Wales links to UK wide work, and that progress is being made in line with key milestones.
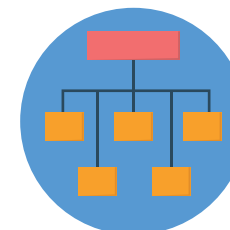
- **Regional arrangements**

  In their responses, most bodies referred to Brexit civil contingencies preparations taking place through the Local Resilience Forums. These regional bodies have statutory responsibilities under the Civil Contingencies Act 2004. They comprise representatives from devolved bodies and non-devolved services, including the local authorities in the area, Police, Fire, NHS bodies, the armed forces and representatives of national bodies such as Natural Resources Wales and the Welsh Government.

- **Local arrangements within individual bodies**

  The arrangements that individual bodies have put in place vary considerably both within and between different sectors. Some have detailed organisation-wide structures, but some simply had a notional lead official. Appendix 1 sets out the arrangements in different sectors in more detail.

8   **Public services report a lack of capacity to manage Brexit, which is also having a significant knock-on impact on other service areas.** Work to prepare for Brexit needs to be understood in the context of a decade of tight financial settlements and a shrinking public sector workforce. The Welsh Government has created 198 additional new staff roles on fixed-term contracts to work on Brexit. However, in many cases, rather than bring in new people, it is moving existing staff from their normal duties to take up Brexit roles and some of the new recruits will cover vacancies created by people moving to work on priority Brexit roles. Officials report that there are gaps in the delivery of non-Brexit related work. Across the wider public service, very few bodies have taken on new staff to prepare for Brexit. Most are absorbing Brexit preparations within, or on top of, their day jobs. Local government is concerned that sustained financial pressures over the last decade have made councils much more focussed on simply sustaining service delivery. As a result, there are now far fewer staff members who still possess the cross-cutting policy and planning expertise that is needed to prepare for Brexit. In the NHS, my wider audit work has identified ongoing concerns about management capacity in relation to transforming services. This same cadre of management staff is being called on to prepare for and manage the implications of a 'no-deal' Brexit. Most bodies reported to us that their work on Brexit was having an adverse impact on other areas, although they did not quantify or spell out the exact nature of those consequences.

9   **All bodies have identified the risks and some opportunities of Brexit, but the extent to which they have plans to mitigate those risks varies.** All public bodies have done some work to understand the implications of a 'no-deal' Brexit, especially the risks. The Welsh Government is taking a lead role in identifying and managing national and strategic risks, working with colleagues in the UK Government and the other devolved administrations. While at times, the Welsh Government has found it difficult to get complete or timely information from some UK Government departments, we were told that those working relationships have improved over recent months. The Welsh Government has a detailed programme of work to address the implications of a 'no-deal' Brexit, which links to UK-wide planning. For those projects where it is leading on preparations, the Welsh Government appears to be largely on track against its milestones. The Welsh Government also oversees the use of its EU Transition Fund (Box 3) for a varied range of projects and programmes aimed at helping to prepare Wales for Brexit. The Welsh Local Government Association reported that since we carried out our fieldwork, it has bid into the EU Transition Fund for additional capacity to support corporate co-ordination of Brexit planning across local government. Also, service areas such as social care and environmental health, where there are specific risks, are in the process of preparing bids for additional funding for preparation work.

Box 3: the EU Transition Fund

In January 2018, the Welsh Government announced a £50 million EU Transition Fund. The fund is intended to help businesses, public services and the third sector to prepare for Brexit, in line with the priorities identified in the Welsh Government's key policy paper on Brexit: 'Securing Wales' Future'.

The Fund focuses on those Brexit-related matters that sit within devolved powers, works alongside existing methods of Welsh Government financial support, and is intended to be available through the transition period to December 2020. The Welsh Government has adopted a flexible approach in considering applications for funding, using broad criteria that can cover a wider range of potential projects.

To date the Welsh Government has allocated approximately half of the £50 million fund across a wide range of proposals. More proposals are currently being developed with potential recipients. Funding approved to date has included the following areas:

- £7.5 million to fund a Business Resilience scheme to aid business in Wales to adapt to a post Brexit business environment;
- £6.0 million for training and up-skilling the workforce in Wales' automotive and aero-industry sectors;
- £5.0 million to support farming, food and fishing sectors post-Brexit;
- £3.5 million support for Welsh Universities to drive international partnerships and promote Wales as a study destination;
- £0.35 million to partner with the Organisation for Economic Co-operation and Development (OECD) to inform the future regional investment approach;
- £0.20 million for research work on likely impacts and implications for the social care workforce;
- £0.21 million to help prepare the health service in Wales for Brexit, including £150,000 for the Welsh NHS Confederation to lead on engagement and communication and £60,000 to Public Health Wales NHS Trust to work on health security;
- £0.15 million for the Welsh Local Government Association to support local authorities with plans and preparedness for Brexit;
- £0.15 million to support the Welsh Council for Voluntary Action to consider how Brexit will impact on community services in Wales.

10   Across NHS Wales, individual organisations have been helped in understanding their exposure to risks and possible opportunities by work by Public Health Wales and through work on supply chains related to medical devices and clinical consumables carried out by Deloitte. The NHS is putting place detailed plans, working with UK partners, to manage those risks it has identified.

11   In local government, many councils have been using a guide that the Welsh Local Government Association commissioned Grant Thornton to produce. Based on their self-assessments, only a minority of councils had clear plans to deal with the risks they have identified. Some bodies were delaying work until there is greater certainty.

12   My overall summaries of the different sectors based on the evidence they supplied are set out in Appendix 1. However, I recognise that many bodies were in the process of accelerating their plans as they completed their self-assessments before Christmas and I would expect that many of those bodies will now be developing clearer and more detailed action plans. Figure 3 sets out the key issues that public bodies have identified. I have not tested whether the plans to address those issues are likely to mitigate the risks in a 'no deal' scenario.

Figure 3: key issues that public bodies have identified

- **Ports:** There are concerns over the impact Brexit could have on Welsh ports due to additional customs and regulatory checks. The key policy areas around ports – such as customs, border control, new ICT systems and immigration – are not devolved. The Welsh Government is working with the UK Government, through the Wales Ports and Airport Border Planning Steering Group, and the relevant local authorities to plan for possible traffic disruption if there is a 'no-deal' Brexit.

- The Welsh Government considers Holyhead in Anglesey to be of higher risk than other ports as it is the busiest port in Wales and has less flexibility than the ports in West Wales to manage queues of lorries in the immediate vicinity of the port. The Welsh Government and Isle of Anglesey County Council are developing contingency plans, including plans for 'holding' lorries facing delays, in the event of a 'no-deal'. As well as the extra checks, the Welsh Government and local authorities are also seeking to address broader concerns relating to the wider impact on the local area and economy around the ports, due to the important role they play in providing employment.

- The National Assembly's External Affairs and Additional Legislation Committee reported[5] in November 2018 on preparedness for Brexit in ports and the Welsh Government responded[6] in January 2019 to the Committee's recommendations.

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5   External Affairs and Additional Legislation Committee, **Preparing for Brexit – follow-up report on the preparedness of Welsh ports**, November 2018

6   Welsh Government, **Written Response by the Welsh Government to the report of the External Affairs Committee entitled Preparing for Brexit: Follow-up report on the preparedness of Welsh Ports**, January 2019

- **Medical and consumables supply chains:** There has been much speculation about the availability of medicines, in the event of disruption to supply chains at ports and airports. The Welsh Government's Health and Social Services Group has been working with their counterparts across the UK. The UK Government is leading on work with the pharmaceutical industry to develop contingency plans to create a 'buffer' supply of medicines. The Welsh Government advises that individual NHS bodies, care homes and the public should not stockpile medicines and other medical supplies themselves.

- The Welsh Government and NHS bodies are taking a lead in developing plans to ensure continued supply of consumables and equipment. NHS bodies worked with Deloitte to look at potential risks to supply chains in Wales. The action to manage these risks includes procuring additional warehouse capacity to stockpile supplies.

- The NHS in Wales is also working with the rest of the UK to develop contingency plans for other medicines and supplies, such as radioactive isotopes, with a short life-span where stock-piling may not be a solution. The Welsh Government is working with the UK Government on contingency plans, which potentially include extra capacity to fly such medicines and supplies in the event of a 'no-deal' Brexit.

- Some NHS bodies told us that the process of reviewing supply chains had positive benefits beyond mitigating risks, as they were now much more aware of wider opportunities to make their supply chains more efficient and effective.

- **Food supply chains:** The UK Government has recognised that there may be disruption to supplies of some perishable foods in a "no-deal' Brexit scenario. Many food producers and retailers are stockpiling refrigerated goods. However, some imported fresh food with a very short shelf life could get caught up in delays at the UK's ports and airports.

- Several bodies highlighted to us risks of disrupted food supplies to hospitals, schools, care homes and for meals on wheels. At the time of drafting, planning for potential food shortages was accelerating: some individual bodies were reviewing their food supply chains and developing individual plans and there was some early thinking being done on pan-public service approaches.
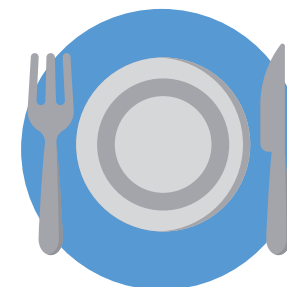
- **Workforce:** There are around 48,400 EU nationals working in Wales (around 3.6% of the workforce). Welsh Government figures show EU nationals make up around 2% of the public sector workforce. That figure varies across different public services. For example, around 7% of medical and dental staff are EU nationals. Most bodies have tried to assess the number of EU staff they employ, although many found it difficult as they do not record the nationality of all staff.

- There are also concerns, particularly among NHS bodies, about whether there will be mutual recognition of qualifications after Brexit and uncertainty about the impacts of future migration policy on recruitment and retention in areas where there are staff shortages.

- In general, public bodies told us that they thought the workforce risks were more medium to long-term and that the risk of staff suddenly leaving in March 2019 was limited. Nonetheless, most said they would keep a watching brief and were seeking to reassure their EU staff.

- There were specific concerns expressed to us about some parts of the health and social care sector, which are particularly dependent on EU workers. Social Care Wales has commissioned an in-depth review of the EU social care workforce, using £0.2 million from the Welsh Government European Transition Fund. The review is due to report in March 2019.

- NHS Wales Shared Services Partnership are considering whether there is any significant variation in the levels of non-UK EU nationals employed through agencies.

- **Financial risks:** Many bodies identified concerns around the nature and financial value of any replacement for European Union funding. Our 2018 reports on the Structural Funds[7] and the Rural Development Programme[8] set out the key issues and show that planning for a 'no-deal' scenario has been in place for some time.

- The UK Government has guaranteed to cover Wales' allocation of EU Funds under the current round of funding, in the event of a 'no-deal' Brexit. There remains uncertainty over what will replace EU funds over the longer-term. The Welsh Government and Welsh European Funding Office are doing a lot of work to prepare for whatever new schemes are agreed.

- Several bodies also identified key risks around the wider fiscal impacts of a 'no-deal' Brexit, if there is a hit to the economy and a consequent squeeze on public finances. Some also highlighted the risk of increased costs of some supplies, due to changes in the exchange rates and any additional customs duties.

- **Legislation:** One of the key challenges for the Welsh Government and National Assembly for Wales is the volume of legislative work required to prepare for Brexit. Many of the laws and regulations that the Welsh Government applies are based on EU laws or refer to the European Union. These laws will need to be amended ahead of Brexit. By early February 2019, 29 Statutory Instruments related to Brexit have been laid for sifting in the National Assembly for Wales. The Welsh Government has hired new staff to deal with Brexit related legislation. The National Assembly for Wales has reprioritised existing staff to work on Brexit and is continuing to closely monitor its capacity to manage the increased legislative workload resulting from Brexit.

- **Agricultural exports:** Some rural authorities and national parks raised immediate concerns about the potential loss of the EU market for lambs that will be born in spring, around the time of Brexit. The Welsh Government is analysing the impacts of a 'no-deal' Brexit on the red meat industry, is developing contingency plans and has provided £2.15 million of funding to support the Welsh red meat sector. Some councils are also concerned about the wider implications on the local economy and demand for services if farmers face economic difficulties.

7   Wales Audit Office, **Managing the Impact of Brexit on EU Structural Funds,** August 2018

8   Wales Audit Office, **Managing the Impact of Brexit on the Rural Development Programme in Wales,** November 2018

- **Economic impacts:** One of the key concerns that has been identified by the Welsh Government and some bodies is the wider economic impact of a 'no-deal' Brexit on Wales. The Welsh Government has been clear that the negative economic impacts cannot simply be managed away. The Welsh Government provided £7.5 million of funding through the European Transition Fund to set-up the Business Resilience Fund, aimed at assisting businesses to prepare for a different trading relationship after Brexit. From this fund, Business Wales have been assigned £1 million to provide emergency financial support to small and medium-sized businesses in Wales. One local authority told us it had been working with local businesses to understand how they can work with them to manage the risks and exploit any opportunities from Brexit.

- **Wider well-being:** Some public bodies provided evidence about wider risks to well-being.

- Public Health Wales has carried out a Health Impact Assessment analysis which assesses Brexit from a Welsh perspective using the public health lens of the social determinants of health and population health and detailed work looking at the potential health and wider well-being implications of Brexit, identifying a range of potential negative impacts as well as opportunities[9].

- A few local authorities also raised concerns about community cohesion and tensions. The Welsh Government has approved £2 million of additional funding from the Community Facilities Programme to develop community facilities that improve community cohesion.

9   Public Health Wales, **The Public Health Implications of Brexit in Wales: A Health Impact Assessment Approach**, January 2019

Appendix 1 – Sector based summaries

Local government

1.   Councils are looking to the Welsh Government and the Welsh Local Government Association (WLGA), for centralised support in preparing for Brexit. The WLGA has received £150,000 funding from the Welsh Government's European Transition Fund to deliver a Brexit Transition Support Programme for Welsh local authorities and has produced briefings and guidance, including guidance to support scrutiny committees. The WLGA has been working with counterparts across the UK to share intelligence on Brexit. Councils have been liaising with the WLGA and the Welsh Government, responding to consultations, attending events and using the WLGA toolkit. However, formal collaboration and sharing of resources between councils has been limited.

2.   The structures and processes in place and amount of preparation varies greatly across the sector. While senior leadership teams have general oversight for the preparing for Brexit, very few have dedicated Brexit officers or resources, with work instead being undertaken on top of the day job. Specific and detailed political scrutiny of Brexit preparedness has generally been limited. Brexit features on risk registers considered by Audit Committees, but the detail is varied: some councils have separate Brexit issue logs whilst others have little detail beyond listing Brexit as a risk.

3.   Councils have identified a range of risks but few opportunities. The issues that councils raised generally match those in the main report (Figure 3). However, many councils emphasised that the prolonged period of tight funding settlements made it much more difficult to prepare for the risks they had identified.

4.   In general, the Brexit implications that councils identified are short term in nature, although some had considered longer term economic and social impacts. Only a minority of bodies had clear plans in place to mitigate the impacts of Brexit that they identified. Some bodies have expressed the view that preparedness work has been deliberately limited due to the uncertainty surrounding the outcome of Brexit. Some councils have adopted a watch and wait approach, although the pace of preparedness is increasing. The Welsh Local Government Association told us that those authorities that were taking a watch and wait approach have more recently started to take action to progress their planning for a 'no-deal' Brexit.

5.   Councils identified the importance of providing consistent outward facing messages concerning Brexit to external stakeholders, and the risk of providing inaccurate information. However, communication to external stakeholders has been limited to date, partly because of the uncertainties surrounding Brexit and the risk of providing inaccurate information. However, communication is now increasing as Brexit nears, and some councils have dedicated Brexit sections on their websites.

NHS bodies

6.   At a European and UK level NHS bodies are represented by the Welsh Government and the Welsh NHS Confederation who participate in various forums that discuss and plan for Brexit. The Welsh Government is working particularly closely with the UK Government on areas, such as medical supplies that have implications for the whole UK.

7.   Information from these forums is disseminated to the Health Boards via several Welsh Government led groups, Public Health Wales and Welsh NHS Confederation updates. The Welsh Government's Health and Social Services EU Transition Leadership Group oversees the work of five all-Wales groups covering: supply chain resilience; health security; the NHS Senior Responsible Officers (the leads on Brexit from each NHS body); communications; and civil contingency planning. The supply chain group has been supplemented by health board specific groups who have been tasked with identifying and liaising with local suppliers. In addition to the sector specific groups, NHS bodies take part in forums that bring together all public services; these include the Local Resilience Forum, Regional Partnership Boards and the Public Service Boards.

8.   At local level, each health body has recognised and discussed Brexit within its Executive Team and Board meetings. Some bodies are liaising with their counterparts to continue research and development links. The level of resource inputted varies, with some health bodies setting up Brexit specific task and finish groups. One body [Public Health Wales] will be in receipt of EU transition funding, and therefore have a Brexit specific post. Health bodies rely on their internal governance processes to monitor and scrutinise their arrangements.

9.   NHS bodies have identified a range of risks and some opportunities. Some of these are described in the main report, notably medical supplies, food supplies, workforce and wider well-being. Other key issues include:

   i.   research and development: Clinical research, including clinical trials, and innovation are key components of health and social care activity across the UK and healthcare organisations have a long tradition of EU collaborative research.

   ii.   reciprocal healthcare: at present all EU nationals have the right to access healthcare treatment in any of the 28 EU countries. Once the UK leaves the European Union, these reciprocal rights will come to an end, unless both the UK and the EU agree to continue or replace them.

10. NHS bodies are working with some key stakeholders, including other public bodies and those involved in their supply chains. There has been limited engagement with the wider public. Public Health Wales has put information about Brexit on its website. The Welsh NHS Confederation website has a set of Frequently Asked Questions and provides links to the technical notices. But at the time of submitting their evidence, NHS bodies had not pro-actively engaged with the public. At the time of drafting, the Welsh Government was developing a communications plan for sharing messages across the NHS and social care both in respect of messages for professionals and the wider public.

11. NHS bodies report that they face practical challenges in preparing for Brexit. Many reported that ongoing political uncertainty about the final form of Brexit was a challenge, as there are different implications in the different possible scenarios. Many NHS bodies are also concerned that preparing for Brexit is putting pressure on already limited resources, given that most of the staff are undertaking Brexit work on top of the day job.

Welsh Government Sponsored Bodies and associated organisations

12. The range of bodies within this group are diverse and the extent to which Brexit is likely to impact them varies significantly. The extent to which bodies have started to respond to, and prepare for, Brexit is largely dependent upon these expectations.

13. Most bodies are looking to Welsh Government for leadership, although many are collaborating with each other and looking wider for guidance and support; for example, there is evidence of collaboration with sister organisations across the UK.

14. All bodies have done some work to identify the implications of Brexit, both on their own functions, and for the wider sectors they operate in. Some have gone further and begun to take mitigating actions against significant risks, including through use of the Welsh Government's EU Transition Fund.

15. Some implications specific to individual bodies have been identified, and many expressed common concerns about the availability of future funding and the wider economic impact Brexit might have. Problems envisaged include the uncertainty about what Brexit will look like, which is making preparing difficult. Capacity constraints which might hinder the ability to respond quickly to challenges following Brexit is also a concern for many.

Fire and Rescue Services

16.   Authorities have carried out an analysis of the key risks of a no-deal Brexit in conjunction with the National Fire Chiefs Council. This has highlighted some common risks around the supply of specialist equipment from the EU and increased pressures that might result from delays at ports or the need to assist police, among others.

17.   Each of the Services will be affected differently, but all have contingency plans in place and are working as part of the Local Resilience Forums to prepare appropriately.

National Park Authorities

18.   Authorities are engaging with Welsh Government Brexit groups and working with each other to identify the implications of Brexit. All authorities see the loss of EU regulation around agriculture and the environment as likely to have an impact, although there is recognition of the opportunity for the Welsh Government to design bespoke replacement policies and programmes to provide most benefit to Wales.

19.   Authorities are concerned about the impact that a reduction in tourism and changes to trade tariffs might have on their ability to raise income after Brexit. They also see the uncertainty and lack of financial resilience as problematic in determining the best action to take to fully prepare for Brexit, and then in responding to the challenges as they become known.

Appendix 2 – Pan public-sector and Welsh Government arrangements

Pan public-sector and Welsh Government arrangements[10]

European Transition Governance Structure

Internal

- PSG
- EPS
- ESNR
- H&SS
- OFM

External
includes

- European Advisory Group
- Council for Economic Development
- ERA Brexit Roundtable
- Health Ministerial Stakeholder Reference Group
- Local Government (EU) Preparedness Advisory Panel

Cabinet

↑

Cabinet Sub-Committee on European Transition

↑

European Transition Officials Group (ETOG)

↑

ETOG Sub-Groups

- Economy
- Frameworks
- Funding
- Preparedness
- Comms
- Legislation Board

Secretariat

10   In addition to the structures outlined, the Executive Committee of the Welsh Government meets regularly to focus on EU exit preparedness issues, and EU exit is also a standing item at the Welsh Government Board meetings.

Cabinet Sub-Committee on EU Transition (CSC-EU) – provides strategic direction for Welsh Government's work aimed at securing the best possible outcome for the people of Wales on issues arising from Brexit.

European Transition Officials Group (ETOG) – established to develop and implement a coordinated response to Brexit by bringing together policy leads from across Welsh Government departments.

European Transition Team (ETT) – responsible for leading on the co-ordination of the Welsh Government's Brexit position to ensure consistency of approach.

ETOG Sub-Groups;

Economy – going forward the sub-group will focus on coordinating Welsh Government involvement in negotiations on the Future Economic Partnership.

Frameworks – sub-group oversees the process of agreeing UK-wide frameworks by engaging with Welsh Government policy leads to ensure a cohesive approach to the development of new frameworks.

Funding – sub-group works to coordinate and advise the CSC-EU through the Cabinet Secretary for Finance on the allocation of funding from the EU Transition Fund.

Preparedness – sub-group works to ensure Welsh Government departments are as prepared as possible for the practical implications of Brexit.

Comms – sub-group considers Welsh Government Brexit communications and headline messages.

Legislation Board – sub-group supports and advises Welsh Government departments on their delivery plans for legislative changes as a result of Brexit.

External groups engaging with Welsh Government:

European Advisory Group – advises the Welsh Government on challenges and opportunities for Wales arising from Brexit.

Council for Economic Development – brings together representatives from businesses, social enterprises and trade unions to provide advice to inform Welsh Government on policies affecting the economy. The Council has a sub-group – the EU Exit Working Group – which includes a wide range of stakeholder from the business, voluntary and public sectors.

Environment and Rural Affairs (ERA) Brexit Roundtable – comprising of stakeholders from across the sector, the group aims to influence policy and programmes relating to Brexit via discussions with Welsh Government, DEFRA and other UK government departments.

Health Ministerial Stakeholder Reference Group – involves key health and social care stakeholders through the main representative bodies: Welsh NHS Confederation, WLGA, Association of Directors of Social Services Cymru and Social Care Wales alongside specific groups and organisations such as Public Health Wales, the Royal College of Nurses, the Association of the British Pharmaceutical Industry (ABPI) Cymru Wales, and NHS Chairs and Chief Executives.

Local Government (EU) Preparedness Advisory Panel – recently established to coordinate Brexit preparedness work within local government, encourage the sharing of resources and oversee the implementation of the WLGA led Brexit Transition Support Programme.

Internal operational groups within Welsh Government:

PSG – Permanent Secretary's Group

EPS – Education and Public Services

ESNR – Economy, Skills and Natural Resources

H&SS – Health and Social Services

OFM – Office of the First Minister

Appendix 3 – Audit Methods

Self-assessment and call for evidence

We requested that all the main devolved public sector bodies complete a self-assessment and call for evidence. The self-assessment and call for evidence contained questions relating to Brexit preparedness. Questions included the bodies' arrangements for the identification and management of Brexit, focusing on implications, challenges, monitoring, collaboration and communication. We also requested that the bodies provide any relevant documents to support their responses.

The number of bodies that we issued with a call for evidence and self-assessment, and the number returned completed is set out below. We also received comments from the Welsh Language Commissioner, Future Generations Commissioner, Public Services Ombudsman, Children's Commissioner, and Older People's Commissioner.

Sector	Number of bodies issues with the call for evidence and self-assessment	Number of responses	Percentage response rate
Local Authorities	22	22	100%
Fire and Rescue Authorities	3	3	100%
National Park Authorities	3	3	100%
Health	11	11	100%
Welsh Government Sponsored Bodies (WGSBs) and wholly owned companies	13	13	100%

Document reviews

We reviewed a range of documents including:

- Information provided to us to support the call for evidence and self-assessments

- Local and national risk assessments and briefing papers

- Welsh Government guidance and policy documents on Brexit

- Welsh Local Government Association and Welsh NHS Confederation guidance

- UK Government guidance, including the various 'no deal' advice notices

- EU documents and guidance on Brexit planning

- Evidence submitted to Assembly Committee enquiries and Assembly Committee reports

Interviews

We carried out interviews with the central Welsh Government Brexit team, Welsh Government policy leads, National Assembly for Wales officials, the Welsh Local Government Association, and the Welsh NHS Confederation.

Audit Committee **14.3.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Wales Audit Office Structured Assessment 2018
Report Author:	Wales Audit Office
Responsible Director:	Grace Lewis-Parry ~ Board Secretary
Public or In Committee	Public
Purpose of Report:	The Board considered the Structured Assessment from the Wales Audit Office (attached as Appendix 1) and the associated management response at its meeting on 24.1.19. At that meeting Members had noted that the report contained a single recommendation which was for the Board to fully complete previous outstanding recommendations made by the WAO in 2016/2017. Some of the WAO's previous recommendations had been closed for the purposes of the audit tracker tool, as they were now being measured and monitored as part of embedded standard business processes. Discussion ensued covering mental health, concerns management, estates, the need for appropriate infrastructure to be in place for the transformational journey and the importance of getting governance right in terms of ensuring changes were made in response to WAO recommendations. The Board resolved to receive the report, accept the recommendations in the Structured Assessment, and also receive and approve the management response to the Structured Assessment - noting that actions recorded as closed would, where appropriate, be included in the relevant plans such as the Three Year Plan, Annual Operational Plan, and workforce or quality strategy and plans. Wales Audit office will seek to gain assurance that this has happened and review progress against outstanding recommendations in April 2019. An updated version of the management response is now attached as Appendix 2. This version has an additional column which provides a position update regarding future monitoring arrangements.
Approval / Scrutiny Route Prior to Presentation:	The report had previously been reviewed and considered by the Executive Team as well as the full Board at its workshop in November 2018.
Governance issues / risks:	The overall conclusion from Wales Audit Office for the 2018 Structured Assessment work is that the Health Board had strengthened its governance arrangements and the arrangements for strategic planning

	were developing. However, the Health Board needed to focus on the key strategic goals to overcome the significant challenges it faced.
Financial Implications:	n/a
Recommendation:	The Committee are asked to receive the report together with the updated management response which provides a position update regarding future monitoring arrangements.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	WFGA Sustainable Development Principle *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	**x**
2.To target our resources to those with the greatest needs and reduce inequalities	**x**	2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences	**x**		
Special Measures Improvement Framework Theme/Expectation addressed by this paper *Leadership and Governance*			
Equality Impact Assessment *n/a*			

Board/Committee Coversheet v10.0

Structured Assessment 2018 – **Betsi Cadwaladr University Health Board**

Contents

While the Health Board is strengthening its governance and management arrangements, it continues to struggle to develop financially sustainable medium-term plans and improve priority areas of performance

Structured assessment

About this report

1   This report sets out the findings from the Auditor General's 2018 structured assessment work at Betsi Cadwaladr University Health Board (the Health Board). The work has been undertaken to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

2   Our 2018 structured assessment work has included interviews with officers and Independent Members, observations at board and committee meetings and reviews of relevant documents, performance and financial data. We also conducted a survey of board members across all health boards and NHS trusts. Eight of the 22 board members invited to take part at the Health Board responded. As the survey response rate is limited, we have used the results alongside our interviews and observations to inform our evaluation, rather than report findings based solely on survey responses.

3   This year's structured assessment work follows similar themes to previous years' work, although we have broadened the scope to include commentary on arrangements relating to procurement, asset management and improving efficiency and productivity. The report groups our findings under three themes – the Health Board's governance arrangements, its approach to strategic planning and the wider arrangements that support the efficient, effective and economical use of resources. The report concludes with our recommendations.

4   Appendix 1 summarises the action that has been taken to address previous year's structured assessment recommendations.

Background

5   The Health Board is currently in special measures under the NHS Wales Escalation and Intervention Framework. As part of the special measures arrangements, the Health Board is expected to secure improvements in the areas of leadership and governance, strategic and service planning, mental health and primary care including out of hours services. This reflects ongoing challenges in a number of key areas including its ability to produce an approvable and financially balanced Integrated Medium-Term Plan (IMTP), fragility of primary care and mental health services, and concerns about specific aspects of its performance.

6   The Health Board reported a financial deficit of £38 million at the end of 2017-18. A growing year-on-year cumulative deficit stood at £88 million at the end of March 2018. The Health Board was not able to produce an IMTP that was approvable by Welsh Ministers in 2017-18 and is currently working to a one-year operational plan. The Health Board is failing to meet key targets set by the Welsh Government for time spent in A&E as well as referral-to-treatment targets, although the latter is improving. There is also a growing and significant backlog of follow-up outpatients. In contrast, we have seen some signs of improvement in relation to healthcare-associated infection rates and a strengthening focus on quality, which the Health Board will need to build upon.

7   The Health Board also received reports from HASCAS[1] (May 2018) and Ockenden[2] (July 2018) on the quality of care and governance arrangements for the Tawel Fan Mental Health Ward. The Health Board has recently established an Improvement Group to respond to the 15 recommendations in the HASCAS report and the 14 recommendations in the Ockenden Governance Review. We have not commented on the effectiveness of those groups in this report as they are in their early phases.

8   During the last 12 months, there has been some turnover at the Board level both in respect of executives and Independent Members. The previous Chair completed their term so there is a new Chair. The role of chief operating officer role was removed, and those responsibilities redistributed amongst the executive team. The Board has also reintroduced the post of Executive Director of Primary and Community Care, which should help to drive strategic improvements in this important area.

9   Our 2017 structured assessment acknowledged the Health Board was facing significant ongoing challenges in respect of its finances and performance. We also identified that the Health Board continued to evolve its corporate arrangements for governance, financial management, strategy development and workforce planning but those arrangements had not sufficiently enabled the Health Board to be where it needed to be with its finances and performance.

10   This report provides a commentary on key aspects of progress and issues arising since our last structured assessment review. This report should therefore be read with consideration to **our previous review**.

Main conclusion

11   Our main conclusion is **while the Health Board is strengthening its governance and management arrangements, it continues to struggle to develop financially sustainable medium-term plans and improve priority areas of performance**.

12   We describe several factors that contribute to the position on finances and performance throughout this report. The Health Board cannot improve its position significantly without making changes to key aspects of services; disinvesting in estate that is not fit for purpose or good value for public money and strengthening the way it works with partners to develop community and preventative services.

13   The findings which underpin our overall conclusion are considered in more detail in the following sections. The Health Board has made progress against previous recommendations, but in many areas, they still need further work to address in full. This is highlighted throughout the report and cross-referenced with a summary of overall progress against recommendations in Appendix 1.

[1] Link to the HASCAS report into the care and treatment on Tawel Fan ward:
http://www.wales.nhs.uk/sitesplus/861/document/324118

[2] Link to the Ockenden report on the governance arrangements relating to Tawel Fan:
http://www.wales.nhs.uk/sitesplus/861/page/75258

Governance

14   As in previous years, our structured assessment work has examined the Health Board's governance arrangements. We comment on the way in which the Board and its sub-committees conduct their business, and the extent to which organisational structures are supporting good governance and clear accountabilities. We also looked at the information that the Board and its committees receive to help it oversee and challenge performance and monitor the achievement of organisational objectives. We have drawn upon results from our survey of board members to help understand where things are working well, and where there is scope to strengthen arrangements.

15   We found that **the Health Board is strengthening its governance and management arrangements, but it needs to focus on the key strategic goals to overcome significant challenges**.

Conducting business effectively

16   We looked at how the Board organises itself to support the effective conduct of business. **We found the Health Board has good arrangements to support board and committee effectiveness, and shows recent signs of strengthened scrutiny, and is working to develop a strong focus on fewer but key priorities**.

17   Sound governance arrangements are fundamental to help provide strategic direction, challenge the effectiveness of delivery and ensure that corrective actions resolve issues where they arise. The Board and committees have a good 'cycle of business' approach that ensures key aspects are covered in the agenda. The administration of the Board meeting is generally good, and it is clear when decisions are made and there is recording of decisions. There is a good flow of assurance and risk between the committees and the Board. This includes a formal mechanism to escalate assurances, risks and issues, and sufficient time is routinely given at the Board to enable committee chairs to present matters arising.

18   The Board has agreed three strategic programmes: care for more serious health needs (acute services), care closer to home, and health inequalities and health improvement. While there is a good focus on acute services, and an improving focus on community care and aspects of primary care, it is not clear that reducing health inequalities and health improvement is yet an equal priority of the Board. Improving population health will be a significant factor in the long-term demand for healthcare. We identify later in this report that there are many objectives, aims, priorities and priority actions described in strategies and plans. The Board recognises the need to focus on a reduced number of fundamental priorities. The executive team has taken this forward with the wider Board and published these at the October Board.

19   The quality of board-level scrutiny has been quite variable during the year but has recently become more focussed and challenging both at the Board and across committees. Scrutiny and challenge in committees have generally been good and have improved over the last couple of months. However, we found that over the last 12 months, committees have not consistently challenged those responsible for delivery. Instead, challenge has focussed on corporate enablers such as central finance, central performance and central planning teams. We have now started to see committees take a firmer stance, call in those responsible for the delivery of finances, performance and operating plan actions,

and call those back in where they have not provided necessary assurance on progress. Over time, this should strengthen accountability for improvement.

20   There have been several changes to board membership over the last 12 months. We have seen strengthened challenge, accountability and improving focus to shape core priorities since the new Chair took up their role at the beginning of September. The changes to board membership have, however, left the board with no Independent Member with a specialty in finance. As a result, the Board is looking to supplement financial skills by commissioning bespoke support. This should help strengthen independent financial expertise. It should also help to support and challenge the financial sustainability of services for example.

21   We understand that new Independent Members have completed an initial induction and will shortly participate in the national induction programme. The Health Board recently issued an invitation to tender for a 2019 board development programme. The requirements of the proposed programme are clear, but a shortage of tenders resulted in the need to reassess options.

22   With the turnover of board members, the number of board member walkabouts and ward visits has reduced over the last six months. We have been told that this programme restarted in November to support new independent member orientation, but also, importantly, to listen to staff, observe services, understand pressures and consider quality of services.

23   We have previously challenged the intensive frequency of meetings. In September 2018, the Board agreed to reduce the frequency of board meetings and some of the committees' meetings. It has reviewed and changed the terms of reference for its Finance and Performance Committee (Recommendation 8, 2017), and has created an Information Governance and Informatics Committee. This should help balance the workload of the Finance and Performance Committee, and fewer meetings of the Board and some committees should provide the space to concentrate on delivering priorities and have greater impact.

Managing risks to achieving strategic priorities

24   We looked at the Board's approach to assuring itself that risks to achieving priorities are well managed. We found that **work is still ongoing to develop a board assurance framework and supporting risk management processes; this is now being helpfully supported by a comprehensive underpinning legislative assurance framework**.

25   The Health Board has continued to develop its board assurance map. This work has been ongoing for some time, although the Health Board is now more logically linking existing objectives to sources of assurance. At present, the way some of those objectives are described makes it difficult to identify the required assurance. In general, the Health Board has continued to make progress, but assurance mapping has been slowed by a lack of an approved IMTP with clear objectives (Recommendation 2, 2016). Underpinning the Board Assurance Framework, the Health Board has now created a Legislation Assurance Framework. This is a positive development and includes a comprehensive review of all primary and secondary legislative requirements (over 600 Acts and measures). The Health Board has determined the aspects which are relevant to each division and is seeking assurance in those aspects from the divisions.

26   In general, the strategic risk management arrangements are fit for purpose. The Health Board has, however, delayed its review of the risk management strategy to ensure roles and responsibilities align

to the Scheme of Reservation and Delegation being updated in November 2018. Risk management is core to the operation of the Board, and the board appropriately delegates accountability for oversight of corporate risks to the relevant committees. The committees then actively review those risks and summarise the risks, assurances received and the sufficiency of that assurance in their committee annual reports. The Health Board recognises it needs to focus more on risk appetite and is undertaking a development session on this in December. It should be noted that a review of the operation of risk management arrangements within divisions and teams was beyond the scope of our structured assessment work.

Embedding a sound system of assurance

27   We also examined whether the Health Board has an effective system of internal control to support board assurance. We found that **while formal internal controls are in place, there needs to be stronger accountability for the delivery of financial, performance and service change plans within divisions**.

28   Our work has identified that Standing Orders are up to date, while the Scheme of Reservation and Delegation will be revised in November 2018 to reflect changes in accountability at an executive level. The Standing Financial Instructions follow the 2016 all-Wales model and will be updated in line with ongoing national work.

29   There has been good work on the Register of Interest, Gifts and Hospitality which has seen strengthening of management controls and embedding the use of an electronic system to record and monitor declarations. This has resulted in better compliance compared to 12 months ago. The Audit Committee has reviewed both the Register of Interests and Declarations of Gifts and Hospitality and continues to focus on these and associated policies, particularly where exceptions have been reported.

30   We considered the work of Internal Audit, the Local Counter Fraud service and the Post-Payment Verification team[3]. We found a well-focussed programme of work for each, with sufficient resources for delivery, and effective approaches for reporting assurances or concerns. We also considered the progress made in addressing our recommendation on clinical audit. However, our work indicates that the approach for local clinical audit planning has not significantly improved, and the resulting assurance reporting arrangements are limited. There remains much opportunity to utilise local clinical audit to provide key assurances on the Health Board's priority quality aims and risks (Recommendation 9, 2017).

31   The Health Board continues to strengthen its quality governance arrangements. The Health Board's harms quality dashboard is now providing a stronger focus on specific aspects of possible harm and it enables triangulation between indicators to understand possible patterns and trends. The Health Board is also in the process of introducing ward-level whiteboards to provide staff and patients with quality information related to ward performance. Our interviews indicate that operational quality and safety groups are improving, and there is now a better flow of risks, issues and assurance from these groups into the executive level Quality and Safety Group, and then into the Quality and Safety Committee. **Putting Things Right** processes and complaints response arrangements are slowly

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[3] Link to more information on post-payment verification: http://www.primarycareservices.wales.nhs.uk/ppv

improving, but there is more to do to ensure timeliness of response and ensure lessons are learnt and applied across operational services and sites (Recommendations 4 and 5, 2016). This has been a longstanding area that we have been concerned about since 2016 and further improvement is needed. Performance against many of the Health Board's quality indicators is broadly the same as it was 12 months ago, but some improvements to healthcare associated infection rates are evident and now need to be sustained and built upon. We compared the latest available data on quality (August 2018) with the same period for last year. Acknowledging there are fluctuations throughout the year, there has been improvement in C. Difficile rates, MRSA rates and MRSA and MSSA cases reported in month. However, the incidence of healthcare-acquired pressure ulcers has increased slightly and requires a greater focus.

32   We reviewed performance management arrangements. While there is a clear, logical and formal approach for performance management, it has not resulted in the required improvements in performance. We heard frequently during interviews and identified in our board and committee observations some opportunities to strengthen performance accountability and focus more on the timeliness and impact of remedial action for poor performance. We also considered the breadth of performance information provided to Board and Committees. We agree with the Board's own assessment that the formats of performance reports make it hard to focus on the priorities. The Health Board is now in the process of reviewing its performance management arrangements and reports for the Board and committees. The full Board reviewed the developing arrangements at its development day in October 2018. We also note the move of the performance team into the portfolio of the new Director of Planning and Performance. The full Board reviewed the developing arrangements at a workshop in October 2018. This move should enable a stronger focus that brings together service planning and its impact on operational performance. We further describe performance against some specific national indicators later in the report.

33   The Health Board has now embedded its process for tracking Internal Audit and External Audit recommendations and reporting actions to the Audit Committee. Its monitoring system allows the progress against target deadlines to be reported. Where progress is not sufficient, the system issues automated reminders to officers. The approach is providing an improved understanding on progress against recommendations and has enabled the Audit Committee to challenge senior management where progress is not sufficient. There may be opportunity to utilise this system to co-ordinate the action in response to other inspections and external reviews such as Healthcare Inspectorate Wales and Ombudsman reports. This approach would help support delivery of recommendation 10 of the recent Ockenden review on Tawel Fan and could provide additional assurance into the Quality and Safety Committee.

34   Information governance arrangements are being further strengthened, with the Health Board taking a proactive approach to preparing and responding to the requirements of the General Data Protection Regulations (GDPR). However, more work is needed to fully complete information asset registers, improve staff training rates and update required policies and procedures to achieve full compliance. Staff compliance with the mandatory national information governance training programme can be improved from the current 79% towards the target compliance rate of 95%. The Health Board invited the Information Commissioner's Office (ICO) to undertake a review of its data protection arrangements. This review provided reasonable assurance over governance and accountability for data protection arrangements and records management. However, the ICO reported a limited

assurance assessment on personal data access, and work is in progress to address these recommendations.

35   The Health Board has had an external cybersecurity assessment which identified improvement actions. The Health Board is also responding to these recommendations and in doing so updating security patches and replacing unsupported software and hardware. Cybersecurity arrangements and resourcing are being strengthened by establishing a specialist team to bolster resilience and incident response plans. The Health Board needs to ensure that its ICT disaster recovery plans are updated for recent changes to the ICT infrastructure.

Ensuring organisational design supports effective governance

36   We looked at how the Health Board organises itself to deliver strategic objectives collectively while ensuring clear lines of accountability for delivery. We found that **gaps in management capacity have limited the extent and pace of improvement, particularly in secondary care, but changes to executive roles and lines of accountability create a better spread of responsibilities across the executive team**.

37   The Health Board has not made significant changes to its overall operational structure since our last review. However, there are changes to lines of accountability at an executive level including:

- removing the role of Chief Operating Officer, and redistributing those responsibilities amongst the executive team;
- **re**-establishing the role of **Executive** Director of Primary and Community Care;
- responsibility for the secondary care division resting with the **Executive** Director of Nursing; and
- movement of the performance team to the **newly appointed Executive** Director of Planning and Performance.

38   These revised arrangements should help to provide a better spread of responsibility amongst the Executive Directors. The Health Board should keep these arrangements under review to ensure that executive officers maximise their collective and individual contribution.

39   We highlighted in previous years' work concerns about capacity within services and the ability to secure improvements and service change. The Health Board, with the financial support of the Welsh Government, is strengthening the management capacity in its Secondary Care Division (Recommendation 10c, 2017). In addition to speciality-based operational managers, a clinical, nursing and management triumvirate has been added, focused solely on emergency and urgent-care access. Those arrangements should help strengthen well-needed clinical engagement, but this remains an ongoing challenge (more information on clinical engagement arrangements can be found in Appendix 1, Recommendation 10e, 2017). Overall, the new management positions should create a consistent structure across the acute hospital sites and the posts will be recruited to over the autumn. This should help provide the required capacity and capability to proactively drive service management and improvement.

Strategic planning

40 Our work examined how the Board engages partners and sets strategic direction for the organisation. We assessed how well the Health Board plans the delivery of its objectives, finances, workforce and other resources. We considered the extent that plans are sufficiently joined up, both externally and internally and if they are realistic and time bound. Finally, we wanted to know if the Health Board is monitoring progress with these plans effectively. We found that **while strategic planning arrangements are developing, these have yet to result in an approvable Integrated Medium Term Plan and the Health Board's approach to monitoring the delivery of its existing plans has not been strong enough.**

Setting the strategic direction

41 We looked at how the Board goes about setting its priorities having engaged with key stakeholders and whether agreed objectives are clearly defined in strategic plans. We found that **the Health Board's engagement approach continues to develop and inform strategy development but there is a need for greater clarity on the shape of services**.

42 The Health Board has a comprehensive engagement approach that both seeks feedback on strategic aims and priorities, and the shape of services. The Health Board has continued its public engagement approach[4], enabling the public to provide their views, volunteer, join a group and respond to specific surveys. For example, the Health Board is currently seeking feedback on outpatients' services. The Health Board's 2017-2019 engagement strategy identifies four public engagement aims. These focus on building public confidence in the Health Board and driving greater public and patient involvement. This work aligns to a special measures improvement requirement and the approach reflects the National Principles for Engagement produced by Participation Cymru. The Health Board has agreed to engage at individual service, locality area, and whole of north Wales levels. The aim of this is to focus effort, discussions and development of services on the most relevant area of the population and involve key stakeholders.

43 The Health Board agreed its 10-year 'Living Healthier Staying Well[5]' strategy in March 2018. It sets out a logical argument for change, highlights the Health Board's wellbeing objectives and recognises that the Health Board needs to focus more on outcomes. The strategy identifies three main programmes:

- Health Improvement and Health Inequalities
- Care Closer to Home
- Care for more serious health needs (in general, acute based services)

44 The Board has, through a number of development sessions, agreed its corporate objectives and has assessed the objectives and recognises that they are, in part, aligned to wellbeing goals. The strategy provides a high-level intent for the direction of travel for services, but it does not provide the detail on the shape of services. The Health Board will need to ensure greater clarity is arrived at during the 2019-2022 IMTP development.

[4] Betsi Cadwaladr UHB engagement website: https://www.bcugetinvolved.wales/

[5] 'Living Healthier Staying Well': https://www.bcugetinvolved.wales/lhsw

45   A continuing challenge the Health Board faces is aligning an organisational strategy to strategies of partner organisations at both a Health Board and sub-regional level. Our observations of the Board and committees, and findings from interviews indicate that the Health Board is putting more emphasis on partnership working and building relationships with key partners. the Health Board is strengthening its representation at partnership fora and has also appointed a second third-sector Independent Member.

Developing plans

46   We considered the Health Board's approach to developing its annual and medium-term plans, and whether the approach is underpinned by appropriate analyses of costs, resources and potential savings. We found that **whilst the Health Board has strengthened its planning approach, it has not yet been able to generate an approvable IMTP; it has the ambition to do this for the 2019-2022 IMTP round although this will present a significant challenge for the Health Board**.

47   Throughout 2017, the Health Board had a clear and agreed planning approach, which helped to co-ordinate plan development activity. This approach has helped to focus planning efforts, but it did not result in the Welsh Government approving the draft IMTP in 2018. In the absence of an approved IMTP, the Health Board has been working to an annual operating plan (Recommendation 6, 2016). It has, however, developed a three-year plan which positively sets a longer timeframe upon which services will change, in lieu of an IMTP. Whilst the Board endorsed the three-year plan in March 2018, it did not sign off the annual operating plan until July 2018, making delivery of it within the 2018-19 financial year challenging. Our review of the three-year plan and annual operating plan indicate that in general they contain too many objectives, priorities and actions, which makes it difficult to plan for delivery. The plan clearly identifies savings and which aspects are funded and unfunded (Recommendation 4 and 7, 2017). This clarity on funding is helpful, however, the plan does not indicate the implication for the Health Board where workstreams are unfunded, for example, a few health improvement and health inequalities initiatives.

48   At present, the Health Board still does not have an agreed clinical strategy. The Living Healthier Staying Well 10-year strategy provides a high-level framework, but this does not set out the preferred clinical models going forward in sufficient detail. Nevertheless, there are a growing number of clinical plans for individual services which are at various stages. These include:

- the Sub-Regional Neonatal Intensive Care Centre, which has now been implemented;
- centralising vascular services;
- development of orthopaedics plan and ophthalmology plans;
- proposals for hyper-acute stroke services; and
- intention to introduce robotic surgery for urology services.

While work is progressing, it is important that greater clarity is provided around the future models of specialist services. This clarity is needed if the medical and non-medical workforce, acute and community estate, technology and medical equipment requirements are to be effectively planned. We first highlighted the urgent need for an agreed clinical strategy to support the delivery of clinically and financially sustainable services in our 2013 joint review of governance arrangements with Healthcare Inspectorate Wales. The Health Board is aiming to provide greater detail on clinical models as part of the IMTP process for 2019/22.

49   Senior management indicated that sufficient central resource is available to support IMTP development. However, findings from our interviews highlighted opportunities to adopt a business partner model like that used by the finance department. The existing planning model is devolved and requires division and directorate engagement and ownership. In some divisions this has been reasonably successful but was more problematic where there have been changes to key management posts and where services have been under significant ongoing pressure and demand, such as secondary care.

50   The Health Board is now starting the IMTP development process for the period 2019-2022, building upon the existing population and service demand analysis. Preparation of an IMTP that is approvable by Welsh Ministers by the required deadline will clearly present a significant challenge for the Health Board. Our work this year indicates that there needs to be a better focus on a smaller set of core priorities, better grouping into deliverable service change programmes and clearer description of future service models and programme milestones. Moreover, the long-standing financial deficit is likely to create a significant risk to the approval of an IMTP.

51   The Health Board has had some additional funds to support its turnaround function (Recommendation 10b, 2017). These funds have been provided on a fixed two-year basis. The Director of Turnaround was appointed in April 2018 and is now in the process of developing the turnaround function, which will include the current programme management office, the improvement team and some additional temporary capacity if required. The turnaround function is currently focussed on financial recovery, but in our view will need to start to focus on transformation to enable sustainable service models.

Monitoring delivery of the strategic plan

52   Finally, we looked at whether progress with implementing current plans and supporting strategic change programmes is effectively monitored. We found that **arrangements to monitor delivery of the annual operating plan have not ensured effective delivery of it**.

53   As part of our review we considered the level of scrutiny and challenge on Annual Operating Plan (AOP) delivery as well as the content of the plans which are presented to the Strategy, Partnerships and Population Health Committee and the Board. Until recently, the central planning team presented progress against plans and was held to account by the Strategy, Partnerships and Population Health Committee. This did not ensure effective delivery of plans. Of the 615 actions in the 2017-18 annual operating plan only 56% were delivered, and as at the end of quarter 1 for 2018-19, only 51% of the 110 quarter 1 actions were delivered. This clearly demonstrates that existing monitoring and accountability approaches are not driving effective delivery of agreed plans. We have seen some improvement recently with the committee clearly highlighting concerns about pace of progress and also holding divisional management to account on their plan delivery responsibilities. However, the absence of formal tracking of delivery of the plan at Board level is a concern. The Health Board needs to ensure that the oversight of its overarching plan for delivery of improved and sustainable services and population health improvement is core to its business.

54   We also found that the content of the AOP progress reports do not enable effective monitoring. The plan progress reports are lengthy, and their content makes it hard to determine the consequence of non-delivery from last year on the current year's plan, on pace of change or whether intended benefits have been realised (Recommendation 10f, 2017). The central planning team is encouraging a stronger focus on the quality of business cases. This may provide clearer identification of desired

outcomes and, therefore, enable better monitoring of progress against expected outcomes and business benefits.

Wider arrangements that support the efficient, effective and economic use of resources

55   Efficient, effective and economical use of resources largely depends on the arrangements the organisation has for managing its workforce, its finances and other physical assets. In this section we comment on those arrangements, and on the action that the Health Board is taking to maximise efficiency and productivity. We also examine if the Health Board is procuring goods and services well.

56   We found that **the Health Board is continuing to experience significant challenges in managing its workforce, finances and physical assets, and it needs to develop a more transformational approach to improve service performance and efficiency.**

Managing the workforce

57   The workforce is the Health Board's biggest asset, not least because pay represents such a significant proportion of expenditure. It is important that the workforce is well managed and productive because staff are critical for day-to-day service delivery and for delivering efficiency savings and quality improvements. Our work identified that **new executive leadership and a commitment to develop a workforce strategy by the end of 2018 create an opportunity to address a number of existing and challenging workforce issues.**

58   The following table shows how the Health Board is performing in relation to some key measures compared with the Wales average.

Exhibit 1: performance against key workforce measures, July 2018[6]

Workforce measures	Health Board	Wales average
Sickness absence	4.9%	5.3%
Turnover	8.7%[7]	6.9%
Vacancy	2.7%	2.6%
Appraisals	66%	67%
Statutory and mandatory training	85%	73%

Source: NHS Wales Workforce Dashboard, Health Education and Improvement Wales

[6] Sickness: rolling 12-month average at July 2018; Turnover (Excluding Medical and Dental): 12-month period July 2017 to June 2018; Vacancy: advertised during July 2018; Appraisal: preceding 12 months; Statutory and mandatory training: at July 2018.

[7] This staff turnover figure includes Medical and Dental trainees. Health Board data for the month of July 2018 indicates an 8.1% turnover rate excluding Medical and Dental trainees.

59   Exhibit 1 shows that the Health Board's performance is better than average on sickness absence and statutory training, but unplanned staff turnover is a problem. This is a particular concern for medical and dental staff whose turnover rate is over 10%, and recruitment and retention remain a significant challenge across some acute specialties, primary care and nursing. At present, this is resulting in high temporary staff usage which, although reducing remains a significant challenge for the Health Board.

60   Resources to support recruitment have improved slightly (Recommendation 11b, 2017), with some additional temporary recruitment officers in place until December 2018. We understand that this has started to help co-ordinate effort and create better and more appealing offers to potential applicants for hard-to-fill places such as training or research opportunities, or exposure to different clinical case-mix. The Health Board has continued with its ongoing Train.Work.Live.[8] recruitment approach to help attract staff to North Wales. In addition, the project search[9], and step-into-work initiatives continue to enable work experience placements. In many instances, these lead to recruitment into positions where candidates may otherwise have had difficulty gaining these opportunities. The Health Board has developed a new retention process which involves staff interviews once they have notified their intention to leave. This approach might mean some of these staff are retained and should enable lessons to be learnt and applied to help reduce the turnover rate.

61   A continuing challenge is securing medical and other health professional training placements in North Wales. This has led to a lack of potential candidates coming through formal training routes which then translates into shortages of candidates for permanent substantive posts. The Health Board needs to develop solutions for the short, medium and long-term and work strategically with Healthcare Education Improvement Wales, and key partners in south Wales, within the north Wales region and with the north-West of England (Recommendation 11a, 2017).

62   The Health Board has put arrangements in place to meet the requirements of the Nurse Staffing (Wales) Act 2016, but there remain ongoing challenges to ensuring sufficient levels of nurse staffing, because of shortfalls of available staff and increased service demand. The Act, however, has provided a positive standard which senior nursing management are using to prioritise the quality of care.

63   The Health Board has undertaken a training needs survey and analysis at middle/senior management level. The analysis identifies the top 20 development needs (ranked) as well as the development/training delivery methods. These include the Proud to Lead framework including senior leadership masterclasses, modular workshops, active learning sets, coaching and mentoring, executive cohort sponsorship and post programme review (Recommendation 12, 2017). The training needs have been translated into a work programme delivered in co-operation with private-sector providers and education institutes such as Coleg Cambria and locally co-ordinated programmes in Conwy Business Centre.

64   Our work indicates that consultant job planning is progressing reasonably well across the organisation, and central support arrangements have enabled an improvement from 40% to 61% in nine months, albeit some sites are performing better than others. There is more to do to:

- address the variation in compliance and to strengthen overall compliance (80% or above); and
- use consultant job planning at a team level to enable service modernisation and efficiency.

[8] Train work live: https://www.trainworklivenorthwales.co.uk/

[9] Project search: http://www.wales.nhs.uk/sitesplus/861/news/49548

65   Staff engagement development is ongoing and some of the successes in the Health Board include the Seren Betsi monthly award[10] and the annual staff awards ceremony. The 2016-2018 staff engagement strategy focussed on several areas including staff engagement, Proud to Lead leadership development and involvement in locally developed 'discover, debate and deliver' exercises. In addition to the biennial NHS staff survey, the Health Board is starting quarterly staff surveys in the autumn on a rolling basis in different parts of the organisation (Recommendation 5, 2016). The 2018 NHS staff survey indicates that there has been a continued improvement in 2018 from the 2013 and 2016 NHS staff surveys. Improvements include the measure on overall staff engagement, staff advocacy and recommendation and ability to contribute toward improvements at work. There are some areas where the Health Board also needs to focus on, including work-related stress, bullying and harassment from patients, and the need for the Executive to communicate a clear vision. The Health Board has set out a clear timescale for the next three months to develop improvement plans.

66   The workforce department has a newly appointed Executive Director of Workforce and OD, replacing interim management arrangements. With the appointment has come greater clarity on the function and structure of the workforce teams, how they operate, work together and on departmental priorities. The new structure should bring together approaches for developing and managing the temporary workforce. There is currently no workforce strategy in place, but the department is working to prepare this by December 2018, to inform the 2019-2022 IMTP. We understand it will be supported by an establishment review and workforce modelling and service planning where possible (Recommendation 10d, 2017).

Managing the finances

67   We considered financial and budget management, financial controls, and operational support and processes. We found that **whilst aspects of financial governance and management are improving, the Health Board is projecting a significant year-end deficit and is still some way from being able to reach a position of financial balance.**

68   The Health Board's financial position remains a significant and long-term challenge. For the year 2017-18, the Health Board reported a £38.8 million deficit against the revenue resource limit, and for 2018-19 it is predicting a £35 million deficit after taking account of a planned £45 million in savings and efficiencies. In the absence of an IMTP with clear workforce and service models, the Health Board does not currently have a financial strategy, and its financial plans do not take a long enough view to help focus on recurring efficiencies or creating economy through transformation of services. Without a viable financial plan for the next three years it is unlikely that a 2019-2022 IMTP will be approvable.

69   Our annual accounts work has consistently identified that the Health Board has adequate budgetary financial management and control arrangements. The controls are designed to ensure clear lines of delegated budgetary responsibility, ensure accuracy of operational financial reporting, drive compliance to required financial standards and legislation. However, we are not yet clear that there is sufficient financial accountability in place and, irrespective of the control arrangements in place, the Health Board continues to overspend against its allocation.

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[10] Seren Betsi: http://www.wales.nhs.uk/sitesplus/861/page/92953

70   Over the past 12 months, the finance team has continued to support budget holders through financial business partners, training and financial information. In addition, the finance team alongside the newly developing turnaround function and programme management office has adopted an improving approach to help strengthen financial savings arrangements (Recommendation 3, 2017). There were clearer savings plans earlier in the 2018-19 year than in previous years, but unplanned cost growth driven by demand for unscheduled care and mental health care packages during the year remains a challenge. This growth places greater pressure on saving schemes to recover the financial position. All savings schemes are subject to quality impact assessments which are signed off by the clinical executives (Recommendation 5, 2017). We understand that the impact assessments are highlighted to the Quality, Safety and Experience Committee where the process identifies a concern regarding quality, although we have not undertaken specific work to assess the robustness of these arrangements.

71   The Health Board has strengthened its use of its project management system, which helps track and manage savings schemes. This has helped to free the capacity of the Programme Management Office to start to focus more on efficiencies which should become more prominent for the next financial year. However, current savings approaches continue to rely on schemes focussed within the 12-month period and are weighted towards the back end of the year. (Recommendation 1, 2017). The Health Board needs to focus more and earlier on recurring savings and clinical productivity. We comment more on this issue later in this report.

72   Financial reporting to the Finance and Performance Committee has improved, with information that better highlights pockets of concern. The Committee's turnaround report is starting to extend the focus and intent beyond short-term cost controls and towards efficiencies. Turnaround arrangements include divisional monitoring and weekly accountability meetings and escalation processes. Over the coming months, the Health Board should reflect on the effectiveness of these arrangements to ensure they are impactful (Recommendation 6, 2017).

73   The Health Board's procurement arrangements are largely devolved to the NHS Wales Shared Services Partnership. There is an all-Wales Procurement Strategy, and this is underpinned by an all-Wales business plan. There is an overarching service level agreement between the Shared Services Partnership and the Health Board, but we understand the Health Board does not use it proactively to manage the 'contractual' relationship. We understand that the Health Board has good day-to-day relationships with the procurement service, focused on operational procurement and procurement cost reduction. However, it could adopt a more strategic approach to use procurement to help deliver wellbeing of future generation objectives and focus more on assets coming to end of life and better overall long-term value. This approach may require a richer skill mix and higher resource in the procurement team and/or an enhanced contribution and role by the finance department.

Improving performance, efficiency and productivity

74   We looked at what the organisation is doing to improve performance, efficiency and productivity. We found that: **the Health Board is not delivering against key access targets and service productivity and efficiency needs to be improved.**

75   The Health Board has had a challenging year, and **while some performance metrics have improved, meeting waiting-time targets, particularly for time spent in emergency departments, remains a significant challenge**. The Health Board is failing to deliver against its four-hour emergency department waiting-time target, having recorded a significant deterioration over the summer. Combined emergency department and minor injury unit performance as at October 2018 is 70.6% of patients seen within four hours, with the greatest pressure being felt in Ysbyty Maelor and Ysbyty Glan Clwyd whose performance is 54.1% and 58.5% respectively. This indicates both the overall extent of demand, and also the capacity and efficiency of the wider unscheduled care system and in-hospital patient flow.

76   The Health Board's own analysis indicates seasonal peaks during the summer at two sites. We understand that this seasonal effect is proportionately higher than other major health boards in Wales. While the overall emergency department attendance rate is slightly lower in winter than in the summer[11], it is likely that the acuity of patients may be greater over that period. This suggests that summer and winter unscheduled care plans need to be shaped according to patterns of attendance, for example, trauma or medical presentation, frailty, disease, and time of demand. The Board is now making unscheduled care its key priority. It has already invested some significant resource to address immediate performance concerns, and remodel services to achieve better patient flow and community-based services.

77   With regards to scheduled care, there has been improvement in comparison to last year with a small reduction in 26 and 36-week referral-to-treatment wait target breaches. This improvement has been supported by additional funding from the Welsh Government. However, the impact of that funding has not been as significant as was planned and may result in some financial claw-back if agreed target performance is not met.

78   Follow-up outpatients are a growing concern for the Health Board. The number of follow-up outpatients with a delayed appointment increased from 70,530 in August 2017 to 85,164 in August 2018. Welsh Patient Administration System (WPAS) system implementation issues are partly responsible for the increase in delays, but the extent of the increase is a concern. Over the last 12 months, we have also seen some deterioration in urgent suspected cancer performance, but some improvement in relation to GP out-of-hours access and stroke performance measures.

Productivity and efficiency

79   Our work this year has considered the Health Board's efficiency and productivity arrangements. Our findings indicate that **the Health Board actively engages in benchmarking exercises and clubs to identify areas where there are inefficiencies, but it needs to become better at securing improvements in efficiency and productivity**. This work is supported by benchmark costing undertaken by a costing team in the finance department, and performance analysis of productivity and efficiency by the central performance and improvement teams. The Health Board has good and improving information on efficiency and productivity. However, there is less clarity on the extent to

[11] StatsWales data on the Health Board's unscheduled care activity can be found at the following link https://statswales.gov.wales/v/Elaf

which this intelligence is being used to target savings, service change, productivity improvements and clinical decision making.

80   As part of our review, we considered information from NHS benchmarking and compared them to the benchmark group and all-Wales average. They indicate that generally:

- day-case rates are better than average;
- day-of-surgery admission rates are better than average; but
- average lengths of stay are higher than average.

81   We also considered the Health Board's surgical productivity benchmarking approach. Their ATOM tool provides a good mechanism to support service planning and determine inefficiencies. It has the potential to inform discussion on continuous improvement with clinicians. The tool provides a forecast of session activity and productivity plans against 'best in class'. At present the Health Board plans many of its sessions at below the best in class rates, and the actual productivity is between 5% and 10% short of those plans. This indicates that for some surgical specialties, there remains room for improvement in productivity.

82   The Health Board recognises its need to make efficiencies and has a number of workstreams to improve efficiency which should deliver both cash and non-cash savings. These include:

- theatre efficiency;
- reduction in length of stay, hospital-initiated cancellations and 'did not attends';
- community hospital length of stay and improving acute to community flow;
- primary-care clinical variation, focussing on inappropriate primary-care referrals;
- secondary-care clinical variation, although that workstream does not appear to sufficiently focus on productivity.

83   At present, these approaches are not having the desired effect in terms of delivering cashable efficiencies. The Health Board needs to continue to pursue where opportunities are the greatest and where this helps support financially sustainable services in the longer term.

84   Some of these efficiencies can be achieved through better operational management focus and processes. But, the greatest potential for improvement will be through effective clinically led innovation, clinical decision making, clinical productivity and prudent and value-based service models. A Value Steering Group has been created which includes executive team leadership and a range of appropriate members. The committee has agreed to focus on CT Colonoscopy and Diabetes, seeking to make changes which demonstrate improved outcomes and better value. The Health Board should then be able to use these demonstrator projects to support and encourage improvement (Recommendation 2, 2017).

Use of informatics to support service delivery

85   We assessed the Health Board's arrangements to utilise technology to support service delivery. Our work identified that **there is a good strategic approach in the informatics service, but this will require focussed investment and there also needs to be stronger oversight on the effect of national system risks on the Health Board.**

86   The Health Board has an agreed five-year informatics strategic outline programme. This was first produced and agreed in late 2016. It is currently being redrafted and reprioritised in line with Health

Board priorities and budget availability. The work of the informatics department has been overseen by the Finance and Performance Committee over the past 12 months but will soon be overseen by the new Information Governance and Informatics Committee. Overall informatics resources were increased in 2017-18 and the new server rooms at the Wrexham Maelor and Glan Clwyd sites are a positive investment. However, there remain several risks relating to medical records storage, and delays in national systems. For example, the national roll-out of the Welsh Community Care Information System has been delayed and this presents a lost opportunity, because of the lack of reliable community-based service and productivity information.

87   There are several positive local initiatives and pilot projects that use technology to support patient-flow improvement, digital dictation and tele-health. At present we believe the informatics department is well managed but continues to be resource constrained (Recommendations 10d and 13, 2017). This may limit the extent to which ICT can support service change through enabling digital technologies and may also present business continuity and resilience risks because of ageing ICT infrastructure.

Managing the estate and other physical assets

88   Finally, we considered how the estate and physical assets are managed. We found that **within a context of a large legacy estate and asset base and limited discretionary capital, day-to-day administration and maintenance of assets are managed reasonably well, but there is a need for a more strategic approach**.

89   We found the Health Board has no overarching asset or estate-management strategy. Instead it has a comprehensive asset register that identifies the scale and cost of replacement. The Health Board applies a risk-management approach, overseen by an asset-management group. This arrangement helps to prioritise the limited discretionary capital allocation across estate, ICT infrastructure, medical equipment and other related assets. The Health Board flexes and responds to new priorities, for example, where urgent and unexpected health and safety risks occur, or there is unexpected equipment failure. We understand that this results in some aspects of previously planned investments being postponed. We also found:

- clear lines of accountability for managing the estate and physical assets;
- improving capital project and expenditure reporting into the Finance and Performance Committee; and
- ongoing work to update and ensure corporate policies and processes for managing asset and estate are fit for purpose.

90   There have been a number of major capital projects funded through an application process in which business cases are submitted to the Welsh Government for scrutiny. Our interviews indicated the capability to prepare large or complex capital business cases is generally good. However, the capability within divisions to prepare small to medium-sized business cases is not sufficient, and bids often result in refusal of the application. We also heard that the capital and revenue analyses which support small to medium-sized business cases were, in general, not good enough. It may be that some proposals are sound, although not sufficiently rigorous to be successful. In this case, it would be helpful for the Health Board to continue to develop such proposals (Recommendation 10a, 2017).

91   The Health Board has a large legacy estate and asset base, and while some of this is relatively new or recently refurbished, there remains a significant backlog maintenance requirement. High-risk estate

backlog maintenance is currently £49 million. We heard that some parts of the current estate are, in some circumstances, unlikely to support new service models and promote efficient ways of working, and it will be difficult to bring to the required environmental standards. The Health Board has committed to develop an estates strategy to support the IMTP, and it should look to disinvest where existing assets and estates do not provide good public value for money, and alongside this determine the opportunity for more significant capital schemes.

Recommendations

92   The areas for improvement and further development identified in this year's Structured Assessment are already either covered by recommendations from previous years' Structured Assessment work, or form part of ongoing improvement activity by the Health Board. We therefore do not intend to include a further lengthy list of recommendations in this report. However, it is important that the Health Board tackles our recommendations from previous years' work with sufficient pace and grip. We have made one further recommendation below in relation to this.

Exhibit 2: 2018 recommendation

2018 recommendation
R1   We recommend that the Health Board sets a clear target for implementation of each of the outstanding recommendations from our previous structured assessments. As a minimum, these targets should ensure that all outstanding recommendations are implemented by the end of December 2019. In doing this, the Health Board should ensure that specific priority is given to: • change management arrangements, including programme management and monitoring; • strengthening performance and financial accountability; and • continued rollout of quality improvement initiatives.

Appendix 1

Progress implementing previous recommendations

Exhibit 3: actions in response to 2017 and outstanding previous recommendations

Recommendation	Action taken in response	Progress
2016 structured assessment recommendations		
R2 The Health Board should build upon its assurance mapping work and work towards a board assurance map to complement the corporate risk register, and ultimately the IMTP.	The Health Board has now shaped its overarching board assurance arrangements. During 2018, officers developed a board assurance map as part of a board assurance framework which was presented at Audit Committee. The pace of preparing this has been limited by not having an agreed IMTP that contains clear priorities. The board assurance map needs to be aligned to the key priorities of the Health Board as part of the 2019-2022 planning round. There has also been innovative work to develop and start to implement a legislation assurance framework.	In progress
Learning lessons		
R4a The Health Board should look at further steps to improve clinical leadership and ownership of Putting Things Right processes, to support the improvement needed in response times and learning from complaints, incidents and claims.	The Health Board has made good progress with developing stronger quality assurance arrangements and leadership. There is a multi-strand approach to quality improvement, and stronger arrangements for putting things right. A number of metrics have improved since 2016, and we are aware of a better focus on the quality of response to complaints. We are also aware that there are improved approaches to reviewing serious incidents on a weekly basis.	In progress
R4b The Health Board should strengthen its processes for systematically reporting, cascading and implementing lessons learnt.	The Health Board needs to continue to strengthen lessons learnt processes, how those lessons learnt are adopted across sites and teams, and demonstrate improvement.	In progress

Recommendation	Action taken in response	Progress
2016 structured assessment recommendations		
Culture R5 Work to support a positive and open culture from ward to board needs to expand beyond the most challenged teams to help the wider organisation understand and apply positive values and behaviours.	The Executive Director of Nursing and Midwifery and Medical Director are leading on quality improvement initiatives. This includes improving work on harms, mortality, leadership walkabouts, executive 'back to floor' days in July 2018 and progress with the 'harms quality dashboard' as mentioned above. Ward-based whiteboards, which include a range of metrics, will be implemented across all wards soon. Staff engagement has been ongoing, and the last 2016 staff engagement strategy will be refreshed to respond to the results of the recent NHS staff survey and align to the developing workforce strategy. The 2016 staff engagement strategy focussed on several areas including Proud to Lead leadership development and involvement in Discover, Debate and Deliver exercises. In addition to the biennial NHS staff survey, the Health Board is also undertaking quarterly staff surveys on a rolling basis in different parts of the organisation. While there is more to do, progress in arrangements is promising, and further progress on culture, behaviour and quality should be secured through respective quality improvement and workforce strategies.	Complete
Strategy and Planning R6 The Health Board must maintain focus on developing its strategy and plans to ensure it meets its own challenging timescales.	The Health Board has agreed its Living Healthier Staying Well strategy and has developed a three-year plan. More needs to be done to translate the strategic intent into clearly defined service models supported by deliverable programmes of change and improvement. However, as the requirement to develop an IMTP is set out by the Welsh Government in response to legislation, this recommendation is closed.	Closed

Recommendation		Action taken in response	Progress
2017 structured assessment recommendations			
R1	Embed a savings approach based on targeting savings at areas where benchmarking demonstrates inefficiencies, to deliver longer-term sustainability.	Benchmarking data was used to identify the Board's savings opportunities for 2018-19. These opportunities are being progressed under the turnaround programme. There remains more to do to target savings plans on productivity and efficiency improvements, as well as shifting to lower cost service models.	In progress
R2	Identify where longer-term and sustainable efficiencies can be achieved through service modernisation and application of approaches such as value-based healthcare, productivity improvements and invest to save	A Value Steering Group has been created which includes executive team leadership and a range of appropriate members. The group has agreed to focus on CT Colonoscopy and Diabetes. Progress is needed to make changes in these areas which improve outcomes and deliver better value. The Health Board should then be able to use these as demonstrator projects to support and encourage improvement.	In progress
R3	Ensure that budget holders receive the necessary specialist support from enablers such as the Programme Management Office, workforce, procurement and informatics teams.	Budget holders are supported by financial business partners, training, financial information. A review of Corporate Services will also be undertaken with a view to ensuring that the support provided to the organisation is appropriate.	In progress
R4	Ensure that financial savings assumptions are fully integrated into annual and medium-term plans so that savings efficiencies form part of service modernisation.	The financial savings identified for 2018-19 are reflected in the organisation's annual plan. Improvement areas such as theatres, length of stay and referral improvements are supporting operational delivery and performance requirements as well as financial improvement. The Health Board has indicated that as the IMTP is developed, the turnaround programme for 2019-2022 will be embedded to ensure that financial and service deliverables are aligned.	In progress
R5	Develop an approach for providing assurance to the relevant committee where delivery of savings schemes may affect service quality or performance.	All savings schemes are subject to quality impact assessments which are signed off by the clinical executives. Where this process identifies a concern regarding potential adverse quality impacts these will be escalated to the Quality, Safety and Experience Committee with appropriate reporting for assurance.	Complete

Recommendation		Action taken in response	Progress
2017 structured assessment recommendations			
R6	Further strengthen the corporate monitoring approach to ensure it supports and enables savings plans which are slipping, and encourages longer term savings and efficiency programmes.	Monitoring of savings progress at a divisional level is in place with escalation action as required. This is effected both by direct follow-up through the Director of Turnaround and Director of Finance with the divisional directors as part of turnaround arrangements. There continues to be a need, however, for a focus on longer-term and recurring efficiencies. The Health Board needs to strengthen these arrangements.	In progress
R7	Ensure that plans presented to the Board include costed options where applicable and contain sufficient information to indicate to the Board that they are affordable in the short, medium and long term.	There is generally better financial information within the plans agreed by the Board, and identification of key areas of the plan which are unfunded. This helps inform the Board on affordability when deciding to approve or not and will be critical as part of the 2019-2022 approval process. The clarity on affordability of plans will need to be increasingly strengthened over the coming year.	In progress
R8	Review the remit of the Finance and Performance Committee with particular consideration to breadth of current responsibilities.	The remit of the Finance and Performance Committee has now been reduced to enable a stronger focus on core aspects of turnaround and improvement.	Complete
R9	Build on the Health Board's programme of clinical audit to ensure it a) aligns with quality strategy priorities and risks; b) sets out patient/quality outcomes or impact as a requirement of audit planning to help it understand the value that clinical audit is contributing and c) informs the Quality, Safety and Experience Committee with clear and focussed assurance reports.	The Health Board has not significantly altered its clinical audit planning approach or strengthened its reporting to better provide targeted assurance into the Quality, Safety and Experience Committee.	Limited progress

Recommendation		Action taken in response	Progress
2017 structured assessment recommendations			
R10	Consolidate, strengthen and sufficiently resource the change-enabling capability of the organisation.	See component parts of the recommendation (below R10a to R10f).	
R10a	Ensure financial savings are embedded into change programmes and plans.	There is better identification of financial savings in the overall corporate plans, but at present there appears to be more to do to consistently identify savings within programmes, project plans and business cases.	In progress
R10b	Strengthen capacity and capability within centrally managed change programmes.	The Health Board has endorsed its approach to turnaround and supported investment in additional central resources to drive critical change and savings programmes. As part of this a formal programme management approach is being established with additional staff resources to bring a consistent methodology and discipline. Potential programmes of work will be assessed in terms of capacity and capability to deliver at inception to ensure optimal delivery.	In progress
R10c	Strengthen change enabling capability and capacity in divisions.	The Health Board has recognised the need to enhance managerial capacity and capability within divisions. Specific additional resource has been secured from Welsh Government to enhance capacity, particularly in secondary care. This will add capacity to focus on key change programmes as well as operational delivery. The Health Board has indicated that it has increased finance skills development, and we understand there is training commencing to support local change management capability.	In progress

Recommendation	Action taken in response	Progress
2017 structured assessment recommendations		
R10d Ensure workforce, informatics and other enabling resources are integral to change delivery arrangements.	Informatics have worked with the quality improvement team to develop a ward-level harms dashboard which provides real time information on the elements of harm reduction and quality improvement within the Quality Improvement Strategy. This real-time data is a prerequisite for quality improvement and is starting to have some impact. Informatics services are better engaging with services and have stronger clinical leadership to help shape informatics support for service change. Involvement with IMTP developments at a programme and project level, and the alignment of the informatics strategic outline plan should be priorities in the year ahead. We are also aware that the workforce team are more engaged on service modelling and design as part of this year's IMTP development, this will need to continue and contribute to the developing workforce strategy.	In progress

Recommendation	Action taken in response	Progress
2017 structured assessment recommendations		
R10e Ensure clinical engagement and leadership are integral elements within change programmes.	The Health Board has recognised its lack of clinical leadership within the Health Board both in terms of capacity and capability and has outlined several strands of work to improve arrangements. It has: • acted to strengthen structures and lines of accountability: – appointed a substantive Secondary Care Medical Director. Beneath this, secondary care clinical service leads have been appointed. – all clinical director roles in Mental Health services have now been appointed. – the newly appointed Director of Primary Care and Community Services is experienced in driving clinical transformation in primary and community settings and all primary-care cluster leads have been appointed. • developed and is delivering its internal leadership programme and extended this to all doctors. The Health Board is looking to Academi Wales for additional external training support. • involved and engaged clinicians: – driving strategy formation in vascular surgery, urology, ophthalmology, orthopaedics and stroke. – with the development of the unscheduled care 90-day plan. – in job planning, with more to do. – improving engagement in reduction of hospital-acquired infection. These new arrangements show a promising and concerted effort by the Health Board and will take time to develop and bed in.	In progress
R10f Strengthen accountability for progress against plans, including the annual operating plan and, when developed, the IMTP.	The Health Board still needs to strengthen accountability for delivery against plans, both in regards of progress against timescales and in terms of benefits realisation.	In progress

Recommendation	Action taken in response	Progress
2017 structured assessment recommendations		
R11a Work with educational partners, research partners and internal stakeholders to shape new job roles to increase the attractiveness of the job offer as part of clinical staff recruitment.	The Workforce and Organisational Development (WOD) team has good links with educational partners and continues to engage with them in respect of commissioning needs, working closely with nursing and other clinical colleagues. There are some good examples of working with the university sector, but more needs to be done to consolidate efforts and develop a more co-ordinated and strategic approach.	In progress
R11b Increase tactical recruitment capacity to support delivery of R11a.	Some additional temporary recruitment capacity was made available and continued to be funded to the end of the calendar year. The Health Board will need to review those arrangements, in line with existing operational recruitment needs, recruitment effectiveness, and workforce strategy.	In progress
R12 Strengthen middle and senior management skills to provide sufficient breadth of business and financial capability and to support succession planning.	The Health Board has undertaken training needs survey and analysis at middle/senior management level which has considered training needs by area and role. The analysis identifies the top 20 development needs (ranked) as well as the development/training delivery methods. The Proud to Lead framework includes senior leadership masterclasses, modular workshops, active learning sets, coaching and mentoring, executive cohort sponsorship and post programme review. Training needs have been translated into a work programme in co-operation with private-sector providers and education institutes such as Coleg Cambria and locally co-ordinated programmes in Conwy Business Centre.	Complete
R13 Increase investment in technology where this clearly will result in a greater level of returned cashable efficiencies or transformational economies.	Informatics have developed a strategic outline plan, which has received support from the Health Board, the Exec Team and Welsh Government. However, even though these developments could deliver significant cost reductions, the investment to implement them has not been to date available. This is being progressed with the Welsh Government through National Informatics Management Board (NIMB) and spend-to-save applications. The application for digital dictation has been successful. The framework for additional investment in technology is in place through engagement in planning an investment process, but the business case process and service engagement with the process (eg engagement with Digital Transformation Group) needs to improve to identify major technology investment.	In progress

Wales Audit Office Structured Assessment
Management Response January 2019

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By when	Position update regarding future monitoring arrangements
2016 structured assessment recommendations					
R2 The Health Board should build upon its assurance mapping work and work towards a board assurance map to complement the corporate risk register, and ultimately the IMTP.	The Health Board has now shaped its overarching board assurance arrangements. During 2018, officers developed a board assurance map as part of a board assurance framework which was presented at Audit Committee. The pace of preparing this has been limited by not having an agreed IMTP that contains clear priorities. The board assurance map will be aligned to the key priorities of the Health Board as part of the 2019-2022 planning round. There has also been innovative work to develop and start to implement a legislation assurance framework.	Whilst the original recommendation has been completed, there is work ongoing to refine the board assurance map template and ensure that is actively used to frame assurance requirements against organisational objectives in the three year plan once approved by the Board. This will in turn be used as a basis to develop the assurances and supporting information for management groups; committees and the Board	Grace Lewis-Parry	Closed The ongoing work will be embedded in operational practice with progress monitored by the Audit Committee.	Closed on TM – AC will receive an update in May 19 on the Board Assurance mapping with a view to presenting a revised Risk Management strategy and BAF and populated Assurance Map together with the CRR at the September meeting
Learning lessons R4a The Health Board should look at	The Health Board has made good progress with developing stronger quality assurance arrangements and	The Executive Director of Nursing and Midwifery has provided clinical and executive	Gill Harris	Closed	Closed on TM. No further

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By when	Position update regarding future monitoring arrangements
further steps to improve clinical leadership and ownership of Putting Things Right processes, to support the improvement needed in response times and learning from complaints, incidents and claims.	leadership with the executive Nurse Director taking on the leadership for Putting Things Right(PTR) in May 2017. There is a multi-strand approach to quality improvement, and stronger arrangements for putting things right including a better focus on the quality of response to complaints and a number of metrics which have improved since 2016, There are improved approaches to reviewing serious incidents on a weekly basis which are organisation wide . The Health Board is triangulating quality information and focussing on key areas.	leadership for PTR since 2017 . This has been further strengthened through the appointment of an associate director of quality assurance to provide continued support and drive to maintain improvements in response times and learning from patients experiences. There is now a clear process in place to identify where lessons learnt are applicable to other divisions and teams in the organisations and a process to share those lessons across teams.			actions required.
R4b The Health Board should strengthen its processes for systematically reporting, cascading and implementing lessons learnt.	Core data sets are provided monthly to the divisions for review and sharing of lessons learnt . Divisions then report back to the refreshed quality and safety group(QSG) lead by the Executive Nurse director for scrutiny . QSG provide an exception report to the	Whilst the original recommendation has been completed and there is clear evidence of systems being strengthened for reporting, cascading and implementing lessons learned, this work will continue to be refined and developed as an integral part of	Gill Harris	Closed The ongoing work will be embedded in operational practice with progress	Closed on TM (awaiting AC sign off). QSE Committee will as part of Cycle of Business receive x3 listing and

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By when	Position update regarding future monitoring arrangements
	quality safety and experience committee of the Board. This is underpinned by weekly incident review meetings chaired by the Associate director of quality assurance in which all divisions participate.	the ambition set out within the quality improvement strategy. This will be overseen by the Quality & Safety group and reported to the Quality, Safety & Experience Committee.		monitored by the Quality, Safety & Experience Committee.	learning reports per annum and x3 learning from incidents reports (at alternate meetings)

Recommendation	Action taken in response	Progress at January 2019	Executive Lead	By When	Position update regarding future monitoring arrangements
2017 structured assessment recommendations					
R1 Embed a savings approach based on targeting savings at areas where benchmarking demonstrates inefficiencies, to deliver longer-term sustainability.	Benchmarking data is used to identify the Board's savings opportunities. These opportunities are being progressed under the turnaround programme. This is an iterative process and there remains more to do to target savings plans on and ensure productivity and efficiency improvements, as well as shifting to lower cost service models.	This savings approach will be used to set the next three years savings targets as part of the 3 year plan. Benchmarking data shows there are significant savings opportunities in some parts of the organisation. This will be used to vary the savings targets based on those parts of the business with greatest inefficiency and opportunity for cashable efficiency, thus different parts of the organisation will have different percentage saving targets.	Russ Favager	March 2019	Added to TM for tracking.

Recommendation	Action taken in response	Progress at January 2019	Executive Lead	By When	Position update regarding future monitoring arrangements
R2	Identify where longer-term and sustainable efficiencies can be achieved through service modernisation and application of approaches such as value-based healthcare, productivity improvements and invest to save.	A Value Steering Group has been created which includes executive team leadership and a range of appropriate members. Consideration is given to benchmarked indicators of productivity and efficiency. Areas of work have been identified by the group which have informed future plans .A turn round function and PMO was established in 2018to drive through sustainable efficiencies whilst ensuring service improvement remains aligned to the corporate strategy. New Invest to save initiatives have been submitted to WG .If supported they will provide required income as an enabler to create cashable efficiency savings. Orate strategy.	Whilst the original recommendation has been completed, the Value Steering Group needs to continue to mature and identify areas of focus as part of the corporate strategy. The alignment of spend with outcomes to ensure best use of resources will continue to be a key strand of future programmes.	Russ Favager	Closed The Health Board will embed actions in financial strategy and plans and monitor through the Finance & Performance Committee.	Closed. Not tracked on TM. The core business at F&P Committee is looking at financial savings and plans to drive service transformation . This will be monitored through routine financial reporting.

	Recommendation	Action taken in response	Progress at January 2019	Executive Lead	By When	Position update regarding future monitoring arrangements
R3	Ensure that budget holders receive the necessary specialist support from enablers such as the Programme Management Office, workforce, procurement and informatics teams.	Budget holders are supported by business partners with the relevant expertise, enabling them to work smarter to deliver efficiencies afforded by technology changes and by using the appropriate skills mix. Budget holders are aware of the PMO expertise and function and the capacity they can access. Work is ongoing to ensure that there is clear guidance in place to support budget managers to establish savings plans in a timely manner	Budget holders will be aware of who the subject matter experts are for the individual disciplines and can then draw down on their expertise as necessary to enable transformation and improvement and to support their work to improve workflow and drive out inefficiency. This will ensure smarter ways of working and efficiencies afforded by changing technology and skill-mix models.	Russ Favager	Closed The ongoing work will be embedded in operational practice with progress monitored by the Finance & Performance Committee as part of the arrangements to monitor the progress of the three year/annual plan.	Closed. Not tracked on TM. F&P will continue to monitor the effectiveness of the arrangements to drive the delivery of savings.
R4	Ensure that financial savings assumptions are fully integrated into annual and medium-term plans so that savings efficiencies form part of service modernisation.	Financial savings identified are reflected in the organisation's three year plan.	The three year savings plans are contained within the Health Boards three year plan. Key improvement programmes are outlined in medium term and annual plans.	Russ Favager/ Mark Wilkinson	March 2019	Added to TM for tracking

	Recommendation	Action taken in response	Progress at January 2019	Executive Lead	By When	Position update regarding future monitoring arrangements
R6	Further strengthen the corporate monitoring approach to ensure it supports and enables savings plans which are slipping, and encourages longer term savings and efficiency programmes.	Operational management and Turnaround Functions have been enhanced using additional funds from Welsh Government. The PMO Management Group is Executive led and Chaired by the Chief Executive. Monitoring of cross cutting and Divisional savings divisional level is in place with divisions, including escalation action as required. This is effected both by direct follow-up through the Director of Turnaround and Executive Director of Finance with the divisional directors as part of Turnaround arrangements. Where necessary escalation meetings are held including the Chief Executive. The Health Board is strengthening arrangements to ensure longer term efficiencies.	A revised BCU accountability framework will be implemented to ensure that post holders are fully held to account for their savings schemes.	Russ Favager/ Geoff Lang/ Mark Wilkinson	Closed The ongoing work will be embedded in operational practice with progress monitored by the Finance & Performance Committee as part of the arrangements to monitor the progress of the three year/annual plan.	Closed. Not tracked on TM. The core business at F&P Committee is looking at financial savings and plans to drive service transformation. This will be monitored through routine financial reporting and progress of annual plan

	Recommendation	Action taken in response	Progress at January 2019	Executive Lead	By When	Position update regarding future monitoring arrangements
R7	Ensure that plans presented to the Board include costed options where applicable and contain sufficient information to indicate to the Board that they are affordable in the short, medium and long term.	Arrangements are in place to ensure that appropriate and sufficient financial information is contained within the plans submitted to the Board, including affordability, to aid decision making. Any plans which contain financial implications have been through the appropriate governance structures of the Health Board.	Appropriate governance arrangements are in place which ensure that options are costed and an affordability assessment is made and presented to the Board to enable a decision to be made. Work will continue to ensure that strategic service change proposals have been through the appropriate governance structures of the Health Board.	Russ Favager/Grace Lewis-Parry	Closed	Closed. Not tracked on TM. No requirement for ongoing monitoring

	Recommendation	Action taken in response	Progress at January 2019	Executive Lead	By When	Position update regarding future monitoring arrangements
R9	Build on the Health Board's programme of clinical audit to ensure it a) aligns with quality strategy priorities and risks; b) sets out patient/quality outcomes or impact as a requirement of audit planning to help it understand the value that clinical audit is contributing and c) informs the Quality, Safety and Experience Committee with clear and focussed assurance reports.	The Health Board has not significantly altered its clinical audit planning approach or strengthened its reporting to better provide targeted assurance into the Quality, Safety and Experience Committee.	There is a structured process for planning clinical audit which is based on analysis of clinical risk and aligned to organisation level Quality Improvement Strategy objectives. This will be overseen by the quality safety and experience committee and will include a formal approach for determining the level of assurance arising from the clinical audit as well as an explicit expectation that audits identify improvement actions aligned to the priorities set out in the Health Board's quality improvement strategy.	Adrian Thomas	September 2019	Added to TM for tracking

Recommendation		Action taken in response	Progress as at January 2019	Executive Lead	By When	Position update regarding future monitoring arrangements
2017 structured assessment recommendations						
R10	Consolidate, strengthen and sufficiently resource the change-enabling capability of the organisation.	See component parts of the recommendation (below R10a to R10f).				Not added to TM: Overarching Rec covers 10a-f
R10a	Ensure financial savings are embedded into change programmes and plans.	See R4	See R4	Russ Favager / Mark Wilkinson	March 2019	Added to TM for tracking
R10b	Strengthen capacity and capability within centrally managed change programmes.	The Health Board has endorsed its approach to turnaround and supported investment in additional central resources to drive critical change and savings programmes. As part of this a formal programme management approach is being established with additional staff resources to bring a consistent methodology and discipline. Potential programmes of work will be assessed in terms of capacity and capability to deliver at inception to ensure optimal delivery.	The programme office and turnaround function is fully appointed to, and this is resulting in allocated support for core organisation programmes and projects. Reporting of performance against programme delivery is in place and providing assurance to the Board .	Geoff Lang	May 2019	Added to TM for tracking

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By When	Position update regarding future monitoring arrangements
R10c Strengthen change enabling capability and capacity in divisions.	The Health Board has recognised the need to enhance managerial capacity and capability within divisions. Specific additional resource has been secured from Welsh Government to enhance capacity, particularly in secondary care. This will add capacity to focus on key change programmes as well as operational delivery. The Health Board has increased finance skills development, and there is training commencing to support local change management capability within operational teams .	The additional secondary care , PMO, and mental health posts supported by Welsh Government are fully appointed to. The impact of the additional capacity and access to training is reflected in positive improvements..	Mark Wilkinson /Sue Green/ Geoff Lang	December 2019	Added to TM for tracking

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By When	Position update regarding future monitoring arrangements
R10d Ensure workforce, informatics and other enabling resources are integral to change delivery arrangements.	Informatics have worked with the quality improvement team to develop a ward-level harms dashboard which provides real time information on the elements of harm reduction and quality improvement within the Quality Improvement Strategy. This real-time data is a prerequisite for quality improvement and is starting to have some impact. Informatics services are better engaging with services and have stronger clinical leadership to help shape informatics support for service change. Involvement with IMTP developments at a programme and project level, and the alignment of the informatics strategic outline plan should be priorities in the year ahead. The workforce team are more engaged in service modelling and design as part of this year's 3 Year Plan development, this will need to continue and contribute to the developing workforce strategy.	There are clear, approved and realistic workforce, informatics and estates plans that support and enable clinical and operational service improvements. The plans are approved and sufficiently resourced.	Mark Wilkinson	March 2019	Added to TM for tracking

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By when	Position update regarding future monitoring arrangements
2017 structured assessment recommendations					

R10e Ensure clinical engagement and leadership are integral elements within change programmes.	The Health Board has recognised its lack of clinical leadership within the Health Board both in terms of capacity and capability and has outlined several strands of work to improve arrangements. It has:
	
	• acted to strengthen structures and lines of accountability:
	  – appointed a substantive Secondary Care Medical Director. Beneath this, secondary care clinical service leads have been appointed.
	  – all clinical director roles in Mental Health services have now been appointed.
	  – the newly appointed Executive Director of Primary Care and Community Services is experienced in driving clinical transformation in primary and community settings and all primary-care cluster leads have been appointed.
	  – developed and is delivering its internal leadership programme and extended this to all doctors. The Health Board is looking to Academi Wales for additional external training support.
		Specialty (and/or sub-specialty) plans are developed and supported by clinical staff. Clinical leadership is helping to drive and inspire improvement, and continued clinical engagement will ensure plans are effectively delivered, reduce variation of practice and meet project timeframe and quality expectations. In 2019, these improvements will be demonstrated in 2-3 specialty service change plans.	Evan Moore	Closed
				
				The ongoing work will be embedded in operational practice with progress monitored as part of the arrangements to monitor the progress of the three year/annual plan.
					Closed. Not tracked on TM. SPPH and Board will oversee the developments of clinical services strategy and will monitor the robustness/ effectiveness of clinical engagement.

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By when	Position update regarding future monitoring arrangements
R10e continued	• involved and engaged clinicians: 　– driving strategy formation in vascular surgery, urology, ophthalmology, orthopaedics and stroke. 　– with the development of the unscheduled care 90-day plan. 　– in job planning, with more to do. 　– improving engagement in reduction of hospital-acquired infection. These new arrangements show a promising and concerted effort by the Health Board and will take time to develop and bed in.		Evan Moore		
R10f Strengthen accountability for progress against plans, including the annual operating plan and, when developed, the IMTP.	The Health Board is working to strengthen accountability for delivery against plans, both in regards of progress against timescales and in terms of benefits realisation. A revised performance and accountability framework is being finalised following detailed discussion and input from the Executive Team and the full Board.	The key principles in the revised performance and accountability framework will support the Health Board to deliver the strategy set out in the three year plan. It will ensure operational ownership of key priorities and clarity of expectation as to the level of performance expected. Revised arrangements will be put in place over the next 6 months and tested to ensure that they provide more robust and effective arrangements.	Mark Wilkinson	September 2019	Added to TM for tracking

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By when	Position update regarding future monitoring arrangements
2017 structured assessment recommendations					
R11a Work with educational partners, research partners and internal stakeholders to shape new job roles to increase the attractiveness of the job offer as part of clinical staff recruitment.	The Workforce and Organisational Development (WOD) team has good links with educational partners and continues to engage with them in respect of commissioning needs, working closely with nursing and other clinical colleagues. There are some good examples of working with the university sector, but more needs to be done to consolidate efforts and develop a more co-ordinated and strategic approach.	Work is underway to develop a clear integrated plan for education as well as new strategies for addressing recruitment challenges which are expected to lead to a reduced level of clinical vacancies in key specialities.	Sue Green	Closed The ongoing work will be embedded in the revised WOD structured with progress monitored as part of the arrangements for the three year/annual plan.	Closed. Not tracked on TM. Ongoing work will be overseen by SPPH and Board in line with commitments made in the Workforce Strategy which underpins the 3 year plan.

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By when	Position update regarding future monitoring arrangements
R11b Increase tactical recruitment capacity to support delivery of R11a.	Some additional temporary recruitment capacity was made available and continued to be funded to the end of the calendar year. The Health Board will need to review those arrangements, in line with existing operational recruitment needs, recruitment effectiveness, and workforce strategy.	New structure in WOD is being implemented and will incorporate "Resourcing" section This ensures that focussed recruitment initiatives increasingly result in successful appointments, particularly in hard to attract positions.	Sue Green	Closed The ongoing work will be embedded in the revised WOD structured with progress monitored as part of the arrangements for the three year/annual plan.	Closed. Not tracked on TM. Ongoing work will be overseen by SPPH and Board in line with commitments made in the Workforce Strategy which underpins the 3 year plan.

Recommendation	Action taken in response	Progress as at January 2019	Executive Lead	By when	Position update regarding future monitoring arrangements
R13 Increase investment in technology where this clearly will result in a greater level of returned cashable efficiencies or transformational economies.	Informatics have developed a strategic outline plan, which has received support from the Health Board, the Exec Team and Welsh Government. However, even though these developments could deliver significant cost reductions, the investment to implement them has not been to date available. This is being progressed with the Welsh Government through National Informatics Management Board (NIMB) and spend-to-save applications. The application for digital dictation has been successful. The framework for additional investment in technology is in place through engagement in planning an investment process, but the business case process and service engagement with the process (eg engagement with Digital Transformation Group) needs to improve to identify major technology investment.	There is a clear link between technology investment plans and expected savings as a result of that investment (ie it is treated as invest to save). Return on investment is assessed and achieved.	Evan Moore	Closed The ongoing work will be embedded in operational practice with progress monitored as part of the arrangements to monitor the progress of the three year/annual plan.	Closed. Not tracked on TM. The IGI Committee will oversee the implementation of the HBs Digital Strategy to drive the investments in technology.

Audit Committee	
14/3/19	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
	To Improve Health and Provide Excellent Care

Report Title:	**Audit Committee Workshop – 30th November 2018 – Update Report**
Report Author:	Dawn Sharp, Assistant Director and Deputy Board Secretary
Responsible Director:	Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Purpose of Report:	This report provides an update on the feedback and observations from the Audit Committee Workshop held on 30th November 2018.
Approval / Scrutiny Route Prior to Presentation:	Board Secretary
Governance issues / risks:	As outlined in the report
Financial Implications:	None identified
Recommendation:	**That** **(1) the update be received and actions taken be endorsed; and** **(2) Members indicate whether there are any other topics they would wish to be included in the workshop on 14th May and whether there is a desire for a further workshop later in the year.**

Health Board's Well-being Objectives *(Indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper:

Leadership and Governance
http://www.wales.nhs.uk/sitesplus/861/page/81806

Equality Impact Assessment

No equality impact assessment was considered necessary for this paper

AUDIT COMMITTEE WORKSHOP – 30TH NOVEMBER 2018 – UPDATE REPORT

At the last meeting Members noted the suggestions put forward at the 30th November Workshop, as part of the discussions regarding Audit Committee effectiveness, some of which related to wider matters of governance and assurance. The Committee agreed for the Board Secretary to consider the feedback and report to the March meeting as appropriate.

The issues identified are set out in the table below with supporting narrative in terms of the actions taken:-

Suggestion/Issue identified	Action taken
More effective structuring of agenda to deal with papers for noting and possibly re-introduction of consent items.	Discussed and agreed by CBMG at its meeting on 10th January. Agenda continue to be refined in discussion with respective Chairs and Leads.
Committee self-assessment process – could be carried out as a continuous year round process, possibly using CBMG as the conduit.	Discussed and agreed by CBMG at its meeting on 10th January.
Forward planning – use of deep dive session at each meeting (avoiding cross over with any other deep dives already being undertaken e.g. Finance and Performance Committee).	This will be considered as the draft agenda stage for each meeting. Given the number of reports coming forward for the March meeting it was considered not appropriate to conduct a 'deep dive' session at this meeting.
Re-examining role of CBMG – potential for it to take on more of an integrated governance role	CBMG is now performing more of an integrated governance role and its terms of reference will be reviewed to formally incorporate this function as part of the next iteration of Board Committee Terms of Reference updates.
Quality of reports, timeliness and holding Executive to account	This is an ongoing iterative process. All Directors and authors have been informed of the Board's expectations.
Re-examination of Care Home escalation arrangements	In May 2009, the Welsh Assembly Government issued statutory guidance surrounding escalating concerns with the closure of care homes that were registered with Care Inspectorate Wales (CIW) to provide services to adults, including those providing nursing care. It set out local authorities' and local health boards' and suggested ways in which these could be discharged, including the establishment of local/regional procedures.

	The Health Board, together with North Wales Local Authorities agreed that the management and assurance of quality services in line with contract agreements and arrangements in response to care home closures should have distinct and separate procedures. The North Wales Social Care and Wellbeing Services Improvement Collaborative have reviewed the former North Wales Escalating Concerns and Home Closures Procedures (2015) and developed revised procedures which are due for ratification.
	These revised procedures focus on proactively assuring quality services (*for children, young people and adults*) and preventing (where possible) the need for care and support services entering into a formal concerns process. The procedure has been revised in light of Part 9 of the Social Services and Well-being (Wales) Act 2014, the Regulation & Inspection of Social Care (Wales) Act 2016 and the developing approach to integrated commissioning of care and support services.
	The Health Board and Local Authorities in North Wales feed into a live database that is held the CHC Corporate Team, and a monthly RAG report is produced monthly which details all Nursing Homes, Residential Homes and Independent Hospitals with concerns ensuring information is shared to area teams. The RAG report is presented monthly to the Complex Care and Commissioning Group and also is distributed to the North Wales Local Authorities and Area Nurse Directors.
Review of resources to support Contract Management team	The Finance Executive and Senior Management Team continually review its resources and support provided to all Divisions and Budget Areas across the Health Board. Over the last three years the Contracting Team has been strengthened at both senior and operational levels and more recently a joint Contracting post has been developed with the Specialist Commissioners (WHSSC) based in Mold. The resources required to support Contracting continue to be reviewed, both from within Finance but more importantly from across the Clinical teams within the Divisions.

Review Executive management governance and oversight arrangements to ensure appropriate escalation from Ward to Board.	A review of the executive governance arrangements is taking place in the light of the management restructuring and portfolio changes.

Members also suggested at the Workshop that additional workshops/training sessions could be held in year. The Audit Committee has a further workshop which will now be held on 14th May (changed from 16th May). This workshop is primarily to review the suite of other Committee Annual Reports in order to inform its own Annual Report. The session will also be used to review the Board Assurance Map and Framework document. Members are asked whether there are any other topics that they would wish to be included in the programme for the day and to indicate whether there is a desire for a further workshop later in the year.

RESOLVED: That

(1) the update be received and actions taken be endorsed; and

(2) Members indicate whether there are any other topics they would wish to be included in the workshop on 14th May and whether there is a desire for a further workshop later in the year.